		AND HUMAN SERVICES				FORM	APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1		(<u>)MB NO.</u>	0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION G		E SURVEY PLETED	
		34G078	B. WING	ì		08/29/2023		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
WATSON	I'S GROUP HOME			1310 ELWELL AVENUE GREENSBORO, NC 27420				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	REGULATORY OR L Develop EP Plan, F CFR(s): 483.475(a) §403.748(a), §416. §441.184(a), §460. §443.475(a), §484. §485.542(a), §485. §485.542(a), §486. §494.62(a). The [facility] must of Federal, State and preparedness requi develop establish a emergency prepare requirements of this preparedness prog limited to, the follow (a) Emergency Plar and maintain an em that must be [review every 2 years. The following: * [For hospitals at § §485.625(a):] Emer CAH] must comply State, and local em requirements. The develop and mainta emergency prepare requirements of this all-hazards approat * [For LTC Facilities	Action Science (Section 2) (Science (Section 2) (Secti		i	CROSS-REFERENCED TO THE APPROI DEFICIENCY)			
		aredness plan that must be ated at least annually.						

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

TITLE

(X6) DATE

PRINTED: 08/31/2023

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	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		34G078	B. WING			08/	29/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WATSON	'S GROUP HOME				310 ELWELL AVENUE REENSBORO, NC 27420		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 004	Plan. The ESRD fac maintain an emerge	ge 1 ies at §494.62(a):] Emergency cility must develop and ency preparedness plan that], and updated at least every 2	E	004			
	Based on record refailed to ensure the plan (EPP) was revision biennially. The find Review on 8/28/23 that it was updated review of the EPP sclients in the facility	of the facility's EPP revealed on 3/13/2020. Continued showed evidence of 3 out of 6 r information that included a					
E 037	information needs t Interview on 8/29/23 confirmed that the B	3 with the facility director EPP needed to be updated to nt specific information. m	E ()37			
	§441.184(d)(1), §46 §483.73(d)(1), §483 §485.68(d)(1), §483	16.54(d)(1), §418.113(d)(1), 60.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 5.542(d)(1), §485.625(d)(1), 85.920(d)(1), §486.360(d)(1),					
	Hospitals at §482.1						

Facility ID: 922844

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G078 B. WING 08/29/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1310 ELWELL AVENUE** WATSON'S GROUP HOME GREENSBORO, NC 27420 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 037 Continued From page 2 E 037 (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		34G078	B. WING			08/;	29/2023
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WATSON	I'S GROUP HOME				1310 ELWELL AVENUE GREENSBORO, NC 27420		
(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 037	procedures are sign must conduct training procedures. *[For PRTFs at §44 program. The PRTF (i) Initial training in e policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) After initial training preparedness training (iii) Demonstrate state procedures. (iv) Maintain docum preparedness training procedures are sign must conduct training procedures. *[For PACE at §460 organization must of (i) Initial training in e policies and proced staff, individuals pro- arrangement, contra- volunteers, consisted (ii) Provide emergent least every 2 years. (iii) Demonstrate state procedures, including what to do, where the case of an emergent (v) If the emergent (v) If the emergent	1.184(d):] (1) Training F must do all of the following: emergency preparedness ures to all new and existing oviding services under rolunteers, consistent with their ng, provide emergency ng every 2 years. aff knowledge of emergency ng. y preparedness policies and hificantly updated, the PRTF ng on the updated policies and ent with their expected roles. ures to all new and existing oviding on-site services under actors, participants, and ent with their expected roles. hcy preparedness training at aff knowledge of emergency ng at the term of the services under actors, participants, and ent with their expected roles. hcy preparedness training at aff knowledge of emergency ng informing participants of o go, and whom to contact in	E	037			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G078 B. WING 08/29/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1310 ELWELL AVENUE** WATSON'S GROUP HOME GREENSBORO, NC 27420 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 037 Continued From page 4 E 037 must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the followina: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF

