CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO. 0938-03         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       34G127       B. WING       09/25/2019         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       4263 NORTH EDGE ROAD		-	ID HUMAN SERVICES				FORM	APPROVED		
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       4263 NORTH EDGE ROAD	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		· /			(X3) DATE SURVEY				
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         4263 NORTH EDGE ROAD	34G127		B. WING			09/25/2019				
PITT COUNTY GROUP HOME #2 AYDEN, NC 28513				·	STREET ADDRESS, CITY, STATE, ZIP CODE 4263 NORTH EDGE ROAD					
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     (X5)       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE     COMPLETIC       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     TAG     CROSS-REFERENCED TO THE APPROPRIATE     DATE	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION		
E 039 EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: "[For LTC Facilities at \$483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that may include, but is not limited to the following: (A) A second individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency pana, a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility]s personse to and maintain documentation of all drills, tabletop exercises, and emergency pana, sended.	E 039	CFR(s): 483.475(d)(2 (2) Testing. The [facill RNHCIs and OPOs] r test the emergency p [facility, except for RN all of the following: *[For LTC Facilities at The LTC facility must the emergency plan a unannounced staff dr procedures. The LTC following:] (i) Participate in a full community-based or exercise is not access facility-based. If the [ actual natural or man requires activation of [facility] is exempt fro community-based or full-scale exercise for the actual event. (ii) Conduct an addition include, but is not lim (A) A second full-sc community-based or (B) A tabletop exer discussion led by a fa clinically-relevant emo of problem statement prepared questions d emergency plan. (iii) Analyze the [facility maintain documentatic exercises, and emergency commendation of the facility commendation of the facility maintain documentation exercises, and emergency commendation of the facility maintain documentation exercises, and emergency commendation of the facility commendation of the faci	ty, except for LTC facilities, must conduct exercises to lan at least annually. The NHCIs and OPOs] must do t §483.73(d):] (2) Testing. conduct exercises to test at least annually, including ills using the emergency facility must do all of the -scale exercise that is when a community-based sible, an individual, facility] experiences an -made emergency that the emergency plan, the m engaging in a individual, facility-based to he following: cale exercise that may ited to the following: cale exercise that is individual, facility-based. cise that includes a group acilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an ty's] response to and ion of all drills, tabletop gency events, and revise the	E	039					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 09/26/2019

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/26/2019 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		, <i>i</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G127	B. WING			09/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PITT COUNTY GROUP HOME #2					4263 NORTH EDGE ROAD AYDEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From page	31	E	039			
	must conduct exercise plan. The [RNHCl and following: (i) Conduct a paper-b least annually. A table discussion led by a fa clinically relevant eme of problem statements prepared questions de emergency plan. (ii) Analyze the [RNH to and maintain docur exercises, and emerg [RNHCl's and OPO's] needed. This STANDARD is r Based on record revi failed to ensure a faci tabletop exercise was emergency plan. The The facility's Emerger did not include comple facility/community-bas exercise. Review on 9/24/19 of plan dated July 2019 exercise or full scale of Interview on 9/25/19 of confirmed the facility	ing. The [RNHCI and OPO] es to test the emergency d OPO] must do the based, tabletop exercise at etop exercise is a group acilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an ICI's and OPO's] response mentation of all tabletop gency events, and revise the emergency plan, as not met as evidenced by: tew and interview, the facility lity/community-based or s conducted to test their e finding is: ncy Preparedness (EP) plan etion of sed exercise or tabletop emergency drill. With the Executive Director had not evacuated during mergency circumstances					

Facility ID: 922406

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 09/26/2019 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		34G127	B. WING			-	09/	25/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE	-		
PITT COU	NTY GROUP HOME #2				263 NORTH EDGE ROAD AYDEN, NC 28513				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
W 249 W 249	PROGRAM IMPLEME CFR(s): 483.440(d)(1 As soon as the interdi formulated a client's in each client must rece treatment program co interventions and serv and frequency to supp	ENTATION ) isciplinary team has ndividual program plan, ive a continuous active		249 249					
	Based on observation review, the facility fail clients (#3, #6) receiv treatment plan consis as identified in the ind in the areas of indeper skills. The findings in 1. Staff failed to assis knife and cutting up h During observations of #6 was assisted to see muffin for his breakfas picked up his sausage pieces off of it during	t client #6 with using his							
	no independence usir can use a fork and sp	ited 10/3/18 revealed he has ng a knife to cut his food. He							

