PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-0391

REGULATORY OR LSC IDENTIFYING INFORMATION)  E 030  Names and Contact Information CFR(s): 483.475(c)(1)  §403.748(c)(1), §416.54(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §483.73(c)(1), §485.682(c)(1), §485.682(c)(1), §485.682(c)(1), §485.682(c)(1), §485.682(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).  [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:  (i) Staff.  (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].  (y) Volunteers.  *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (i) Staff.  (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].  (y) Volunteers.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				X3) DATE SURVEY COMPLETED	
SHADYLAWN 901 SHADYLAWN DR  (P4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOUL) BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOUL) BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECED BY FULL PRECEDED BY FULL PRECED BY FULL PRECEDED BY FULL			34G255	B. WING			10/	04/2022	
EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  E 030  Names and Contact Information CFR(s): 483.475(c)(1) \$403.748(c)(1), \$416.54(c)(1), \$481.113(c)(1), \$441.184(c)(1), \$460.84(c)(1), \$482.15(c)(1), \$483.73(c)(1), \$483.475(c)(1), \$483.73(c)(1), \$483.475(c)(1), \$485.68(c)(1), \$485.68					9	001 SHADYLAWN DR			
CFR(s): 483.475(c)(1)  §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §486.562(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).  [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:  (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.  *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (1) Names and contact information for the following: (1) Names and contact information plan must include all of the following: (1) Names and contact information for the following: (1) Names and contact information for the following: (1) Names and contact information for the following: (1) Rintities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPERTY.	) BE	COMPLÉTION	
*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE		CFR(s): 483.475(c)  §403.748(c)(1), §443 §441.184(c)(1), §443 §483.73(c)(1), §483 §485.68(c)(1), §483 §494.62(c)(1).  [(c) The [facility mule emergency prepared that complies with Fand must be review 2 years [annually for communication plan following:  (i) Names and confollowing:  (ii) Entities providing (iii) Patients' physic (iv) Other [facilities]  (v) Volunteers.  *[For Hospitals at § §485.625(c)] The coinclude all of the fol (1) Names and confollowing:  (ii) Entities providing (iii) Patients' physic (iv) Other [hospitals (v) Volunteers.  *[For RNHCls at §4 communication plan following:	(1) (6.54(c)(1), §418.113(c)(1), 60.84(c)(1), §482.15(c)(1), 3.475(c)(1), §484.102(c)(1), 5.625(c)(1), §485.727(c)(1), 36.360(c)(1), §491.12(c)(1), st develop and maintain an edness communication planedness communication for the stact information for the development of the services under arrangement.  482.15(c) and CAHs at communication plan must lowing: tact information for the granedness cand CAHs].  483.15(c) and CAHs at communication plan must lowing: tact information for the granedness cand CAHs].		030			(X6) DATE	

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		34G255	B. WING			10/0	04/2022
NAME OF F	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SHADYLAWN DR CHAPEL HILL, NC 27516		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 030	following: (i) Staff. (ii) Entities providing (iii) Next of kin, gual (iv) Other RNHCIs. (v) Volunteers.  *[For ASCs at §416 plan must include at (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Patients' physic (iv) Volunteers.  *[For Hospices at § communication plant following: (1) Names and confollowing: (1) Names and confollowing: (i) Hospice employe (ii) Entities providing (iii) Patients' physic (iv) Other hospices  *[For HHAs at §484 plan must include at (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Patients' physic (iv) Volunteers.	tact information for the g services under arrangement. rdian, or custodian.  .45(c):] The communication ill of the following: tact information for the g services under arrangement. ians.  418.113(c):] The n must include all of the tact information for the ees. g services under arrangement. ians.  .102(c):] The communication ill of the following: tact information for the g services under arrangement. ians.  .3360(c):] The communication	E	030			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G255	B. WING		10/	04/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 SHADYLAWN DR CHAPEL HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