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		AND HUMAN SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G078	B. WING	i		08/	29/2023
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WATSON	I'S GROUP HOME				1310 ELWELL AVENUE GREENSBORO, NC 27420		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 037	must conduct training procedures. *[For CAHs at §485 The CAH must do at (i) Initial training in e policies and proced reporting and exting and where necessal personnel, and gue cooperation with fire authorities, to all ne individuals providing and volunteers, cor roles. (ii) Provide emergen least every 2 years. (iii) Maintain docum (iv) Demonstrate st procedures. (v) If the emergen procedures are sign must conduct training procedures. *[For CMHCs at §4 CMHC must provid preparedness polic and existing staff, in under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on record re	ng on the updated policies and 5.625(d):] (1) Training program. all of the following: emergency preparedness lures, including prompt guishing of fires, protection, ary, evacuation of patients, sts, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, hisistent with their expected ncy preparedness training at entation of the training. aff knowledge of emergency cy preparedness policies and hificantly updated, the CAH ng on the updated policies and 85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new hidividuals providing services , and volunteers, consistent	E	037			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G078 B. WING 08/29/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1310 ELWELL AVENUE** WATSON'S GROUP HOME GREENSBORO, NC 27420 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 037 Continued From page 6 E 037 the facility's emergency preparedness plan (EPP) at least biennially. The finding is: Review on 8/28/23 of the facility's EPP revealed no evidence of initial or biennial in-service training on the EPP. Interview on 8/29/23 with the facility director confirmed that initial training and biennial training for current staff were not completed. E 039 **EP** Testing Requirements E 039 CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years: or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G078 B. WING 08/29/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1310 ELWELL AVENUE** WATSON'S GROUP HOME GREENSBORO, NC 27420 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 039 Continued From page 7 E 039 functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise: or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 922844

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G078	B. WING			08/;	29/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WATSON	'S GROUP HOME				310 ELWELL AVENUE GREENSBORO, NC 27420		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	onset of the emerge (ii) Conduct an add opposite the year the exercise under para is conducted, that in to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaster (C) A tabletop exer a facilitator and incl a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The he exercises to test the year. The hospice (i) Participate in an is community-based (ii) Participate in an is community-based (A) When a commu accessible, conduct facility-based functii (B) If the hospice ex- man-made emerge the emergency plar engaging in its next based or facility-base following the onset (ii) Conduct an add may include, but is (A) A second full-se	ency event. litional exercise every 2 years, litional exercise or functional agraph (d)(2)(i) of this section hay include, but is not limited cale exercise that is or a facility based functional r drill; or cise or workshop that is led by udes a group discussion using <i>r</i> -relevant emergency of problem statements, or prepared questions ge an emergency plan. lices that provide inpatient tospice must conduct e emergency plan twice per must do the following: annual full-scale exercise that d; or mity-based exercise is not t an annual individual onal exercise; or kperiences a natural or ncy that requires activation of a, the hospice is exempt from required full-scale community sed functional exercise that not limited to the following: cale exercise that is or a facility based functional	E	039			

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		AND HUMAN SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G078	B. WING			08/2	29/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WATSON	I'S GROUP HOME				310 ELWELL AVENUE GREENSBORO, NC 27420		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	 (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepachallenge an emerge (iii) Analyze the host maintain document exercises, and emerge hospice's emergend *[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 function (B) If the [PRTF, Hot actual natural or ma- requires activation of [facility-based function (actual natural or ma- required full-scale of facility-based function (and that may include following: (A) A second full-scale of functional exercise; (B) A mock 	 A construction of the emergency plan. A construction of all drills, tabletop A construction of all	E	039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		34G078	B. WING	;		08/:	29/2023
NAME OF P	PROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
WATSON	'S GROUP HOME				1310 ELWELL AVENUE GREENSBORO, NC 27420		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	discussion, using a emergency scenarie statements, directed questions designed plan. (iii) Analyze the maintain documents exercises, and emergen [facility's] emergend *[For PACE at §460 (2) Testing. The PACE following: (i) Participate in an is community-based (A) When a community-based (A) When a community-based following: (i) Participate in an is community-based (A) When a community-based following in its next based or individual, exercise following the event. (ii) Conduct an years opposite the y exercise under para is conducted that m the following: (A) A second full-sec community-based of functional exercise; (B) A mock disaster	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. 0.84(d):] CE organization must conduct e emergency plan at least 5 organization must do the annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or beriences an actual natural or ncy that requires activation of h, the PACE is exempt from a 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 tay include, but is not limited to cale exercise that is or individual, a facility based or	E	039			
		cise of workshop that is led by					

Facility ID: 922844

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		E SURVEY IPLETED
		34G078	B. WING			08/;	29/2023
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WATSON	'S GROUP HOME				310 ELWELL AVENUE GREENSBORO, NC 27420		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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	using a narrated, cl scenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain document exercises, and eme PACE's emergency *[For LTC Facilities (2) The [LTC facility test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functii (B) If the [LTC facility actual natural or ma requires activation of LTC facility is exem required a full-scale individual, facility-based (ii) Conduct an ado may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically-r	udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. CE's response to and ation of all drills, tabletop orgency events and revise the plan, as needed. at §483.73(d):]] must conduct exercises to plan at least twice per year, ced staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or inity-based exercise is not t an annual individual, onal exercise. ty] facility experiences an an-made emergency that of the emergency plan, the pt from engaging its next e community-based or ased functional exercise that not limited to the following: cale exercise that is or an individual, facility based or	E	039			

