STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		ONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY MPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			MPLETED
		34G166	B. WING			0	9/07/2023
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	•	
YADKIN II	o III			3220	& 3224 US HWY 21		
	α III			HAN	IPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
E 037	EP Training Program CFR(s): 483.475(d)(1		E	037			
§4 §4 §4 §4 §4 §4 §4 §4 §4 [H at un R (i) po st ar e) (ii) po st ar (ii) pr (v pr (v pr m	§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).						
	Hospitals at §482.15, at §484.102, REHs a under §485.727, OPC RHC/FQHCs at §491 (1) Training program the following:	.12:] . The [facility] must do all of					
	policies and procedur staff, individuals prov arrangement, and vo expected roles. (ii) Provide emergence	nergency preparedness res to all new and existing iding services under lunteers, consistent with their cy preparedness training at					
	preparedness training (iv) Demonstrate staf procedures.	ntation of all emergency g. f knowledge of emergency preparedness policies and					
	procedures are signif	icantly updated, the [facility] on the updated policies and					
	hospice must do all c (i) Initial training in er policies and procedur hospice employees, a services under arrang	18.113(d):] (1) Training. The of the following: nergency preparedness res to all new and existing and individuals providing gement, consistent with their					
	expected roles.						

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 09/12/2023

FORM APPROVED

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	MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	1 ° ′			MPLETED	
		34G166	B. WING		09/07/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
YADKIN II	& III			3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
E 037	E 037 Continued From page 1		E 03	37			
		f knowledge of emergency					
	procedures.						
		ncy preparedness training at					
	least every 2 years. (iv) Periodically revie	ew and rehearse its					
		Iness plan with hospice					
		g nonemployee staff), with					
		aced on carrying out the ry to protect patients and					
	others.	Ty to protect patients and					
	(v) Maintain docume	ntation of all emergency					
	preparedness trainin	•					
		r preparedness policies and ficantly updated, the hospice					
		g on the updated policies and					
	procedures.						
		.184(d):] (1) Training					
		must do all of the following: mergency preparedness					
		ires to all new and existing					
		viding services under					
	•	olunteers, consistent with their					
	expected roles. (ii) After initial trainin	g, provide emergency					
	preparedness trainin						
		ff knowledge of emergency					
	procedures.	ntation of all amorganou					
	preparedness trainin	entation of all emergency a.					
		preparedness policies and					
		ficantly updated, the PRTF					
	must conduct trainin procedures.	g on the updated policies and					
		84(d):] (1) The PACE					
	organization must do	o all of the following: mergency preparedness					
	i (i) iniuai u alfillig lli e	menyency prepareditess	1			1	

Facility ID: 922912

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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 **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G166 B. WING 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 YADKIN II & III HAMPTONVILLE, NC 27020 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 037 Continued From page 2 E 037 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE 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 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 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	NO. 0938-039	
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COI	MPLETED	
		34G166	B. WING _		09/07/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
YADKIN II	& III			3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
E 037	 (ii) Provide emergence least every 2 years. (iii) Maintain document (iv) Demonstrate staff procedures. All new p and assigned specific the CORF's emergent their first workday. The include instruction in alarm systems and si equipment. (v) If the emergency procedures are signiff must conduct training procedures. *[For CAHs at §485.6] The CAH must do all (i) Initial training in empolicies and procedur reporting and extingu and where necessary personnel, and guest cooperation with firefi authorities, to all new individuals providing and volunteers, consir roles. (ii) Provide emergence least every 2 years. (iii) Maintain document (iv) Demonstrate staff procedures. (v) If the emergency procedures are signiff 	ey preparedness training at ntation of the training. f knowledge of emergency bersonnel must be oriented c responsibilities regarding cy plan within 2 weeks of he training program must the location and use of gnals and firefighting r preparedness policies and icantly updated, the CORF on the updated policies and con the updated policies and con the following: nergency preparedness res, including prompt ishing of fires, protection, r, evacuation of patients, s, fire prevention, and ighting and disaster	EO	37			

Facility ID: 922912

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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 **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G166 B. WING 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 YADKIN II & III HAMPTONVILLE, NC 27020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 037 Continued From page 4 E 037 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must 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, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff were trained on the facility's emergency preparedness plan (EPP) at least biennially. The finding is: Review on 9/7/23 of the facility's EPP at Yadkin II revealed no evidence of initial or biennial in-service training on the EPP. Interview with the facility administrator on 9/7/23 revealed that direct care staff at Yadkin II were provided in-service training, however evidence of the in-service training was not available during the survey. Continued interview with the facility administrator confirmed that initial training and biennial training for all staff should be completed with staff participation as required. 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).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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 **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G166 B. WING 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 YADKIN II & III HAMPTONVILLE, NC 27020 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 039 Continued From page 5 E 039 *[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 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

