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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G241	A. BUILDING _____ B. WING _____	C 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARCHES-HORIZONS RESIDENTIAL CARE CENTER	5900 BETHABARA PARK BOULEVARD WINSTON SALEM, NC 27106

(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 000	INITIAL COMMENTS There was a recertification survey completed on 3/18/2026 with no deficiencies cited. A complaint survey was completed on 3/18/2026 for intake # NC00236293 and the intake was substantiated and deficiencies were cited.	W 000		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on review of documents and interview, the facility failed to provide nursing services in accordance with the needs of 1 of 3 audited clients (#1). The finding is: Review on 3/17/26 of client #1's appointments in Therap revealed an appointment for client #1 on 2/25/26 at 2:30 PM. Further review revealed that the appointment description noted that the client was sent to Wake Forest Baptist Emergency Department (ED) at the request of DSS/Guardian due to client #1's uncomfortable appearance and crying. The client was admitted from 2/25/26-2/27/26 and treated for fecal impaction. Review on 3/17/26 of client #1's discharge summary for hospital admission from 2/25/26-2/27/26 revealed admission condition to be stable and discharge condition to be fair. Further review revealed that the client's principal problem was a large colonic stool ball with associated chronic constipation and nausea/vomiting. The diagnosis was established via CT of the abdomen/pelvis, which revealed a 5.9 cm stool ball in the rectum and mild mural thickening of the distal sigmoid colon and rectum,	W 331	The respective QIDP and Director of Nursing, in collaboration with the Medical Director for client #1 has been instructed to communicate with client #1 guardian regarding client #1 health issues. This communication will include sharing supportive documentation as appropriate.	3.18.26

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

President & CEO — 3-30-26

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.

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W 331	Continued From page 1 concerning for possible stercoral colitis. The client underwent manual disimpaction with large stool ball removed followed by initiation of an aggressive bowel regimen including MiraLAX twice daily, senna nightly, and as needed an enema. Zofran was used as needed for nausea. Review on 3/17/26 of the facility's 24-hour report follow-up book revealed that on 2/21/26 client #1 vomited x 2 within 2 hours and DON was called/texted and no interventions noted. Further review on 2/22/26 revealed that the client vomited x 2 and no BMs on first shift and no contacts or interventions noted. Continued review revealed that on 2/24/26 client #1 had nausea and vomiting and nurse ordered Zofran. Review on 3/17/26 revealed client #1's intake/elimination record noting that on 2/22/26, 2/23/26, and 2/24/26 the client was noted to have zero bowel movements (BMs). Further review revealed the client's medication administration record for February 2026 that noted the client was prescribed a PRN medication Polyethylene Glycol 3350 Powder by mouth daily as needed if no stool in 3 days. The medication was not administered to the client after no stools for 3 days which were on 2/22/26, 2/23/26, and 2/24/26.There were no current nursing notes provided to surveyor upon request and the last dated nursing notes in record were 2022. Review of records on 3/17/26 for client #1 revealed individual support plan (ISP) dated 3/24/26. Review of the ISP revealed the client's diagnosis of Wolf -Hirschhorn Syndrome, Profound IDD, Microcephaly, Pulmonary Valve Stenosis, Exophthalmos, Myopia, Exotropia, Amblyopia, Hypermature Cataract left eye, Left	W 331	The Director of Nursing will be counseled for failing to ensure intervention on 2.21.26 when notified of client #1 vomiting 2x with two hours and producing no BMs during the shift. All members of Client #1 Interdisciplinary Team will be re-trained on response expectations when health related questions are identified, including potential bowel related conditions. Nursing Team will be re-trained to monitor daily intake data to determine need for communication/collaboration and intervention with Medical Director. All Nursing Care Plans will be reviewed by the Director of Nursing. Nursing Care Plans will be updated or revised as needed during monthly Interdisciplinary Team meetings. Director of Nursing will complete an audit of all medical care plans and related records to ensure adequate oversite to all medical care plans is present and maintained. 100% audit of nursing and health care direct support documentation was initiated on 3/23/26. Missing or incomplete documentation will be immediately corrected / updated.	3.31.26 3.31.26 4.3.26 4.15.26 4.15.26 4.15.26