Facility ID: 922844

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G078	B. WING	i		08/2	29/2023
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WATSON	'S GROUP HOME				1310 ELWELL AVENUE GREENSBORO, NC 27420		
(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 039	messages, or prepa challenge an emerge (iii) Analyze the [LT and maintain docum exercises, and emerge [LTC facility] facility ¹ *[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergen The ICF/IID must de (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based function (B) If the ICF/IID ex- man-made emerge the emergency plane engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and incl using a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the ICF maintain document	ared questions designed to gency plan. C facility] facility's response to nentation of all drills, tabletop regency events, and revise the s emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises cy plan at least twice per year. o the following: annual full-scale exercise that d; or inity-based exercise is not t an annual individual, onal exercise; or. periences an actual natural or ncy that requires activation of a, the ICF/IID is exempt from required full-scale or individual, facility-based following the onset of the tional annual exercise that not limited to the following: ale exercise that is or an individual, facility-based or	E	039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		34G078	B. WING			08/	29/2023
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WATSON	I'S GROUP HOME				1310 ELWELL AVENUE GREENSBORO, NC 27420		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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	ICF/IID's emergence *[For HHAs at §484 (d)(2) Testing. The to test the emergence least annually. The (i) Participate in a fu community-based; ((A) When a correst accessible, conduct facility-based function or. (B) If the HHA or man-made emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi opposite the year the exercise under para is conducted, that limited to the follow (A) A second fu community-based of functional exercise; (B) A mock disa (C) A tabletop e led by a facilitator a discussion, using a emergency scenarie statements, directed questions designed plan. (iii) Analyze the HH.	y plan, as needed. 102] HHA must conduct exercises cy plan at HHA must do the following: ull-scale exercise that is or nmunity-based exercise is not t an annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation lan, the HHA is exempt from required full-scale or individual, facility based following the onset of the tional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section t may include, but is not ing: Il-scale exercise that is or an individual, facility-based or	E)39	>		

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		AND HUMAN SERVICES					FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	0	(X3) DATE	E SURVEY IPLETED
		34G078	B. WING	i			08/2	29/2023
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP	CODE		
WATSON	'S GROUP HOME				1310 ELWELL AVENUE GREENSBORO, NC 27420			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
E 039	to test the emergen following: (i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenarie statements, directed questions designed plan. If the OPO ex man-made emerge the emergency plan engaging in its next following the onset (ii) Analyze the OPC 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 tat discussion led by a clinically-relevant ere of problem stateme prepared questions emergency plan. (ii) Analyze the RNI- maintain document and emergency even	5 needed. 5.360] OPO must conduct exercises hey plan. The OPO must do the based, tabletop exercise or innually. A tabletop exercise is nd includes a group narrated, clinically relevant o, and a set of problem d messages, or prepared to challenge an emergency periences an actual natural or ncy that requires activation of n, the OPO is exempt from a required testing exercise of the emergency event. D's response to and maintain II 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	E	039				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G078	B. WING			08/2	29/2023
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WATSON	'S GROUP HOME				310 ELWELL AVENUE GREENSBORO, NC 27420		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	Continued From pa	ge 15	EC)39			
	failed to conduct bie	eview and interview, the facility ennial testing of the facility's edness plan (EPP). The					
	no evidence of a ful facility-based training	facility-based training or					
W 454	confirmed the facilit full-scale communit second full scale-co training or mock dri		W 4	54			
		ovide a sanitary environment d transmission of infections.					
	Based on observat failed to ensure a sa	s not met as evidenced by: ions and interview, the facility anitary environment to avoid hission of infections. The					
	6:53 AM revealed c C with preparation of Continued observat client #5 to don glov bacon to cook. Furt AM to 7:25 AM reve bacon, eggs, toast,	group home on 8/29/23 at lient #5 to begin assisting staff of the breakfast meal. tion revealed staff C to prompt ves and begin preparing raw ther observations from 6:53 ealed client #5 to prepare dispose of trash, set the table tir eggs and grits with the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							PRINTED: 08/31/2023 FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G078		B. WING			08/29/2023			
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE	-		
WATSON'S GROUP HOME				1310 ELWELL AVENUE GREENSBORO, NC 27420				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE	
W 454	same pair of gloves preparation did sta their gloves. Interview with the f confirmed staff sho changed frequently	age 16 s. At no time during the meal ff prompt client #5 to change acility director on 8/29/23 ould ensure gloves are y during food preparation to nination and ensure a sanitary	W 4	454				

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