STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNY LANE #1	2840 HWY 70 EAST , CLAREMONT, North Carolina, 28610

(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	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 interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the person-centered plan (PCP) and behavior support plan (BSP) for 2 of 4 audited clients (#1 and #3). The findings are: A. The facility failed to provide consistent interventions as identified in the BSP for client #1. For example: Observations at the group home on 4/7/26 from 3:45PM - 6:00 PM revealed client #1 to participate in formal and informal objectives, dinner meal and socializing with both staff and clients. Continued observations revealed client #1 to hug staff, clients and attempt to hug surveyor. Surveyor redirected client #1 to remind him of personal space and initiated fist bumps instead of a hug on several occasions. Further observations revealed clients and staff to exchange hugs with client #1. Subsequent observations revealed client #1 to get into proximity with other clients' and rub their heads and faces. Additional observations revealed staff to occasionally say to client #1 "personal space". Observations on 4/8/26 from 6:30AM – 9:00AM revealed client #1 to spend most of the time in his room, sitting at the dining table and the livingroom. Continued observations revealed client #1 to hug staff, clients and attempt to hug and kiss surveyor behind her head. Surveyor redirected client #1 to remind him of personal space and initiated fist bumps instead of a	W0249		

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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W0249	Continued from page 1 hug on several occasions. Further observations revealed clients and staff to exchange hugs with client #1. Subsequent observations revealed client #1 to get into proximity with other clients' and rub their heads and faces. Additional observations revealed client #1 to kiss another client on the lips twice while the client was sitting at the dining table, while staff were in the kitchen preparing breakfast. When surveyor brought the observation to staff A's attention, staff A revealed that she has never known client #1 to kiss another client. Continued interview with staff A revealed client #1 is very sociable and will attempt to give hugs to anyone he meets. Review of the record for client #1 on 3/8/26 revealed a BSP dated 4/3/25. Continued review revealed the following targeted behaviors; stubbornness/Refusal, physical disruptions, verbal disruptions and skin picking. Review of background information revealed client #1 enjoys physical contact such as touching, hugging and laying his head on others' shoulders. Further review of preventative techniques revealed client #1 enjoys interaction with people; therefore, staff should provide pats on the back, handshakes, fist bumps, and social praise to encourage and enhance his appropriate social skills during his participation in activities. Staff should avoid providing too much social praise particularly when he is performing just for attention. Interview with the behavior specialist (BS) on 3/8/26 revealed staff are not to initiate or engage in hugs with client #1. When surveyor shared the observation of client #1 kissing another client on the lips, the BS revealed that this is the first time she's ever heard of this occurrence. Further interview with the BS revealed the client's BSP interventions should be followed as prescribed. Continued interview with the BS revealed the client's BSP is currently being reviewed and updated to include other targeted behaviors. B. The facility failed to provide formal or informal active treatment opportunities for client #3. For example: Observations at the group home on 4/7/26 from 3:45PM – 6:00 PM revealed client #3 to spend 135 minutes in his wheelchair sitting outside, in the livingroom watching Barney, in the kitchen area looking outside the door, unengaged. Continued observations revealed client #3 to refuse dinner. Subsequent observations did not reveal staff to offer client #3 to participate in formal or informal activities. Additional observations did not	W0249		

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W0249	Continued from page 2 reveal staff to offer the client a visual schedule. Observations on 4/8/26 from 6:30 AM – 9:00 AM revealed client #3 to spend 115 of 150 minutes in his room and livingroom unengaged. Continued observations for the remaining 35 minutes revealed client #3 to participate in the breakfast meal and medication administration. Further observations did not reveal staff to offer the client a visual schedule. Review of the record for client #3 on 4/8/26 revealed a PCP dated 8/25/25 with eight formal training programs. Further review of the training objectives for client #3 included the following: putting on his shirt, tolerates a toothbrush in mouth, cleaning up workspace, cleaning with a mop, waiting for preferred items, walking exercise and wiping his work area. Continued review of the PCP revealed the client's BSP was updated on 1/9/25. Further review revealed staff should develop a visual schedule for the client so he can see the next activity to be pursued over the course of the day. It is likely he knows this, but it can be of use to staff when redirecting him back to task once distracted or in planning transitions. The visual schedule should be portable and laminated so it can be carried with his wheelchair. Interview with staff on 4/7/26 and 4/8/26 revealed client #3 likes to sit outside, dance, listen to music, watch Barney, look out the kitchen window and tilt in his wheelchair. Interview with the BS on 4/8/26 revealed that the client should have a visual schedule attached to his wheelchair and confirmed she has not seen it in a few weeks. Interview with the facility administrator (FA) on 4/8/26 revealed client #3's PCP and program goals are current. Further interview with the FA revealed client #3 should be offered opportunities to participate in informal and formal programming throughout the day.	W0249		
W0340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is NOT MET as evidenced by:	W0340		

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W0340	Continued from page 3 Based on observations and interview, the facility failed to ensure staff was sufficiently trained in proper hygiene during medication administration. This affected 1 of 4 audited clients (#4). The findings is: Morning observations in the group home on 4/8/26 at 8:15 AM revealed client #4 to enter the medication room with staff G. Continued observations revealed staff G to assist client #4 to punch medication Vitamin D3 2000 capsule out of the blister pack and observed the pill to fall onto the floor. Further observations revealed staff G to pick up the capsule off the floor by hand and balled it up into her fist. Subsequent observations revealed staff G to blow into her balled fist, ask the client to blow into her fist, then place the capsule into the medication cup. Additional observations revealed staff G to assist client #4 with punching the following medications into the medication cup; citalopram 40mg, paliperidone 3mg, naltrexone 50mg, cacti/vita D 315-200, aripiprazole 15mg, and buspirone 5mg. Observations then revealed staff G to mix peg 3350 17 grams with water in a cup, client to then swallow all medications. Continued observations revealed staff G to apply ciclopirox 8% cream to client's toenails and Vaseline to client's feet. Interview with the facility nurse on 4/8/26 confirmed staff should have contacted nursing to report the medication had fallen to the floor to get further instructions for disposing and dispensing another capsule from the blister pack to administer to the client. Continued interview verified staff should never administer medications to any clients that have fallen to the floor.	W0340		
W0369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were administered without error. This affected 1 of 4 audited clients (client #4) during medication administration. The finding is:	W0369		

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W0369	Continued from page 4 Morning observations in the group home on 4/8/26 at 8:15 AM revealed client #4 to enter the medication room with staff G. Continued observations revealed staff G to assist client #4 to punch the following medications into a medication cup; vitamin D3 2000, citalopram 40mg, paliperidone 3mg, naltrexone 50mg, cacti/vita D 315-200, aripiprazole 15mg, and buspirone 5mg. Further observations revealed staff G to mix peg 3350 17 grams with water in a cup, client to then swallow all medications. Subsequent observations revealed staff G to apply ciclopirox 8% cream to client's toenails and Vaseline to client's feet. Review of client #4's physician order dated 1/15/26 revealed that the Vaseline is to be administered at 8:00 PM. Interview with the facility nurse on 4/8/26 confirmed that client #4's physician order is current and the Vaseline is to be administered at 8pm. Further interview with the nurse revealed all medications should be administered as prescribed.	W0369		