E 030	following: (i) Staff. (ii) Entities providin (iii) Volunteers. (iv) Other OPOs. (v) Transplant and Donation Service A This STANDARD is Based on docume facility failed to ens Preparedness (EP) developed and mai Federal, State and affected clients #1, The finding is:  Review on 10/3/22 include any informatical interest in the state of the stat	donor hospitals in the OPO's rea (DSA). s not met as evidenced by: nt review and interview, the ure an Emergency communication plan was ntained in compliance with local laws. This potentially #2, #3, #4, #5, #5, and #6.	E 03			
E 036	did not include any care staff who work  During an interview Intellectual Disabilit confirmed the EP p the information abocare staff.  EP Training and Te 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.	on 10/3/22, the Qualified ies Professional (QIDP) lan should have included both out the clients and the direct sting (2014), \$418.113(d), \$44(d), \$482.15(d), \$483.73(d), 102(d), \$485.68(d), 727(d), \$485.920(d),	E 03	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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E 036	Hospice at §418.11 at §460.84, Hospita §484.102, CORFs a "Organizations" und §485.920, OPOs at §491.12:] (d) Traini must develop and r preparedness traini based on the emergaragraph (a) (1) of procedures at parathe communication section. The training be reviewed and up *[For LTC facilities and testing. The LT maintain an emergand testing program emergency plan se section, risk assess this section, policies (b) of this section, a paragraph (c) of thi testing program muleast annually.  *[For ICF/IIDs at §4 testing. The ICF/IID an emergency prepared that is base forth in paragraph (assessment at parapolicies and proced section, and the coparagraph (c) of this	ge 3 3, PRTFs at §441.184, PACE als at §482.15, HHAs at at §485.68, CAHs at §486.625, der 485.727, CMHCs at §486.360, and RHC/FHQs at an gand testing. The [facility] maintain an emergency and testing program that is gency plan set forth in a section, risk assessment at this section, policies and graph (b) of this section, and plan at paragraph (c) of this and testing program must addated at least every 2 years.  Let §483.73(d):] (d) Training and testing program must are graph (a) of this section in paragraph (a) of this section. The training and testing ed on the training and testing ed on the emergency plan set as section. The training and testing ed on the emergency plan set and of this section, risk agraph (a)(1) of this section, risk agraph (a)(1) of this section, ures at paragraph (b) of this munication plan at a section. The training and testing ed on the emergency plan set and of this section, risk agraph (a)(1) of this section, ures at paragraph (b) of this munication plan at a section. The training and testing ed on the emergency plan set and section. The training and testing testion plan at a section. The training and testion plan at a section. The training and testion the training and testion plan at a section. The training and testion the training and testion plan at a section. The training and testion the training and testion plan at a section. The training and testion the training and testion plan at a section. The training and testion the training and testion plan at a section. The training and testion the training and testion plan at a section. The training and testion the training and testion plan at a section. The training and testion the training and testion plan at a section.	E 03	6		

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		34G255	B. WING _		10.	/04/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 SHADYLAWN DR CHAPEL HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 036	requirements for ex §483.470(i).  *[For ESRD Facilities testing, and oriental develop and maintal preparedness trains orientation program emergency plan sesection, risk assess this section, policies (b) of this section, a paragraph (c) of this and orientation program emergency plan sesection, risk assess this section, policies (b) of this section, a paragraph (c) of this and orientation program at every 2. This STANDARD is Based on docume facility failed to dev Preparedness (EP) This potentially affective.	The ICF/IID must meet the vacuation drills and training at vacuation drills and training at es at §494.62(d):] Training, tion. The dialysis facility must ain an emergency ing, testing and patient in that is based on the toforth in paragraph (a) of this sment at paragraph (a)(1) of its and procedures at paragraph and the communication plan at its section. The training, testing gram must be evaluated and years. It is not met as evidenced by: Interview and interview, the elop a Emergency training and testing program. It is to the program where the program is the program and testing program.	E 03	6		
E 039	include any informathe facility's staff.  During an interview there was no formather pertaining to the factor EP Testing Require CFR(s): 483.475(d)  §416.54(d)(2), §418 §460.84(d)(2), §483 §483.475(d)(2), §483	of facility's EP manual did not ation on training or testing of  on 10/3/22, the director stated all written test for the staff cilty's EP Plan.  ments (2) 3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d)(2),	E 03	9		

