STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G243	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTSIDE RESIDENTIAL	**467 SOUTH CREEK ROAD , ORRUM, North Carolina, 28369**

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E0036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at	E0036		

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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E0036	Continued from page 1 paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is NOT MET as evidenced by: Based on document review and interview, the facility failed to ensure all staff received training on the facility's Emergency Preparedness Plan (EPP). The finding is: Review on 4/20/26 of the facility's EPP dated 2/16/26 revealed no documentation regarding staff training on the plan. Interview on 4/20/26 with the Qualified Intellectual Disabilities Professional (QIDP) indicated no training has been provided for direct care staff on the facility's EPP as of the date of the survey.	E0036		
W0240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is NOT MET as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the Individual Program Plan (IPP) for 1 of 3 audit clients (#2) included specific information to support his safety and medical needs, his use of an adaptive helmet, and assistance during domestic tasks. The findings are: A. During observations throughout the survey on 4/20 - 4/21/26, various staff provided one-to-one monitoring and assistance for client #2. The staff remained next	W0240		

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W0240	Continued from page 2 to the client at all times and assisted him with leisure activities and other tasks. The staff also simultaneously interacted with and assisted other clients in the room as well. Interviews on 4/20 - 4/21/26 with various staff indicated client #2 has a one-to-one staff at the day program and in the home due to his seizures. Review on 4/21/26 of client #2's IPP dated 11/10/24 (most current plan) did not include any information or guidelines regarding the use of one-to-one staffing for client #2. Interview on 4/21/26 with the Program Manager (PM) confirmed client #2 has a one-to-one staff daily due to his seizures and high risk for falls. Additional interview confirmed the client's IPP does not include information regarding the use of a one-to-one. B. During observations throughout the survey on 4/20 - 4/21/26, a helmet with a face shield and chin strap was noted near client #2 as he sat in a recliner in the home. The client wore the helmet once as he was assisted to walk from the living room to the dining room table. During other observations, as client #2 was assisted to walk to other areas around the home, he did not wear the helmet. On at least one occasion, client #2 was observed to have a seizure while seated in the recliner. Interview on 4/21/26 with Staff D revealed client #2 is supposed to wear the helmet "all the time" especially when he is walking but not at night in the bed. The staff noted he wears the helmet due to his seizures. The staff noted the client does not like to wear his helmet. Review on 4/21/26 of client #2's IPP dated 11/10/24 revealed he wears a helmet to protect his head in case of falls. Additional review of the plan did not reveal any specific information or guidelines regarding his helmet or its use. Interview on 4/21/26 with the PM confirmed client #2 wears a helmet due to his seizures and it should be worn all the time. Additional interview confirmed the client's IPP did not include any specific guidelines for the use of his helmet. C. During observations in the home throughout the survey on 4/20 - 4/21/26, a Vagus Nerve Stimulation (VNS) device was located in a bag near client #2 as he sat in a recliner in the home. At 7:45am, as the client	W0240		

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W0240	Continued from page 3 sat at the dining room table, Staff E swiped the VNS device across client #2's chest without the client having a seizure. The staff noted she had done this because the client looked like he was going to have a seizure, so she did it to "get him out of it". During additional observations at 8:07am, client #2 dropped forward while seated in a recliner and began to have a seizure. Staff D immediately obtained the VNS and swiped it across client #2's chest. Interview on 4/21/26 with Staff D revealed they use the VNS on client #2 when he has a seizure to keep the seizure from "being so bad". The staff noted the VNS does not stop him from having a seizure. Review on 4/21/26 of client #2's IPP dated 11/10/24 did not include any specific information or guidelines regarding the use of his VNS device or its use. Interview on 4/21/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2's IPP does not include information regarding his VNS device. D. During morning observations in the home after breakfast on 4/21/26 at 7:45am, client #2 was not prompted or assisted to clear his dishes after the meal. His dishes were cleared for him. Interview on 4/21/26 with Staff D indicated they clear client #2's dishes for him as he cannot complete this task. Review on 4/21/26 of client #2's IPP dated 11/10/24 did not include any specific information regarding his ability to clear his dishes after meals. Interview on 4/21/26 with the QIDP revealed client #2 requires hand-over-hand assistance to clear his dishes after meals, however, no information is included in his IPP.	W0240		
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.	W0249		

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W0249	Continued from page 4 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 Individual Program Plan (IPP) in the areas of food preparation, adaptive equipment use and dining. This affected 3 of 3 audit clients (#1, #2 and #3). The findings are: A. During dinner and breakfast preparation in the home on 4/20 - 4/21/26, various staff completed all food preparation tasks without any client involvement. No clients were prompted or encouraged to assist with the preparation of food. Interview on 4/21/26 with Staff E revealed client #1 and client #3 can assist with making toast and set their places at the table. Review on 4/21/26 of client #1's IPP dated 5/16/25 revealed he has adequate gross and fine motor coordination in his arms and hands. The plan noted he can participate in daily living activities without an assistive device. Review on 4/21/26 of client #3's IPP dated 5/28/25 indicated she can complete most activities of daily living. Additional review of the client's Adaptive Behavior Inventory (ABI) dated 5/21/25 noted she has partial independence with preparing a beverage, preparing sandwiches, identifying fruits and kitchen equipment, and using measuring cups/spoons. Interview on 4/21/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 and client #3 can assist with food preparation by pouring, stirring, putting bread in the toaster, or operating the food processor given hand-over-hand assistance. B. During dinner observations in the home on 4/20/26 at 5:56pm, client #2 was briefly provided physical assistance to hold his spoon twice. The client refused. Client #2 was then fed his dinner meal. A regular spoon was used to feed client #2 his dinner meal and no dycem mat was utilized. During additional breakfast observations in the home on 4/21/26 at 7:19am, Staff D applied a spoon containing a strap onto client #2's right hand and assisted him to scoop his food three times. Client #2 was then fed the remainder of his meal by Staff E without further attempts to feed himself. No dycem mat was utilized at the breakfast meal.	W0249		