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Facility ID: 922912

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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 **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G166 B. WING 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 YADKIN II & III HAMPTONVILLE, NC 27020 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 039 Continued From page 6 E 039 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 onset of the emergency event. (ii) Conduct an additional exercise 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 a 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. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 922912

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/12/2023 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	
		34G166	B. WING			_	09/	07/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
YADKIN II	& III				220 & 3224 US HWY 21 AMPTONVILLE, NC 2	7020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	accessible, conduct a facility-based function (B) If the [PRTF, Hosp actual natural or man- requires activation of [facility] is exempt from required full-scale con- facility-based function onset of the emergence (ii) Conduct an [a and that may include, following: (A) A second full-scal community-based or i functional exercise; of (B) A mock of (C) A tabletop exe led by a facilitator and discussion, using a na emergency scenario, statements, directed r questions designed to plan. (iii) Analyze the [f maintain documentati exercises, and emerg [facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE exercises to test the e annually. The PACE of following: (i) Participate in an an is community-based;	or ty-based exercise is not n annual individual, al exercise; or bital, CAH] experiences an -made emergency that the emergency plan, the m engaging in its next nmunity based or individual, al exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based r disaster drill; or ercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed. 4(d):] E organization must conduct emergency plan at least organization must do the nnual full-scale exercise that	E	039				

Facility ID: 922912

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	09/12/2023 APPROVED 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE S COMPLE	URVEY
		34G166	B. WING			09/0	7/2023
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
YADKIN II	9 III		3:	220 & 3224 US HWY 21			
	α m		н	AMPTONVILLE, NC 270	20		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION IVE ACTION SHOULD BE CED TO THE APPROPRIAT FICIENCY)		(X5) COMPLETION DATE
E 039	Continued From page accessible, conduct a facility-based function (B) If the PACE exper man-made emergence the emergency plan, the engaging in its next re- based or individual, fa- exercise following the event. (ii) Conduct an ac- years opposite the ye- exercise under parage is conducted that may the following: (A) A second full-scal community-based or in functional exercise; on (B) A mock disaster of (C) A tabletop exercise a facilitator and includ using a narrated, clini scenario, and a set of directed messages, on designed to challenge (iii) Analyze the PACI maintain documentati exercises, and emerg PACE's emergency pl *[For LTC Facilities att (2) The [LTC facility] re test the emergency pl including unannounce emergency procedure ICF/IID] must do the fi (i) Participate in an at is community-based; of	 9 In annual individual, hal exercise; or iences an actual natural or y that requires activation of the PACE is exempt from equired full-scale community acility-based functional onset of the emergency dditional exercise every 2 ar the full-scale or functional raph (d)(2)(i) of this section y include, but is not limited to le exercise that is individual, a facility based r drill; or se or workshop that is led by des a group discussion, cally-relevant emergency f problem statements, r prepared questions an emergency plan. E's response to and on of all drills, tabletop lency events and revise the lan, as needed. §483.73(d):] must conduct exercises to lan at least twice per year, ed staff drills using the es. The [LTC facility, following: nnual full-scale exercise that 	E 039				
	(A) When a communit	ty-based exercise is not					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	09/12/2023 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING			(X3) DATE S COMPL	SURVEY
		34G166	B. WING			09/0	7/2023
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STAT	LE, ZIP CODE		
YADKIN II	& III			20 & 3224 US HWY 21 MPTONVILLE, NC 270)20		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
E 039	accessible, conduct a facility-based function (B) If the [LTC facility] actual natural or man- requires activation of LTC facility is exempt required a full-scale c individual, facility-bas following the onset of (ii) Conduct an additi may include, but is no (A) A second full-sca community-based or a functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-rel- and a set of problem s messages, or prepare challenge an emerger (iii) Analyze the [LTC and maintain docume exercises, and emerg [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/II to test the emergency The ICF/IID must do t (i) Participate in an ar is community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID expen- man-made emergency	an annual individual, nal exercise. I facility experiences an -made emergency that the emergency plan, the from engaging its next community-based or ed functional exercise the emergency event. onal annual exercise that ot limited to the following: le exercise that is an individual, facility based r drill; or se or workshop that is led by a group discussion, using a evant emergency scenario, statements, directed ed questions designed to ncy plan. facility] facility's response to entation of all drills, tabletop jency events, and revise the emergency plan, as needed. 3.475(d)]: ID must conduct exercises y plan at least twice per year. the following: nual full-scale exercise that or ty-based exercise is not an annual individual,	E 039				