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E 039	"Organizations" und §485.920, RHCs/FG Facilities at §494.62 (2) Testing. The [facto test the emerger must do all of the formusity do all	der §485.727, CMHCs at QHCs at §491.12, and ESRD 2]:  cility] must conduct exercises acy plan annually. The [facility] bellowing:  ull-scale exercise that is every 2 years; or unity-based exercise is not a facility-based functional ears; or y] experiences an actual de emergency that requires a nergency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing:  cale exercise that is or individual, facility-based or	E 03	,		
	a facilitator and incl a narrated, clinically scenario, and a set directed messages designed to challer	ludes a group discussion using y-relevant emergency of problem statements, , or prepared questions age an emergency plan. cility's] response to and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		34G255	B. WING	<u>.</u>	10	/04/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 901 SHADYLAWN DR CHAPEL HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	exercises, and emergacility's] emergence *[For Hospices at 4 (2) Testing for hospatient's home. The exercises to test the annually. The hospice in a community based of the emergency plane em	ation of all drills, tabletop ergency events, and revise the cy plan, as needed.  18.113(d):] pices that provide care in the e hospice must conduct e emergency plan at least pice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not that an individual facility based every 2 years; or experiences a natural or experiences a natural or exercise or individual format required full scale exercise or individual conal exercise following the ency event.  Iditional exercise every 2 years, the full-scale or functional exercise or individual conal exercise or individual conal exercise following the ency event.  Iditional exercise every 2 years, the full-scale or functional exercise that is conal exercise exercise that is conal exercise that	EO	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		34G255	B. WING		10/	04/2022
NAME OF F	PROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 901 SHADYLAWN DR CHAPEL HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
E 039	exercises to test the year. The hospice (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the hospice eman-made emerge the emergency plarengaging in its next based or facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-s community-based of exercise; or (B) A mock disasted (C) A tabletop exercise facilitator that include narrated, clinically-land a set of problem messages, or prepare challenge an emergical iii) Analyze the homaintain document	rospice must conduct e emergency plan twice per must do the following: a annual full-scale exercise that d; or unity-based exercise is not t an annual individual onal exercise; or experiences a natural or ency that requires activation of ency that requires activation of ency the hospice is exempt from et required full-scale community esed functional exercise of the emergency event. ditional annual exercise that enot limited to the following: cale exercise that is er a facility based functional er drill; or ercise or workshop led by a des a group discussion using a relevant emergency scenario, en statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the	E 039			
	§482.15(d), CAHs a (2) Testing. The [PR conduct exercises to	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		34G255	B. WING			10/0	04/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, 901 SHADYLAWN CHAPEL HILL, I		-	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULI FERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	is community-base (A) When a community-base (A) When a community-based function (B) If the [PRTF, Heactual natural or marequires activation [facility] is exempt for the required full-scale of facility-based functionset of the emerging (ii) Conduct and that may include following: (A) A second full-scommunity-based of functional exercise (B) A mocking (C) A tabletopic functional exercise (B) A mocking (C) A tabletopic functional exercise functions designed plan. (iii) Analyze the maintain document exercises, and emergency scenarions designed plan.  (iii) Analyze the maintain document exercises, and emergency facility's] emergency  *[For PACE at §460 (2) Testing. The PACE at §460 (2) Testing. The PACE following:	annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event.  [additional] annual exercise or de, but is not limited to the cale exercise that is or individual, a facility-based for a disaster drill; or exercise or workshop that is und includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared at to challenge an emergency effacility's] response to and action of all drills, tabletop ergency events and revise the cy plan, as needed.  [2.84(d):]  CE organization must conduct the emergency plan at least is organization must do the in annual full-scale exercise that	EC	39			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
