

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER DOVE ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 102 DOVE ROAD CREEDMOOR, NC 27522		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 130	<p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure clients were afforded privacy. This affected 1 of 4 audit clients (#3). The findings is:</p> <p>During observation on 1/13/26, at 6:53 am client #3 use the bathroom with the door open.</p> <p>Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that client #3 needs verbal prompting to close the bathroom door.</p>	W 130			
W 454	<p>INFECTION CONTROL CFR(s): 483.470(l)(1)</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This potentially affected all clients living in the home (#1, #2, #3, #4, #5, and #6). The finding is:</p> <p>During morning observations in the home on 1/13/26 at 6:52am, client #3 was observed using the toilet. At 6:54am. client #3 exited the bathroom without washing her hands. Client #3 then proceed touch a variety of things around the</p>	W 454			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER DOVE ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 102 DOVE ROAD CREEDMOOR, NC 27522		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 454	Continued From page 1 living room (the table, the window blinds, the door to the medication room and the couch when she sat down). At 7:00am, client #3 was asked by Staff B to hold the water pitcher and six cups. Client #3 then followed Staff B to the medication room. At 7:02am, Staff B unlocked the door to the medication room and asked client #3 to hand her the pitcher of water and the cups. Staff B then asked client #3 to open up the door to the medication room, so they both could enter. At no time was client #3 prompted to wash or sanitize her hands. During an interview on 1/13/26 Staff B stated client #3 needs a verbal prompt to wash her hands after using the bathroom. During an interview on 1/13/26, the Home Manager stated staff should have went behind client #3 to ensure that her hands were washed after using the bathroom. During an interview on 1/13/26, the Qualified Intellectual Disabilities Professional (QIDP) stated client #3 needs a verbal or physical prompt to wash her hands after using the bathroom.	W 454			
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 1 of 4 audit clients (#6) received their specially	W 460			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER DOVE ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 102 DOVE ROAD CREEDMOOR, NC 27522		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 460	Continued From page 2 prescribed diet as indicated. The finding is: Observations in the facility on 1/12/26 during dinner at 5:30 pm revealed that client #6 was not offered her supplement boost after she refused to eat dinner. Record review on 1/13/26 of client #6 physician's orders dated 12/22/25 revealed give the supplement of choice if less than 50% of the meal is eaten for every breakfast and dinner. Interview on 1/13/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that client #6 should have receive her supplement boost.	W 460			
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food was served at the appropriate temperature. This potentially affected clients 3 of 6 clients residing in the home (#1, #3 and #5). The finding is: During breakfast observations in the home on 1/13/26 at 7:47am, Staff E removed the oatmeal from the heat of the stove. At 8:09am, client #3 began eating her oatmeal. Client #1 began eating her oatmeal at 8:16am and client #5 began eating her oatmeal at 8:18am. At no time was the oatmeal reheated, nor did Staff E check the temperature of the oatmeal. During an interview on 1/13/26, the Home Manger (HM) revealed the oatmeal should have	W 473			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER DOVE ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 102 DOVE ROAD CREEDMOOR, NC 27522		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 473	Continued From page 3 been reheated prior to clients #1, #3 and #5 began eating. During an interview on 1/13/26, the Qualified Intellectual Disabilities Professional (QIDP) stated the oatmeal can sit out for fifteen minutes, but needs to be reheated afterwards.	W 473			