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

PRINTED: 06/03/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ľ	(X3) DATE SURVEY COMPLETED		
		34G151	B. WING			05/:	24/2022	
	PROVIDER OR SUPPLIER CE LIKE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		N SHOULD E E APPROPRI		(X5) COMPLETION DATE	
	GFR(s): 483.475(d) §403.748(d)(1), §41 §441.184(d)(1), §483 §485.68(d)(1), §485 *[For RNCHis at §4 Hospitals at §482.18 at §484.102, "Orgar OPOs at §486.360, (1) Training prograr the following: (i) Initial training in e policies and procedu staff, individuals pro arrangement, and ve expected roles. (ii) Provide emerger least every 2 years. (iii) Maintain docume preparedness trainir (iv) Demonstrate state procedures. (v) If the emergency procedures are sign must conduct trainin procedures. *[For Hospices at §4 hospice must do all e (i) Initial training in el policies and procedu hospice employees, services under arran expected roles. (ii) Demonstrate stafe procedures.	(1) 6.54(d)(1), §418.113(d)(1), 60.84(d)(1), §482.15(d)(1), 6.475(d)(1), §484.102(d)(1), 6.625(d)(1), §485.727(d)(1), 6.360(d)(1), §491.12(d)(1). 03.748, ASCs at §416.54, 6, ICF/IIDs at §483.475, HHAs nizations" under §485.727, RHC/FQHCs at §491.12:] m. The [facility] must do all of emergency preparedness ures to all new and existing viding services under colunteers, consistent with their ency preparedness training at entation of all emergency ng. off knowledge of emergency preparedness and efficantly updated, the [facility] g on the updated policies and 18.113(d):] (1) Training. The	E 0	The facility will assure that adequately trained in the policies and procedures. Quasked of the staff during the assure adequate knowledge procedures and processe inservice form with staff significate staff participation in activies and training. The molecular being the document after the QIDP manual with them. IN the function of the process of the QIDP is responded and the formulation of the process of the QIDP is responded and the	oreparedne destions will be training of the polices. A training gnatures we hanual will a sign the reviews the true drills of the training on the training of	ess If be to cies, ng vill top also e will cillity s by	7/22/22	

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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	(iii) Provide emerge least every 2 years. (iv) Periodically reviemergency prepare employees (includin special emphasis plantoprocedures necessations) (v) Maintain docume preparedness training (vi) If the emergency procedures are sign must conduct training procedures. *[For PRTFs at §44* program. The PRTF (i) Initial training in epolicies and procedustaff, individuals program arrangement, and vexpected roles. (ii) After initial training preparedness training (iii) Demonstrate state procedures. (iv) Maintain docume preparedness training (v) If the emergency procedures are significated in the emergency procedures. *[For PACE at §460. organization must docume procedures and	ew and rehearse its dness plan with hospice g nonemployee staff), with aced on carrying out the ary to protect patients and entation of all emergency ng. y preparedness policies and ificantly updated, the hospice ag on the updated policies and 1.184(d):] (1) Training must do all of the following: mergency preparedness ures to all new and existing viding services under plunteers, consistent with their ag, provide emergency ng every 2 years. If knowledge of emergency entation of all emergency entation of all emergency gentation of all emergency ag. preparedness policies and ificantly updated, the PRTF g on the updated policies and	E 03	see previous page		

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	arrangement, contravolunteers, consiste (ii) Provide emerger least every 2 years. (iii) Demonstrate staprocedures, includir what to do, where to case of an emergent (iv) Maintain docum (v) If the emergency procedures are sign must conduct training procedures. *[For LTC Facilities are Program. The LTC following: (i) Initial training in epolicies and procedustaff, individuals programs arrangement, and volume expected role. (ii) Provide emergent least annually. (iii) Maintain docume preparedness training (iv) Demonstrate staprocedures. *[For CORFs at §488] CORF must do all of (i) Provide initial train preparedness policies and existing staff, incunder arrangement, with their expected residuals.	actors, participants, and ent with their expected roles. The preparedness training at aff knowledge of emergency and informing participants of the go, and whom to contact in a cy. The entation of all training. The entation of all training and inficantly updated, the PACE and on the updated policies and actificantly updated policies and actificantly must do all of the emergency preparedness are to all new and existing viding services under colunteers, consistent with their action of all emergency at entation of all emergency and procedures to all new dividuals providing services and volunteers, consistent	E	037	. See previous page		