		34G255	B. WING _	<u> </u>	10	/04/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 901 SHADYLAWN DR CHAPEL HILL, NC 27516		
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E 039	accessible, conduct facility-based function (B) If the PACE expression and a man-made emerger the emergency planengaging in its next based or individual exercise following the exercise following the exercise under particular to the following:  (A) A second full-second full-second exercise (B) A mock disaster (C) A tabletop exercise a facilitator and including a narrated, of second functional exercises designed to challer (iii) Analyze the Paraintain document exercises, and emergency exercises (B) The [LTC facilities (C) The [LTC facility test the emergency procedure (C) The	unity-based exercise is not t an annual individual, onal exercise; or periences an actual natural or ney that requires activation of a, the PACE is exempt from t required full-scale community, facility-based functional he onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section nay include, but is not limited to cale exercise that is or individual, a facility based for er drill; or recise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan. (CE's response to and ation of all drills, tabletop ergency events and revise the replan, as needed.  at §483.73(d):]  If must conduct exercises to plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that	E 03	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G255	B. WING		10	/04/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 901 SHADYLAWN DR CHAPEL HILL, NC 275	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
E 039	accessible, conduction facility-based function. LTC facility is exemined a full-scalindividual, facility-befollowing the onset (ii) Conduct an admay include, but is (A) A second full-scommunity-based functional exercises (B) A mock disaste (C) A tabletop exemined a set of problemessages, or prepictually and a set of problemessages, or prepictually and maintain documentated, clinically and maintain documentated and maintain documen	unity-based exercise is not ct an annual individual, ional exercise. ity] facility experiences an an-made emergency that of the emergency plan, the npt from engaging its next ecommunity-based or ased functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based; or er drill; or recise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan.  TC facility] facility's response to mentation of all drills, tabletop ergency events, and revise the degree events are events. It is emergency plan, as needed.  483.475(d)]:  F/IID must conduct exercises that end; or unity-based exercise is not ct an annual individual,	EC	039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 901 SHADYLAWN DR CHAPEL HILL, NC 27516		
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E 039	engaging in its next community-based of functional exercise emergency event.  (ii) Conduct an add may include, but is (A) A second full-so community-based of functional exercise; (B) A mock disaste (C) A tabletop exercial facilitator and inclusing a narrated, of scenario, and a set directed messages designed to challen (iii) Analyze the ICF maintain document exercises, and emergency of the emergency of the emergency pengaging in its next community-based of the emergency pengaging in its next community	in, the ICF/IID is exempt from a required full-scale or individual, facility-based following the onset of the sitional annual exercise that not limited to the following: ale exercise that is or an individual, facility-based or drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan.  F/IID's response to and ation of all drills, tabletop ergency events, and revise the exp plan, as needed.  F-102]  HHA must conduct exercises acy plan at HHA must do the following: all-scale exercise that is or mmunity-based exercise is not that an annual individual, onal exercise every 2 years; experiences an actual natural agency that requires activation alan, the HHA is exempt from	E 03	9		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		34G255	B. WING		10	/04/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 901 SHADYLAWN DR CHAPEL HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 039	opposite the year t exercise under par is conducted, that limited to the follow (A) A second frommunity-based functional exercise (B) A mock dis (C) A tabletop led by a facilitator a discussion, using a emergency scenar statements, directed questions designed plan.  (iii) Analyze the H-documentation of a emergency events emergency plan, a *[For OPOs at §48 (d)(2) Testing. The to test the emergency following:  (i) Conduct a pape workshop at least a led by a facilitator a discussion, using a emergency scenar statements, directed questions designed plan. If the OPO example of the emergency platengaging in its nexal service of the company of the emergency platengaging in its nexal service of the company of the emergency platengaging in its nexal service of the company of the emergency platengaging in its nexal service of the company of th	litional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ving: ull-scale exercise that is or an individual, facility-based; or aster drill; or exercise or workshop that is and includes a group a narrated, clinically-relevant io, and a set of problem and messages, or prepared do to challenge an emergency days response to and maintain all drills, tabletop exercises, and and revise the HHA's seneded.	EO	39		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G255	B. WING		10	/04/2022	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 901 SHADYLAWN DR CHAPEL HILL, NC 27516	<b>.</b>	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
E 039	documentation of a emergency events, OPO's] emergency  *[RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followir (i) Conduct a paper least annually. A tat discussion led by a clinically-relevant error problem stateme prepared questions emergency plan. (ii) Analyze the RNH maintain document and emergency ever emergency plan, as This STANDARD is Based on document facility failed to ensor tabletop exercise Preparedness (EP) potentially affected #6. The finding is:  Review on 10/3/22 include a full-scale exercise for 2022, vin the home.	D's response to and maintain II tabletop exercises, and and revise the [RNHCI's and plan, as needed.  748]: RNHCI must conduct elemergency plan. The RNHCI ng: -based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set nts, directed messages, or designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's entereded.  Is not met as evidenced by: Intreview and interviews, the cure facility/community-based es to test their Emergency plan were conducted. This clients #1, #2, #3, #4, #5, and of the facility's EP plan, did not community-based or tabletop which included all staff working	ΕO	39			
W 137	confirmed there wa		W 1	37			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		34G255	B. WING _		10/	04/2022	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 SHADYLAWN DR CHAPEL HILL, NC 27516	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
W 137	Therefore, the facil have the right to repersonal possession. This STANDARD is Based on observation failed to ensure 2 of had the right to retain findings are:  A. During medication 10/4/22 at 7:12a eyeglasses. Further Qualified Intellectual (QIDP) had removed Review on 10/3/22 Program Plan IPP in on information in regards to the care.  B. During medication 10/4/22 at 7:18a eyeglasses. Further QIDP had removed Review on 10/3/22 2021 revealed there regards to a training care of his eyeglass.	nsure the rights of all clients. ity must ensure that clients tain and use appropriate ons and clothing. It is not met as evidenced by: tions and interviews, the facility of 5 audit clients (#1 and #5) ain personal possessions. The on administration in the home arm, client #5 was given his er observations revealed the all Disabilites Professional and them from a desk drawer. Of client #5's Individual (no date) revealed there was agards to a training objective in of his eyeglasses.  Ition administration in the home arm, client #1 was given his er observations revealed the I them from a desk drawer.  Of client #1's IPP dated March e was no information in gobjective in regards to the	W 13	,			
	and that is the reas medication room. none of the clients	on they are kept locked in the The QIDP also mentioned in the home know how to use the door to the medication					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G255	B. WING			10/04/2022	
NAME OF I	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SHADYLAWN DR CHAPEL HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 213	identify the client's strengths. This STANDARD is Based on record refailed to ensure 3 o #6) Community/Horhad been done. The A. Review on 10/3/Program Plan (IPP) was admitted to the review revealed clients of the review revealed clients Assessment.  B. Review on 10/3/8/3/22 revealed he 9/27/97. Further refor thave a Life Skill C. Review on 10/3/6/23/22 revealed he on 5/29/19. Furthed does not have a Life During an interview Intellectual Disability confirmed clients #Life Skills Assessm INDIVIDUAL PROCETR(s): 483.440(c)  The individual programs as identified by the required by paragrams.	