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W 331	Continued From page 2 lens removed, absolute glaucoma left eye, primary open angle glaucoma right eye, Ocular Hypertension left eye, Dry eye syndrome, Hearing loss, Osteoporosis, GERD, Scoliosis, Seizure Disorder, Multiple Deformities of Upper and lower extremities, Acrocyanosis of feet, Dysmenorrhea and PMS, Generalized Anxiety Disorder, Oropharyngeal Dysphagia, Secundum Atrial Septal Defect(ASD), Pulmonary Valve Stenosis (PS), Chronic Hives (2022), Constipation. Further review of record revealed a nursing care plan for 2026 located in record with no signature or date from nursing staff for client #1. Continued review of record revealed the 2026 plan addresses history of constipation and fecal impaction/colonic fecal residual. Staff will continue to document intake daily, nursing will review intake data daily and determine need for intervention, and any persistent constipation will continue to be reported to the medical director. Interview on 3/17/26 with the director of nursing (DON) revealed that client #1's social worker requested that the client be sent to the hospital. Further interview with the DON revealed that the nurse felt that the facility could have treated the client's fecal impaction.	W 331	• Documentation audit toolkit will be implemented starting 3/25/26 to ensure timely documentation is occurring as required. Audit toolkit includes review of daily health caredocumentation required from direct support staff and the nursing team: o missed charting o Late entries o Missing signatures o MAR errors o Treatments and interventions implemented in timely manner o Physician Orders o Direct Support entries Nursing Team will be re-trained to monitor daily intake data to determine need for communication/collaboration and intervention with the DON and/or Medical Director. The respective QIDP and Director of Nursing, in collaboration with the Medical Director for client #1 has been instructed to communicate with client #1 guardian regarding client #1 health issues. This communication will include sharing supportive documentation as appropriate.	4.15.26 4.3.26 3.18.26
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) 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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.	W 342	• Documentation audit toolkit will be implemented starting 3/25/26 to ensure timely documentation is occurring as required. Audit toolkit includes review of daily health care documentation required from direct support staff and the nursing team: o missed charting o Late entries o Missing signatures o MAR errors o Treatments and interventions implemented in timely manner o Physician Orders o Direct Support entries	4.15.26

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W 342	Continued From page 3 This STANDARD is not met as evidenced by: Based on document review and medication administration record (MAR), nursing services failed to assure that disability support professionals (DSPs) were adequately trained and monitored to meet the prescribed health care needs of 1 of 3 audited clients (#1). The finding is: Review on 3/17/26 of the facility's 24-hour report follow-up book revealed that on 2/21/26 client #1 vomited x 2 within 2 hours and DON was called/texted and no interventions noted. Further review on 2/22/26 revealed that the client vomited x 2 and no BMs on first shift and no contacts or interventions noted. Continued review revealed that on 2/24/26 client #1 had nausea and vomiting and nurse ordered Zofran. Review on 3/17/26 client #1's intake/elimination record revealed that on 2/22/26, 2/23/26, and 2/24/26 the client was noted to have zero bowel movements (BMs). Further review of client #1's MAR for February 2026 revealed that the client was prescribed a PRN medication Polyethylene Glycol 3350 Powder by mouth daily as needed if no stool in 3 days. The medication was not administered to the client after no stools for 3 days which were 2/22/26, 2/23/26, and 2/24/26.There were no current nursing notes provided to surveyor upon request and the last dated nursing notes in record were 2022. Review of records on 3/17/26 for client #1 revealed individual support plan (ISP) dated 3/24/26. Review of the ISP revealed the client's diagnosis of Wolf -Hirschhorn Syndrome, Profound IDD, Microcephaly, Pulmonary Valve Stenosis, Exophthalmos, Myopia, Exotropia,	W 342	Nursing services will ensure appropriate protective and preventative health measures are provided and competence is demonstrated Via: • Training direct support staff to ensure competence in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic health care requirements (nursing care plans). The Director of Nursing will be counseled for failing to ensure intervention on 2.21.26 when notified of client #1 vomiting 2x with two hours and producing no BMs during the shift. • Audit toolkit includes review of daily health care documentation required from direct support staff and the nursing team: o missed charting o Late entries o Missing signatures o MAR errors o Treatments and interventions implemented in timely manner o Physician Orders o Direct Support entries	4.15.26 3.31.26 4.15.26

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W 342	Continued From page 4 Amblyopia, Hypermature Cataract left eye, Left lens removed, absolute glaucoma left eye, primary open angle glaucoma right eye, Ocular Hypertension left eye, Dry eye syndrome, Hearing loss, Osteoporosis, GERD, Scoliosis, Seizure Disorder, Multiple Deformities of Upper and lower extremities, Acrocyanosis of feet, Dysmenorrhea and PMS, Generalized Anxiety Disorder, Oropharyngeal Dysphagia, Secundum Atrial Septal Defect(ASD), Pulmonary Valve Stenosis (PS), Chronic Hives (2022), Constipation. Further review of records revealed a nursing care plan for 2026 located in the client's record with no signature or date from nursing staff for client #1. Continued review revealed the plan addresses history of constipation and fecal impaction/colonic fecal residual. Staff will continue to document intake daily, nursing will review intake data daily and determine need for intervention, and any persistent constipation will continue to be reported to the medical director. Interview on 3/17/26 with the qualified intellectual disabilities professional (QIDP) revealed that client #1's nursing care plan 2026 located in the client's chart was completed a few weeks ago around the plan meeting for the client held on 3/10/26. Further interview revealed that the nursing care plan was not signed nor dated by any nursing staff. Continued interview revealed that staff have not been trained or in-serviced on the plan.	W 342	Shift Nurse "end of shift" checklist will be implemented that includes, MAR signed, Nursing and direct support notes completed, medical orders transcribed, Incident reports completed, all communication / collaboration with Director of Nursing and/or Medical Director recorded, and treatments documented. QIDP will ensure all related support staff assigned to Client # 1 are fully trained regarding her support plan.	4.6.26 3.24.26