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	(iii) Maintain docum (iv) Demonstrate staprocedures. All new and assigned specithe CORF's emerge their first workday. I include instruction in alarm systems and equipment. (v) If the emergency procedures are sign must conduct training procedures. *[For CAHs at §485 The CAH must do at (i) Initial training in expolicies and procedure proting and exting and where necessal personnel, and guest cooperation with fire authorities, to all new individuals providing and volunteers, considerate every 2 years. (ii) Provide emergency (iii) Maintain docume (iv) Demonstrate staprocedures. (v) If the emergency procedures are sign must conduct training procedures. *[For CMHCs at §48]	entation of the training. aff knowledge of emergency of personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must in the location and use of signals and firefighting by preparedness policies and difficantly updated, the CORF ing on the updated policies and controlled the following: firegency preparedness fures, including prompt funishing of fires, protection, formall of patients, fire prevention, and fighting and disaster	EC	137	See previous page			

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NO PLACE LIKE HOME STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306 (X4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 037 Continued From page 4 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain			34G151	B. WING_		05/24/202:	2
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 037 Continued From page 4 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain	· · · · · · · · · · · · · · · · · · ·				4309 NC HWY 87 SOUTH		
preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLÉ	
demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency preparedness (EP) plan. The finding is: During review on 5/23/22 of evidence of all staff receiving EP training, it was revealed that only the Director and qualified intellectual disabilities professional (QIDP) were trained on table top exercises on 1/10/22. There was no evidence that staff received orientation on the EP manual or direct care staff participated in EP training. Interview on 5/24/22 with the QIDP and Director revealed that they did not have any documentation that other drills were conducted or direct care staff participated in EP training. W 263 PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) W 263 The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a	W 263	preparedness polic and existing staff, in under arrangement with their expected documentation of the demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on documentacility failed to ensure adequately trained opreparedness (EP) During review on 5/2 receiving EP training Director and qualified professional (QIDP) exercises on 1/10/2 staff received orient direct care staff part linterview on 5/24/22 revealed that they documentation that direct care staff part PROGRAM MONITY CFR(s): 483.440(f)(c) The committee should be a sure conducted only to consent of the client minor) or legal guard. This STANDARD is Based on record refailed to ensure a refailed to ensure a refailed staff.	ies and procedures to all new ndividuals providing services and volunteers, consistent roles, and maintain he training. The CMHC must nowledge of emergency after, the CMHC must provide idness training at least every 2 is not met as evidenced by: not review and interviews, the ure direct care staff were on the facility's emergency plan. The finding is: 23/22 of evidence of all staff g, it was revealed that only the ed intellectual disabilities were trained on table top 2. There was no evidence that eation on the EP manual or ticipated in EP training. 2 with the QIDP and Director id not have any other drills were conducted or cicipated in EP training. ORING & CHANGE 3)(ii) Ild insure that these programs with the written informed it, parents (if the client is a dian. not met as evidenced by: view and interview, the facility strictive Behavior Support		W263 The facility will not impleme behavior support plans for any mindividuals residing in the facility will the consent of the legal guardial Note: medication consent is not regulatory requirement Separate informed consent for the behavior supoport program (who includes medication or restricible techniques if there are any) will be seen the QIDP via US MAIL specifically client #1. The QIDP will review all client chart those individuals who reside in No Fulke Home to determine which clien have a BSP. The QIDP will assure clients have a consent for the BSP that each BSP contains the use of restrictive techniques such as medical processing the processing the second process.	ore ithout n. a he bih le ent by r for ts for lace ents e all and of	22

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W 263	consent of the guar clients (#1). The fine Review on 5/24/22 he was admitted to his guardian in atterprogram plan meeti review of a psycholorevealed client #1 w. Prozac 10 mg daily, behaviors. On 4/10/client #1 to increase behaviors. On 4/12/was refilled by the pcontinued. There was guardian signed a cobehavior medication. Interview on 5/24/22 disabilities professio (QIDP/RN) revealed about the changes to behaviors. The QID	dian. This affected 1 of 4 audit ding is: of client #1's record revealed the home on 12/8/21 and had address at the individual and on 2/16/22. An additional origical note dated 3/25/22, was started on a trial dose of a due to an increase in 1/22, a BSP was developed for this appropriate social 1/22, the prescription for Prozac physician assistant (PA) and as no evidence that the onsent to authorize a nor BSP. With the qualified intellectual onal/registered nurse I that the guardian was told to address client #1's P/RN acknowledged she did written informed consent by	W 2	263	If consent is needed for any oth individual in the facility, it will also sent to the legal guardian by U mail. The President will monitor the Qi weekly to assure the POC is implemented as written.	be S	7/22/2