

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER HEATH AVENUE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST HEATH AVE , SMITHFIELD, North Carolina, 27577	
(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
W0000	INITIAL COMMENTS A revisit was conducted on April 15, 2026 for all previous deficiencies cited on 2/10/26. Some deficiencies were corrected and one deficiency was recited. The facility remains out of compliance.	W0000		
W0382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is NOT MET as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were kept locked except when being prepared for administration. The finding is: During observations of medication administration in the home on 2/9/26 at 4:10pm surveyor followed medication technician 1 (MT1) and client #5 into the medication room to observe medication pass. Client #5's medication was laying on the counter unattended. MT1 administered client #5's medications and exited the medication room to retrieve another client, leaving the medication cabinet door and the door to the medication room unlocked. Interview on 2/10/26 with the nurse revealed all staff are instructed to lock the medication cabinet any time staff are not occupying the room. The nurse confirmed MT1 should have locked the cabinet when exiting to go and get other clients. The follow up survey completed on 4/15/26 revealed: Review on 4/15/26 of the facility's Plan of Correction (POC) dated 4/11/26 revealed the Qualified Intellectual Disabilities Professional (QIDP), home manager (HM) and nurse would ensure that all staff that had been trained for medication administration make certain that cabinet doors remain locked before exiting the medication room and an in-service training would be provided.	W0382		

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
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W0382	<p>Continued from page 1</p> <p>During observations in the home on 4/15/26 at approximately 6:40am, the surveyor noted the medication room to be unlocked and the key hanging from a lock on the cabinet in the medication room.</p> <p>Further observation on 4/15/26 at approximately 7:05am, the medication technician (MT) assisted client #5 to the med room. The MT opened an unlocked drawer, took out a set of keys and used those keys to unlock the medication cabinet. The MT pulled client #5's medication out of the cabinet, leaving the cabinet unlocked and placed the key on the counter. The MT then left the surveyor and client in the medication room to go obtain pudding. After client #5 consumed his medication, the MT then assisted the client back to the living room again leaving the medication cabinet opened and left the medications as well as the medication cabinet keys on the counter.</p> <p>Interview on 4/15/26 with the QIDP confirmed that the MT should have had the keys on her person at all times during her shift and should not have left the medication room until locking away medications and ensuring the cabinets that contain medications were locked. Therefore, the facility remains out of compliance.</p>	W0382		