DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
		34G273	B. WING			02/2	28/2023
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NODTUS	IDE GROUP HOME			3	3301 BARKSDALE ROAD		
NORTHS				F	FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §482		ΕO	139			
	*[For ASCs at §416 at §485.542, OPO, §485.727, CMHCs	91.12(d)(2), §494.62(d)(2). 5.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]:					
		cility] must conduct exercises icy plan annually. The [facility] bllowing:					
	community-based e (A) When a comm accessible, conduc exercise every 2 ye (B) If the [facilit natural or man-mac activation of the em exempt from engag community-based of	unity-based exercise is not t a facility-based functional					
	years, opposite the functional exercise this section is cond not limited to the fo (A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise	cale exercise that is or individual, facility-based or			TITLE		(X6) DATE

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

PRINTED: 03/01/2023

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.

		AND HUMAN SERVICES				FORM	03/01/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		34G273	B. WING	;		02/:	28/2023
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 DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (iii) Analyze the [fac maintain document exercises, and emer [facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based ef (A) When a commu- accessible, conduct functional exercise (B) If the hospice ex- man-made emerge the emergency plar engaging in its next community-based functionset of the emergency (ii) Conduct an add opposite the year the exercise under para is conducted, that no to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaster (C) A tabletop exer	Judes a group discussion using y-relevant emergency of problem statements, , or prepared questions age an emergency plan. cility's] response to and 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 bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not t an individual facility based every 2 years; or xperiences a natural or ncy that requires activation of n, the hospital is exempt from t required full scale exercise or individual onal exercise following the ency event. ditional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	E	038	9		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/01/2023 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>´</i>		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G273	B. WING			02/;	28/2023
NAME OF	PROVIDER OR SUPPLIER	·			TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHS	SIDE GROUP HOME				301 BARKSDALE ROAD AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The f exercises to test the year. The hospice (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functi (B) If the hospice e man-made emerge the emergency plar engaging 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 or exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-n and a set of problet messages, or prepa- challenge an emerge (iii) Analyze the ho maintain document exercises, and emerge	y-relevant emergency of problem statements, or prepared questions age an emergency plan. bices that provide inpatient hospice must conduct e emergency plan twice per must do the following: n annual full-scale exercise that d; or unity-based exercise is not at an annual individual ional exercise; or xperiences a natural or ency that requires activation of n, the hospice is exempt from t required full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or rcise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to	EO	139			

Facility ID: 932314

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/01/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G273	B. WING			02/:	28/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
NORTHS	IDE 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
E 039	*[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF conduct exercises to twice per year. The do the following: (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based functi (B) If the [PRTF, Ho actual natural or marequires activation of [facility] is exempt for required full-scale of facility-based function (ii) Conduct an and that may include following: (A) A second full-second functional exercise; (B) A mock (C) A tabletop of led by a facilitator at discussion, using a emergency scenario statements, directe questions designed plan. (iii) Analyze the maintain document	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must 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 le, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	E	039			

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		AND HUMAN SERVICES				FORM	03/01/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G273	B. WING			02/:	28/2023
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHS	IDE GROUP HOME				3301 BARKSDALE ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	<ul> <li>(2) Testing. The PAGE exercises to test the annually. The PACE following:</li> <li>(i) Participate in an is community-based (A) When a community-based function (B) If the PACE expressible, conduct facility-based function (B) If the PACE expression (B) If the PACE expression (C) and the emergency planent engaging in its next based or individual, exercise following the event.</li> <li>(ii) Conduct an years opposite the years opposite the years opposite the years community-based of functional exercise;</li> <li>(B) A second full-sec community-based of functional exercise;</li> <li>(B) A mock disaster (C) A tabletop exert a facilitator and inclusing a narrated, clis scenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain documenta exercises, and emere PACE's emergency</li> </ul>	CE organization must conduct e emergency plan at least E organization must do the annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or periences an actual natural or ncy that requires activation of n, 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 hay include, but is not limited to cale exercise that is or individual, a facility based for er drill; or rcise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, , or prepared questions age an emergency plan. ACE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed.	EC	039			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCT		(X3) D	O. 0938-039 ATE SURVEY DMPLETED
	U CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	IG			
		34G273	B. WING _			0	2/28/2023
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRES	CODE		
ORTHS	IDE GROUP HOME			3301 BARKSDA FAYETTEVILL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CO CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
E 039	• · · · · · · · · · · · · · · · · · · ·	-	E 03	39			
	including unannour	r plan at least twice per year, nced staff drills using the ures. The [LTC facility,					
	ICF/IID] must do th (i) Participate in an	e following: annual full-scale exercise that					
		d; or unity-based exercise is not t an annual individual,					
	facility-based functi (B) If the [LTC facili	onal exercise. ty] facility experiences an					
	requires activation	an-made emergency that of the emergency plan, the opt from engaging its next					
	required a full-scale individual, facility-ba	e community-based or ased functional exercise					
	(ii) Conduct an add	of the emergency event. ditional annual exercise that					
	(A) A second full-s	not limited to the following: cale exercise that is or an individual, facility based					
	<ul><li>(B) A mock disaster</li><li>(C) A tabletop exer</li></ul>	er drill; or rcise or workshop that is led by					
	narrated, clinically- and a set of problem	s a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to					
	(iii) Analyze the [L] and maintain docur exercises, and eme	TC facility] facility's response to mentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed.					
		F/IID must conduct exercises ncy plan at least twice per year.					