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W0249	Continued from page 5 Interview on 4/21/26 with Staff D revealed client #2 utilizes a spoon with a strap on his left hand at meals to assist with feeding himself for 5 - 10 minutes, then they feed him. Additional interview indicated a dycem mat is also used under the client's plate at meals. Review on 4/20/26 of a list of each client's diet posted on the refrigerator in the home revealed he utilizes a spoon strap for his left hand, a sippy cup and dycem mat at meals. The list also noted, "Hand over hand feeding for 5 - 10 minutes, once tired, staff will feed". Interview on 4/21/26 with the Program Manager confirmed client #2 uses a spoon with strap on his left hand at meals as well as a dycem mat at meals. Additional interview confirmed staff should assist the client with self-feeding for at least 5 - 10 minutes as indicated.	W0249		
W0260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure client #2's Individual Program Plan (IPP) meeting was held at least annually. This affected 1 of 3 audit clients. The finding is: Review on 4/20/26 of client #2's record revealed an IPP dated 11/10/24. Additional review of the client's record did not include a current IPP. Interview on 4/21/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2's annual IPP meeting had not been held as of the date of the survey.	W0260		
W0263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is NOT MET as evidenced by:	W0263		

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W0263	Continued from page 6 Based on record reviews and interview, the facility failed to ensure written informed consent was obtained from the guardian for all restrictive Behavior Support Plans (BSP). This affected 2 of 3 audit clients (#2 and #3). The findings are: A. Review on 4/20/26 of client #2's BSP dated 3/1/26 revealed an objective to address self-injurious behaviors. The plan included the use of Clonazepam, Hydroxyzine, Lorazepam, Locosamide and Depakote. Additional review of the record did not include a written informed consent for client #2's BSP. Interview on 4/21/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no written informed consent had been obtained for the BSP as of the date of the survey. B. Review on 4/20/26 of client #3's BSP dated 3/1/26 revealed an objective to address failure to make responsible choices and psychotic behaviors. The plan included the use of Zyprexa, Prozac, Keppra, Depakote and Diazepam. Additional review of the record did not include a written informed consent for client #3's BSP. Interview on 4/21/26 with the QIDP confirmed no written informed consent had been obtained for client #3's BSP as of the date of the survey.	W0263		
W0331	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 observations, record review and interviews, the facility failed to ensure client #1 received necessary nail care. This affected 1 of 3 audit clients. The finding is: During observations throughout the survey on 4/20 - 4/21/26, client #1's fingernails were very long and extending well beyond the tips of his fingers. Interview on 4/21/26 with Staff D revealed client's fingernails are usually cut by staff on Wednesdays. The staff noted client #1's fingernails are cut by nursing staff due to his diabetes.	W0331		

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W0331	Continued from page 7 Review on 4/20/26 of client #1's Individual Program Plan (IPP) dated 5/16/25 revealed he has diabetes. Additional review of the client's guidelines for cutting his nails noted, "If the individual is a diabetic, staff will need to contact the nurses to set up arrangements for the nurse to cut the diabetic nails and toes." Interview on 4/21/26 with the facility nurse revealed nurses do not cut client #1's fingernails, however, since the client has diabetes, they would be responsible for ensuring he has his nails cut at the doctor's office. Additional interview with the nurse indicated she was not sure of the last time client #1's fingernails were cut at the doctor's office, and an appointment would need to be made to have this done.	W0331		
W0473	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, document review and interviews, the facility failed to ensure all foods were served at an appropriate temperature. The finding is: During morning observations in the home on 4/21/26 at 6:25am, client #1 was assisted to place a pitcher of milk on the table for the breakfast meal. At 6:42am, a container of oatmeal was removed from the kitchen and placed on the table by staff. The items remained on the table until clients began serving themselves at 7:21am. The temperature of the items was not taken prior to serving. Review of a menu book in the home and procedures for safe food handling, preparation and service (posted in the kitchen) revealed hot foods should be heated to a temperature of 140 degrees and the temperature checked before serving at 110 degrees. The documents also noted cold foods should remain at a temperature of 40 degrees until served and the temperature checked before serving at 45 degrees or less. Further review the information indicated, "Food should be served within 15 minutes of leaving refrigeration or heating service. If longer than 15 minutes, reheat hot foods." Interview on 4/21/26 with Staff C revealed they should be following the posted information regarding food temperatures.	W0473		

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W0473	Continued from page 8 Interview on 4/21/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should be following the posted guidelines regarding food temperatures.	W0473		