e functional assessment must specific developmental so not met as evidenced by: eview and interview, the facility of 5 audit clients (#1, #3 and me/Life Skills Assessments are finding are:  //22 of client #1's Individual of dated 3/2021 revealed here facility on 11/15/10. Further ent #1 does not have a Life of the facility on the view revealed client #3 does also Assessment.  //22 of client #6's IPP dated was admitted to the facility on the view revealed client #3 does also Assessment.  //22 of client #6's IPP dated was admitted to the facility on the view revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or review revealed client #6 was admitted to the facility or was admitted to the facility o	W 2				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		34G255	B. WING _	B. WING		04/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 SHADYLAWN DR CHAPEL HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 249	reviews, the facility clients (#1 and #5) (IPP's) included spet the caring of their e  A. During observate the survey on 10/3 not wearing his eye #1 prompted to weater regards to a training care of his eyeglass.  B. During observate the survey on 10/3 not wearing his eye #5 prompted to weater regards to a training care of his eyeglass.  B. During observate the survey on 10/3 not wearing his eye #5 prompted to weater regards to a training care of his eyeglass.  During observate the survey on 10/3/22 revealed there was training objective in eyeglasses.  During an interview Intellectual Disability revealed both client broken and have be the QIDP stated not an objective to the seyeglasses.  PROGRAM IMPLE CFR(s): 483.440(d)  As soon as the interview intellectual Disability revealed by the seyeglasses.	ions, interviews and record failed to ensure 2 of 5 audit Individual Program Plans ecific information to address yeglasses. The findings are: ions in the home throughout - 4/22, client #1 was observed glasses. At no time was client ar his eyeglasses. of client #1's IPP dated March e was no information in g objective in regards to the ses. ions in the home throughout - 4/22, client #5 was observed glasses. At no time was client ar his eyeglasses. of client #5's IPP (no date) no information in regards to a regards to the care of his  on 10/3/22, the Qualified es Professional (QIDP) is #2 and #5 eyeglasses are seen broken for some time. Either client #2 or #5 has had address the caring of their				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		34G255	B. WING _		10	/04/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 901 SHADYLAWN DR CHAPEL HILL, NC 27516	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 249	treatment program interventions and s and frequency to s	age 17 eceive a continuous active consisting of needed services in sufficient number upport the achievement of the d in the individual program	W 24	49		
	Based on observa interviews, the faci clients (#1, #3 and active treatment pr interventions and s	is not met as evidenced by: tions, record reviews and lity failed to ensure 3 of 5 audit #6) received a continuous ogram consisting of needed tervices as identified in the Plan (IPP) in the area of The findings are:				
	10/3/22 beginning was put on his plat	bservations in the home on at 5:17pm, client #1's dinner e by Staff B. At no time was to put his own food on his				
		of client #1's IPP dated March any information pertaining to amily style dining.				
	10/3/22 beginning was put on his plat	bservations in the home on at 5:17pm, client #3's dinner e by Staff B. Client #3 was put his own food on his plate.				
		of client #3's IPP dated 8/3/22 formation pertaining to his skill /le dining.				
		observations in the home on at 5:17pm, client #6's dinner				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		34G255	B. WING		10/	04/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 SHADYLAWN DR CHAPEL HILL, NC 27516		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 249	client #6 prompted a plate.  Review on 10/3/22 of 6/23/22 did not have his skill level with far During an interview for the last two year clients' food on their precautions.  During an interview Intellectual Disability revealed family style occurring because of PHYSICIAN SERVI CFR(s): 483.460(a)  The facility must profexaminations of each includes an evaluat This STANDARD is Based on record refailed to ensure 1 of an annual examinations:  Review on 10/3/22 of the plate in the profession of the plate in the	e by Staff B. At no time was to put his own food on his of client #6's IPP dated e any information pertaining to mily style dining.  on 10/3/22, Staff B stated that is have been putting all the riplates due to COVID-19  on 10/4/22, the Qualified ies Professional (QIDP) e dining has not been COVID-19. CES	W 2	49		