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		AND HUMAN SERVICES				FORM	03/01/2023 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G273	B. WING	i		02/2	28/2023
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHS	BIDE GROUP HOME				3301 BARKSDALE ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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
E 039	is community-based (A) When a commu accessible, conduct facility-based function (B) If the ICF/IID ex- man-made emergen the emergency plane engaging in its next community-based of functional exercises emergency event. (ii) Conduct an addi may include, but is for (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclu- using a narrated, cli- scenario, and a set directed messages, designed to challen (iii) Analyze the ICF maintain documenta exercises, and emer ICF/IID's emergence *[For HHAs at §484 (d)(2) Testing. The I to test the emergen least annually. The (i) Participate in a fu community-based; of (A) When a cor accessible, conduct	d; or unity-based exercise is not t an annual individual, ional exercise; or. operiences an actual natural or oncy that requires activation of n, the ICF/IID is exempt from t required full-scale or individual, facility-based following the onset of the itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based ; or r drill; or cise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, , or prepared questions age an emergency plan. F/IID's response to and ration of all drills, tabletop ergency events, and revise the cy plan, as needed. IID's response to and ration of all drills, tabletop ergency events, and revise the cy plan at HHA must conduct exercises noy plan at HHA must do the following: ull-scale exercise that is	E	039			

		AND HUMAN SERVICES				FORM	03/01/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G273	B. WING			02/2	28/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHS	DE GROUP HOME				301 BARKSDALE ROAD AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	<ul> <li>(B) If the HHA</li> <li>or man-made emer</li> <li>of the emergency p</li> <li>engaging in its next</li> <li>community-based of</li> <li>functional exercise</li> <li>emergency event.</li> <li>(ii) Conduct an addi</li> <li>opposite the year the</li> <li>exercise under para</li> <li>is conducted, that</li> <li>limited to the following</li> <li>(A) A second functional exercise;</li> <li>(B) A mock disa</li> <li>(C) A tabletop e</li> <li>led by a facilitator at</li> <li>discussion, using a</li> <li>emergency events, directed</li> <li>questions designed</li> <li>plan.</li> <li>(iii) Analyze the HHL</li> <li>documentation of a</li> <li>emergency events, emergency plan, as</li> <li>*[For OPOs at §486</li> <li>(d)(2) Testing. The to</li> <li>to test the emergen</li> <li>following:</li> <li>(i) Conduct a paper</li> <li>workshop at least at</li> <li>led by a facilitator a</li> <li>discussion, using a</li> </ul>	experiences an actual natural rgency that requires activation lan, the HHA is exempt from required full-scale or individual, facility based following the onset of the itional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section it may include, but is not ing: ill-scale exercise that is or an individual, facility-based or aster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared t o challenge an emergency A's response to and maintain II drills, tabletop exercises, and and revise the HHA's s needed.	EC	)39			

		AND HUMAN SERVICES				FOR	ED: 03/01/2023 RM APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION G	(X3) D	ATE SURVEY OMPLETED
		34G273	B. WING	i		0	2/28/2023
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 DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 039	questions designed plan. If the OPO ex man-made emerge the emergency plan engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[ RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followin (i) Conduct a paper least annually. A tak discussion led by a clinically-relevant er of problem stateme prepared questions emergency plan. (ii) Analyze the RNI- maintain document and emergency eve emergency plan, as This STANDARD is Based on document facility failed to ensu- mock drill or an ann conducted and inclu- Emergency Prepare is: Review on 2/27/23 revealed there was Further review indice	to challenge an emergency periences an actual natural or ncy that requires activation of a, the OPO is exempt from a required testing exercise of the emergency event. D's response to and maintain Il tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: -based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's a needed. s not met as evidenced by: nt review and interviews, the ure a full scale evacuation, hual tabletop activity was uded in the facility's edness Plan (EP). The finding	E	039	9		

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		AND HUMAN SERVICES				FORM	: 03/01/2023 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G273	B. WING	i		02/	28/2023
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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 039	Continued From pa	ige 9	E (	039			
	During an interview Intellectual Disabilit confirmed the facili	on 2/28/23, the Qualified ties Professional (QIDP)					

Facility ID: 932314

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