DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR										
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO.	0938-0391			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED				
34G273		B. WING			02/16/2022					
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	2 CODE				
NORTHS	IDE GROUP HOME			3	301 BARKSDALE ROAD					
Northie				FAYETTEVILLE, NC 28301						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE			
	EP Training and Ter CFR(s): 483.475(d) §403.748(d), §416 §441.184(d), §460 §483.475(d), §484. §485.625(d), §485. §486.360(d), §491. *[For RNCHIs at §4 Hospice at §418.11 at §460.84, Hospita §484.102, CORFs a "Organizations" und §485.920, OPOs at §491.12:] (d) Trainin must develop and r preparedness trainin based on the emerg paragraph (a) of thi paragraph (a) of thi paragraph (a) (1) of procedures at paragent the communication section. The trainin be reviewed and up *[For LTC facilities a and testing. The LT maintain an emergent and testing program emergency plan set section, risk assess this section, policies (b) of this section, a paragraph (c) of this	sting 54(d), §418.113(d), 84(d), §482.15(d), §483.73(d), 102(d), §485.68(d), 727(d), §485.920(d),			CROSS-REFERENCED TO THE APPROF DEFICIENCY)		DATE			
		83.475(d):] Training and must develop and maintain								

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

TITLE

(X6) DATE

PRINTED: 02/16/2022

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.

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	02/16/2022 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		```		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
34G273					02/16/2022				
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
NORTHSIDE GROUP HOME		3301 BARKSDALE ROAD FAYETTEVILLE, NC 28301							
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
 program that is based of forth in paragraph (a) of assessment at paragraph policies and procedures section, and the communication paragraph (c) of this sectesting program must be least every 2 years. The requirements for evacual §483.470(i). *[For ESRD Facilities at testing, and orientation. develop and maintain an preparedness training, for orientation program that emergency plan set fort section, risk assessment this section, policies and (b) of this section, and the paragraph (c) of this section, and the paragraph (c) of this section, and the paragraph (c) of this section. This STANDARD is not Based on document refacility failed to develop preparedness (EP) testicis: During review on 2/15/2 revealed there was not conducted any testing for the home. During an interview on 2/15/2 revealed there was not conducted any testing for the home. 	dness training and testing on the emergency plan set of this section, risk ph (a)(1) of this section, s at paragraph (b) of this unication plan at ection. The training and be reviewed and updated at e ICF/IID must meet the lation drills and training at t §494.62(d):] Training, . The dialysis facility must an emergency testing and patient at is based on the th in paragraph (a) of this nt at paragraph (a)(1) of ad procedures at paragraph the communication plan at ection. The training, testing n must be evaluated and rs. of met as evidenced by: eview and interview, the o a emergency ting program. The finding 22 of the facility's EP Plan documentation stating they for the staff who work in	EO	036						

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		AND HUMAN SERVICES				FORM	02/16/2022 APPROVED 0938-0391		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED			
34G273			B. WING	i		02/16/2022			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
NORTHSIDE GROUP HOME					301 BARKSDALE ROAD AYETTEVILLE, NC 28301				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
W 260	PROGRAM MONIT CFR(s): 483.440(f)(ORING & CHANGE (2)	W 2	260					
	must be revised, as process set forth in This STANDARD is Based on record re facility failed to upd plans (IPP's) annua The finding is: Review on 2/15/22 an IPP dated 12/5/2 #4's record revealed 12/5/20. During an interview	the individual program plan s appropriate, repeating the paragraph (c) of this section. s not met as evidenced by: eviews and interviews, the ate the individual program ally for 1 of 3 audit clients (#4). of client #4's record revealed 20. Additional review of client d no updated IPP since							
W 441			W 4	441					
	Based on review or interviews, the facili evacuation drills we This affected all clie	onditions to- s not met as evidenced by: f fire drill reports and ity failed to ensure fire ere conducted at varied times. ents (#1, #2, #3, #4, #5 and nome. The finding is:							
		of the facility's fire drill reports e no fire drills conducted after							
	manager (HM) state conducted while the	on 2/15/22, the home ed no fire drills were e clients where in bed asleep. evealed all 6 clients in the 8pm.							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 093								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
34G273		B. WING	i		02/16/2022			
NAME OF F	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE			
NORTHS	IDE GROUP HOME				3301 BARKSDALE ROAD FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE		(X5) COMPLETION DATE
W 441	Continued From pa	ige 3	W 4	441				
	During an interview intellectual disabiliti	2/15/22, the qualified ies professional (QIDP) stated re dills were not being		7 - 1				

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Facility ID: 932314

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