STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD , ALBEMARLE, North Carolina, 28001**

(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
W0125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is NOT MET as evidenced by: Based on observations and interview, the facility failed to provide dignity and respect to 2 of 6 audited clients (#3 and #4) regarding incontinence pads. The findings are: A. The facility failed to ensure dignity and respect for client #3. For example, Observation in the group home on 3/25/26 at 6:50 AM revealed an incontinence pad visibly in client #3's recliner chair located in the living room. Further observation revealed that client #3 was the only client to utilize the rocker recliner chair with an incontinence pad placed in chair throughout the morning routine. Continued observations at 8:48 AM revealed staff to remove the incontinence pad and take it to the laundry room. Interview on 3/25/26 with staff A revealed that an incontinence pad was placed in client #3's chair to protect the furniture. Further interview with staff revealed that the chairs in the living room have furniture coverings that need to be placed back on the furniture. Interview on 3/25/26 with the qualified intellectual developmental professional (QIDP) revealed that staff should not be placing the incontinence pads on furniture. B. The facility failed to ensure dignity and respect for client #4. For example, Observation in the group home on 3/25/26 at 6:50 AM	W0125		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD , ALBEMARLE, North Carolina, 28001**

(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
W0125	Continued from page 1 revealed client #4 to sit in a living room chair with an activity book and an incontinence pad visibly in the client's chair. Further observation revealed that client #4 was the only client to utilize the chair next to the window in the living room during the morning observations. Continued observations revealed that staff were not observed at any time during the morning observations to remove the incontinence pad from the client's chair. Interview on 3/25/26 with staff A revealed that an incontinence pad was placed in client #4's chair to protect the furniture. Interview on 3/25/36 with the QIDP revealed that staff should not be placing the incontinence pads on the furniture.	W0125		
W0249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is NOT MET as evidenced by: Based on observations, record reviews, and interview, the facility failed to assure a continuous active treatment program identified as an individual need that was not implemented for 2 of 5 audited clients (#2 and #4) relative to prescribed adaptive equipment. The findings are: A. The facility failed to provide prescribed adaptive equipment to client #2. For example: Observations in the group home from 3/24-3/25/26 revealed client #2 to be provided with the following adaptive equipment for the dinner and breakfast meal which includes: High lipped plate, dycem mat, adaptive spoon, 4 oz. cups, and shirt protector. Further observations revealed that at no time during observations were staff observed to provide client #2 with prescribed scoop bowl, plate guard or high sided plate during meals. Review of records for client #2 on 3/25/26 revealed a person-centered plan (PCP) dated 11/10/25. Further	W0249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	1615-B MOSS SPRINGS ROAD , ALBEMARLE, North Carolina, 28001

(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
W0249	Continued from page 2 review of the PCP revealed nutritional report dated 11/13/25 that states the client needs adaptive equipment plate guard, or high side plate, adaptive spoon, scoop bowl, bib, and 4 oz. cups. Interview on 3/25/26 with the qualified intellectual disabilities professional (QIDP) confirmed that client #2's PCP was current. Further interview with the QIDP confirmed that staff should be providing the client with prescribed adaptive equipment. B. The facility failed to provide prescribed adaptive equipment for client #4. For example: Observations in the group home on 3 /24-3/25/26 revealed client #4 to be provided with the following adaptive equipment for the dinner and breakfast meal which includes: High lipped plate, dycem mat, built fork, built spoon, cup with lid and handle, wrist weights, and shirt protector. Further observations revealed that at no time during observations were staff observed to provide client #4 with his prescribed high sided sectional plate during meals. Continued observations on 3/25/26 revealed that staff did not assist the client to eat during the breakfast meal. Review of records for client #4 on 3/25/26 revealed a PCP dated 8/1/25. Further review of the PCP revealed nutritional report dated 11/11/25 that states the client needs adaptive feeding equipment which includes weighted utensils, non-skid place mat, high side sectional plate, bib, use cup with lid and handle, and wrist weights as necessary. It is noted that staff are to assist in feeding. Interview on 3/25/26 with the QIDP confirmed that client #4's PCP was current. Further interview with the QIDP confirmed that staff should provide adaptive equipment as prescribed and assist with feeding.	W0249		
W0368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 5 audited clients (#6) was administered her medication in compliance with the physician's orders (P.O.). The finding is:	W0368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	1615-B MOSS SPRINGS ROAD , ALBEMARLE, North Carolina, 28001