If continuation sheet Page 3 of 7

CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥3) MI II			FORM OMB NC	09/26/2019 APPROVED 0.0938-0391	
	F CORRECTION	IDENTIFICATION NUMBER:	, <i>i</i>			(X3) DATE SURVEY COMPLETED		
		34G127	B. WING			09/25/2019		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
PITT COU	INTY GROUP HOME #2				4263 NORTH EDGE ROAD AYDEN, NC 28513			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 249	Disabilities Profession #6 needs assistance food and should be as 2. Staff did not assist mouth during observations a 6:00am-8:15am, clien onto the table in the d shirt. Direct care staff handkerchief or napki Review on 9/25/19 of 10/31/18 revealed he staff to wipe drool from Interview on 9/25/19 of 10/31/18 revealed he staff to wipe drool from Interview on 9/25/19 of 3. Staff did not promp hands after toileting. During morning obser 9/25/19 at 7:55am, cli bathroom with the dou bathroom light on. He flushing the toilet and without washing his h at 7:57am revealed th retrieve a newspaper the newspaper on a ta Client #3 touched sev he laid the newspape	nal (QIDP) confirmed client using his knife to cut up ssisted during mealtime. client #6 with wiping his ations on 9/25/19. at the facility on 9/25/19 from at #6 was noted to salivate dining room and onto his i did not prompt him to use a in to wipe his mouth. i client #6's ABI dated requires assistance from m his mouth. revealed direct care staff rompt client #6 to wipe his or handkerchief. ot client #3 to wash his rvations in the home on ient #3 was observed in the or cracked open, and e was heard urinating, then exited the bathroom hands. Further observations hat client #3 went outside to , came back inside and laid able in the living room. veral items on the table that or on, then walked by the ere he rubbed his hands buched several of the	W	249				

Facility ID: 922406

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	-	D HUMAN SERVICES				FORM	09/26/2019 APPROVED
STATEMENT OF DEFICIENCIES (X1) PRO		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		34G127	B. WING		-	09/:	25/2019
NAME OF PR	OVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PITT COUNTY GROUP HOME #2			4	263 NORTH EDGE ROAD			
			A	YDEN, NC 28513			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	close the door and to Review on 9/25/19 of an adaptive behavior 10/31/18. The ABI re- wash his hands after f "partially independent not all task independent not to follow to client # when they see him ex ask him "[Client #3] di and he will reply yes of prompted to return to hands. INFECTION CONTRO CFR(s): 483.470(I)(1) The facility must provit to avoid sources and f This STANDARD is in Based on observation interviews, the facility sanitary environment potential for cross-cor This affected all client findings are:	client #3's IPP dated lient #3 is capable of y but may need prompting to wash his hands. client #3's record revealed Inventory (ABI) dated vealed client #3's skill to toileting indicates he is, , able to perform some but ently." with the QIDP revealed that o on a formal training or hand washing. Further expectation is that staff are #3 to the bathroom, but it the bathroom they are to d you wash your hands?" or no. If he states no, he is the bathroom to wash his	W 249				

Facility ID: 922406

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	-	D HUMAN SERVICES MEDICAID SERVICES			FC	TED: 09/26/2019 DRM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) D.	ATE SURVEY DMPLETED
		34G127	B. WING			09/25/2019
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE,	ZIP CODE	
PITT COUNTY GROUP HOME #2				63 NORTH EDGE ROAD /DEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE 0 TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
W 454	<ul> <li>9/25/19 at 6:59am, St sausage patties on the into the plate using hi piece of sausage, and #3, who also grabbed bare hand before putt table. Staff B told cliet "did not tell them to grand client #5 picked t plates with their bare back on the platter. A passed around the tail get a piece of sausage Interview on 9/25/19 with their piece of sausage Interview on 9/25/19 with their piece of sausage the platter, it should have the platter, it should have the platter to assist table.</li> <li>During observations in between 7:33am-7:40 his breakfast items from salivating onto the table wash his hands or cleated their the table.</li> <li>Interview on 9/25/19 with the table.</li> </ul>	ea during mealtime. servations in the home on caff B placed a platter of e table. Client #5 reached is bare hand, grabbed a d passed the plate to client a piece of sausage with his ing the platter down on the ent #3 and client #5 that she et that yet." Both client #3 he sausage up off their hands and put the sausage at 7:03am, the platter was ble for all the residents to e. with Staff B revealed that is should have been ork that was on the platter ausage with. Staff B also e sausage was put back on ave been thrown out and residents. t client #6 with cleaning the an the facility on 9/25/19 bam client #6 was removing	W 454			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/26/2019 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G127		B. WING			09/	25/2019	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
PITT COU	NTY GROUP HOME #2				4263 NORTH EDGE ROAD AYDEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
W 454		e 6 e directed client #6 to wash ct the dining room table.	W	454			

Event ID: YLJR11

Facility ID: 922406

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