W 340	Intellectual Disabilit		W 3	40		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G255	B. WING _		10	/04/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 901 SHADYLAWN DR CHAPEL HILL, NC 27516	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 340	other members of appropriate protect measures that including training clients and health and hygiened. This STANDARD Based on observations are services failed to esufficiently trained. Administration Rectemperatures of st. protocol. This pote #2, #3, #4, #5 and findings are:  A. During morning 10/4/22 at 7:30am. Disabilities Profess for Staff A who had to the client.  During an interview he should not have Further interview regave the medication been the one to significant to accompany the moment of the content	nust include implementing with the interdisciplinary team, tive and preventive health ude, but are not limited to I staff as needed in appropriate e methods. is not met as evidenced by: Intions and interview, nursing ensure that staff were in the signing of the Medication cord (MAR) and the taking the aff in regards to COVID-19 ntially effected all clients (#1, #6) residing in the home. The observations in the home on the Qualified Intellectual sional (QIDP) signed the MAR I actually given the medications of the Covidence of the Staff A. I actually given the medications of the QIDP stated the staff who actually ons to the client should have gen the MAR.  If observations in the home on the QIDP asked Staff C if her aled the QIDP did not use the stally take Staff C's of C proceeded into the home	W 34	40		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION	ļ	(X3) DATE SURVEY COMPLETED	
		34G255	B. WING			10/0	04/2022
NAME OF F	PROVIDER OR SUPPLIER  AWN			STREET ADDRESS, CITY, STATE, ZIP ( 901 SHADYLAWN DR CHAPEL HILL, NC 27516	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
W 340	"1. Screen Upon a employee is screen exposure to COVID During an interview	org dated June 2020 stated, irrival at any RSI homeeach ed for potential illness or -19"	W 3	40			
W 383	take the temperatur one of the screening temperatures of the	have used the thermometer to re of Staff C. The QIDP stated g process is to take the staff as they enter the home. AND RECORDKEEPING 2)	W 3	83			
	keys to the drug sto This STANDARD is Based on observat failed to ensure only	sons may have access to the brage area. Is not met as evidenced by: It ions and interviews, the facility of authorized persons have ne drug storage area. The					
	10/3/22 at 10:25am the home the Qualit Professional (QIDP keys from off of hoo front door. The QID door to obtain the thused to take the ter 10/4/22, the surveyor	servations in the home on when the surveyor entered fied Intellectual Disabilities took a key ring, with several ok which is located right at the DP then proceed to unlock a hermometer which the QIDP inperature of the surveyor. On or observed the door which the previous day is the					
	confirmed the medi been left unattende	on 10/4/22, the QIDP cation key should not have d. Further interview revealed ication technician should have erson at all times.					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  IG		COMPLETED		
		34G255	B. WING _		10	/04/2022	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 901 SHADYLAWN DR CHAPEL HILL, NC 27516			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 436	and teach clients to choices about the chearing and other cand other dand other dand other dand other disciplinary teather than the control of the control of the chearing and other dand other dand other dand other dand other dand other dand of the chear dand of th	rnish, maintain in good repair, use and to make informed use of dentures, eyeglasses, communications aids, braces, dentified by the mas needed by the client. In some that as evidenced by: tions, record review and ity failed to ensure in the properties of the form of the	W 43	66			
W 441	evaluation dated 8/ "Recommendations name] is wearing h  During an interview Intellectual Disabilit revealed client #2's for over one year.  EVACUATION DRICFR(s): 483.470(i)(i) and under varied control of the STANDARD in Based on review of interviews, the facil evacuation drills wearing is wearing to the state of th	s: C. Ensure that [client #2's is glasses throughout the day." on 10/3/22, the Qualified ies Professional (QIDP) eyeglasses have been broken LLS	W 44	.1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G255	B. WING	B. WING			04/2022
NAME OF I	PROVIDER OR SUPPLIER			901 SHADY	DRESS, CITY, STATE, ZIP CODE YLAWN DR HILL, NC 27516	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	( (E	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 441	Review on 10/3/22 revealed there whe October and Noven March, April, July a review revealed the conducted on third.  During an interview Intellectual Disabilit confirmed the fire d and November 202	in the home. The finding is: of the facility's fire drills re no fire drills conducted in nber 2021 and February, nd August 2022. Further are were no fire drills	W 4	41			