(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
W0368	Continued from page 3 Observation in the group home on 3/25/26 at 7:45 AM revealed client #6 to receive MiraLAX in a green cup with her breakfast meal. Further observations revealed the client to be consuming her breakfast meal. Continued observations at 8:01 AM revealed client #6 to knock over her cup containing her prescribed MiraLAX. Subsequent observation revealed staff cleaned the spill and the client finished consuming her breakfast meal. Review of records for client #6 on 3/25/26 revealed P.O.'s dated 2/1/26. Review of the 2/1/26 P.O.'s revealed that client #6 is prescribed Polyethylene Glycol Powder 238GM powder (Mira LAX) to mix 17 GM in 8 oz of water, juice, or tea to drink by mouth once daily. Interview with the facility nurse on 3/25/26 confirmed the 2/1/26 P.O.'s for client #6 to be current. Further interview with the facility nurse revealed that client #6 should be provided with her prescribed medications.	W0368		
W0474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is NOT MET as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve food in a form consistent with the developmental level of 2 of 5 audited clients (#5 and #6) in the facility. The findings are A. The facility failed to provide client #5 with prescribed diet. For example: Observations in the group home on 3/24/26 at 5:30 PM revealed client #5 to participate in the dinner meal which consisted of Sloppy Joe sandwich, sweet potato fries, Cole slaw, and pineapples. Further observations at revealed client #5 to consume his sandwich bun and sweet potato fries in whole consistency. Continued observations revealed that staff assisted the client to cut his second sandwich bun after it was half eaten. Subsequent observation revealed staff did not assist the client with his sweet potato fries to bite size consistency. Observations in the group home on 3/25/26 at 7:45 AM	W0474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD , ALBEMARLE, North Carolina, 28001**

(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
W0474	Continued from page 4 revealed client #5 to participate in the breakfast meal which consisted of cranberry juice, scrambled eggs, wheat toast with jelly and milk. Further observations revealed that at 8:00 AM staff A placed a half piece of toast on the client #5's plate, and the client put the whole piece in his mouth. Staff did not assist the client to provide his toast in a bite size consistency. Review of client #5's record on 3/25/26 revealed a Person-Centered Plan (PCP) dated 11/18/25. Review of the PCP revealed a nutritional report dated 10/21/25 for client #5 to be prescribed a regular diet, food cut into small bite size pieces, seconds as desired. The client feeds himself but needs to be monitored by staff and encouraged to not stuff food in his mouth. Interview with the qualified intellectual disabilities professional (QIDP) on 3/25/26 confirmed client #5's prescribed diet. Continued interview with the QIDP confirmed specially modified diets should be followed as prescribed. B. The facility failed to provide client #6 with prescribed diet. For example: Observations in the group home on 3/24/26 at 5:30 PM revealed client #6 to participate in the dinner meal which consisted of Sloppy Joe sandwich, sweet potato fries, Cole slaw, and pineapples. Further observations at revealed client #6 to consume her dinner meal in whole consistency. Continued observations revealed that staff did not assist the client to provide her sandwich and sweet potato fries in bite size consistency. Observations in the group home on 3/25/26 at 7:45 AM revealed client #6 to participate in the breakfast meal which consisted of cranberry juice, scrambled eggs, wheat toast with jelly and milk. Further observations revealed that at 8:01 AM staff A placed a half piece of toast on the client #6's plate, and the client put the whole piece in her mouth. Staff did not assist the client to provide her with toast in a bite size consistency Review of client #6's record on 3/25/26 revealed a PCP dated 12/6/25. Review of the PCP revealed a nutritional report dated 11/20/25 for client #6 to be prescribed a 1400 KCAL diet, staff to cut her food into bite size pieces, and she needs prompting to slow down.	W0474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G110	A. BUILDING B. WING	**03/25/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD , ALBEMARLE, North Carolina, 28001**

(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
W0474	Continued from page 5 Interview with the QIDP on 3/25/26 confirmed client #6's prescribed diet. Continued interview with the QIDP confirmed that the client should have been provided with her prescribed diet.	W0474		