STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G297	A. BUILDING _____ B. WING _____	R 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE PLACE	704 CAROLINA AVENUE AHOSKIE, NC 27910

(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 A revisit was conducted on 10/29/25 for deficienicies cited on 8/19/25. Four deficiencies were corrected and two deficiencies were recited. The facility remains out of compliance.	W 000		
{W 104}	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure repairs and maintenance at the group home were completed in a timely manner. This affected 6 of 6 clients (#1, #2, #3, #4, #5, and #6). The finding was: Observation on 8/18/25 to 8/19/25 revealed the leather sofa and chair ripped in several places, with a separate den chair completely duct taped on the bottom. In addition, the carpet in the den area was torn across the entire length of thresholds revealing bare underlayment in some spots and causing excessive fraying in other areas. While the walls had been repaired in spots following behavioral incidents, they had not been painted appropriately in many spots, and the entire top of the the kitchen wall was peeling from old wallpaper. Interview on 8/19/25 with the Program Manager revealed some work orders had been submitted, but they had been trying to get management to complete repairs and upgrades. However, they have not done anything about the needed maintenance at this point.	{W 104}		

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

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{W 104}	Continued From page 1 Review of the facility Plan of Correction (POC), submitted on 8/29/25, revealed the Qualified Intellectual Disabilities Professional (QIDP) would ensure a maintenance ticket was submitted for leather furniture repair or purchase, as well as needed carpet repairs. The Area Director would ensure the ticket was completed and follow up as needed. Observation on 10/29/25 revealed no repairs had been completed. The leather furniture remained ripped in several places, and the duct-taped chair remained in the den area. The carpet in the den area remained torn across both major thresholds with excessive fraying and lifting in main areas where clients must walk. Interview on 10/29/25 with the Program Manager revealed she had put in maintenance requests months ago. However, nothing had been repaired. Two clients in the home were particularly at risk for tripping or falling due to being considered falls risks. Interview on 10/29/25 with the QIDP revealed it was difficult to get the maintenance crew in to do the work.	{W 104}		
{W 249}	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	{W 249}		

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{W 249}	Continued From page 2 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 Individual Program Plan (IPP) in the area of safety and supervision. This affected 1 of 4 audit clients (#5). The finding was: Observation on 8/19/25 in the home from 7:40am - 7:50am revealed client #5 sitting in his wheelchair in the den area with no staff consistently present to assist him should he attempt to ambulate. Staff B attended to medication administration in a separate room, and Staff C intermittently walked to the back hallway and bedroom area to attend to other duties. Review on 8/18/25 of client #5's IPP, dated 6/26/25, revealed a diagnosis of cerebral palsy, epilepsy, and joint hyperextension. He is a high falls risk, and staff should follow falls prevention to be close when he ambulates. Review on 8/19/25 of client #5's physical therapy (PT) evaluation, dated 4/18/25, revealed staff should continue falls prevention guidelines and ensure they are close to assist should he attempt to ambulate. Interview on 8/19/25 with A revealed client #5 is a high falls risk and has to be assisted when ambulating. He may attempt to ambulate at any time, so staff should be close.	{W 249}		

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{W 249}	Continued From page 3 Interview on 8/19/25 with the qualified intellectual disabilities professional (QIDP) revealed staff should not leave client #5 unmonitored due to his being a high falls risk, and he may attempt to ambulate. Review of the facility Plan of Correction (POC), submitted 8/29/25, revealed the Qualified Intellectual Disabilities Professional (QIDP) would call a team meeting to evaluate client #5's need for a 1:1 staff. In the interim, to ensure appropriate oversight of client #5, staff assigned to client #5 will be instructed to maintain close proximity at all times. The Program Manager will monitor daily for compliance. The QIDP and nurse will monitor weekly for compliance. Observation in the home on 10/29/25 from 8:07am - 8:14am revealed client #5 sitting in his wheelchair in the den with no staff in the room or in close proximity. Review on 10/29/25 of monitoring data revealed no documentation of monitoring from the QIDP or nurse. Interview on 10/29/25 with the Program Manager revealed she is in the home and monitors every day. A team meeting was held, but no changes were made to client #5's supervision. Staff should be close to him if he is awake and out of bed. Interview on 10/29/25 with the QIDP (by phone) revealed he visits the home once per week to monitor. The QIDP confirmed that staff should be in close proximity to client #5.	{W 249}		