Facility ID: 922912

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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 **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G166 B. WING 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 YADKIN II & III HAMPTONVILLE, NC 27020 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 039 Continued From page 11 E 039 engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/12/2023 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		34G166	B. WING _			09/	07/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
YADKIN II	& III				220 & 3224 US HWY 21		
				н.	IAMPTONVILLE, NC 27020		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	 (ii) Conduct an addition opposite the year the exercise under paragaris conducted, that limited to the following (A) A second full-community-based or a functional exercise; or (B) A mock disass (C) A tabletop exercise; or (B) A mock disass (C) A tabletop exercise; or (B) A mock disass (C) A tabletop exercise; or (B) A mock disass (C) A tabletop exercise; or (B) A mock disass (C) A tabletop exercise; or (B) A mock disass (C) A tabletop exercise; or (B) A mock disass (C) A tabletop exercise; or (B) A mock disass (C) A tabletop exercise; or (B) A mock disass (C) A tabletop exercise; or (B) A mock disass (C) A tabletop exercise (C) A tableto	onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section t may include, but is not g: -scale exercise that is an individual, facility-based r ter drill; or ercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency s response to and maintain drills, tabletop exercises, and nd revise the HHA's needed.	E	039	DEFICIENCY)		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G166 B. WING 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 YADKIN II & III HAMPTONVILLE, NC 27020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 13 E 039 E 039 documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct biennial testing of the facility's emergency preparedness plan (EPP). The finding is: Review of the facility EPP manual on 9/7/23 for Yadkin II revealed a facility EPP manual dated 9/2023. Continued review of the facility EPP manual revealed no client specific information for 6 of 6 clients (#1, #2, #3, #4, #5, #6). Further review of the facility EPP manual revealed no evidence of a full-scale community or facility-based training, a mock drill, or a tabletop exercise. Review of the facility EPP manual on 9/7/23 for Yadkin III revealed a facility EPP manual dated 9/2023. Continued review of the facility EPP manual did not reveal evidence of mock drills or

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	-	ID HUMAN SERVICES				FORM): 09/12/2023 MAPPROVED
STATEMENT C	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		34G166	B. WING		_	09/	07/2023
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
YADKIN II	& III			220 & 3224 US HWY 21 IAMPTONVILLE, NC 27	'020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From page tabletop exercises.		E 039				
W 130	confirmed that the fact full-scale community of mock drill, or a tableto III. Further interview w revealed that client sp facility contact informa Yadkin II. Subsequen administrator verified top exercises should participation as requir PROTECTION OF CI CFR(s): 483.420(a)(7 The facility must ensu	that mock drills and/or table be completed with staff red. LIENTS RIGHTS) ure the rights of all clients. must ensure privacy during	W 130				
	This STANDARD is r Based on observation failed to ensure private of 3 sampled clients (is:	not met as evidenced by: ns and interviews, the facility cy during personal care for 1 #7) at Yadkin III. The finding s on 9/7/23 at 7:00 AM					
	revealed a monitoring table in the living roor revealed the video de room. Further observa staff to escort client # room to complete per observations revealed care to client #7 which monitoring video devi point during the observideo monitoring devi	y video device to sit on the m. Continued observations evice to show client #7's ations at 7:15 AM revealed 7 from the bathroom to her sonal care. Subsequent d staff to provide personal h could be seen from the ce in the living room. At no rvation did staff turn off the ce to ensure the privacy of rsonal care in her room.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/12/2023 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	TPLE CONSTRUCTION		(X3) DATE	
		34G166	B. WING _	<u></u>		09/	07/2023
NAME OF PI	ROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE	<u> </u>	
YADKIN II	& III			3220 & 3224 US HWY HAMPTONVILLE, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH C	/IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD E EFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
W 130	Continued From page	⇒ 15	W 1	130			
W 227	professional (QIDP) a revealed the video mo record activity in clien interview with the QA non-recording monito when client #7 is in he seizure activity. Furth Manager and QIDP re ensure the privacy of the video monitoring of video off when client a in her room. INDIVIDUAL PROGR CFR(s): 483.440(c)(4 The individual program objectives necessary as identified by the co required by paragraph This STANDARD is r Based on observation interview, the facility f centered plan (PCP) f (#2) at Yadkin II inclue relative to wearing a g Observations at Yadk recertification survey revealed client #2 to a throughout the home Continued observatio participate in leisure a breakfast meals, clea in the dishwasher, me interact with his house	m plan states the specific to meet the client's needs, omprehensive assessment h (c)(3) of this section. not met as evidenced by: n, record review and failed to assure the person for 1 of 3 sampled clients ded training objectives gait belt. The finding is: in II throughout the from 9/6/23 - 9/7/23 ambulate independently while wearing a gait belt. ons revealed client #2 to activities, dinner and in up his area, put the dishes edication administration and	W 2	227			

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		MEDICAID SERVICES				NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED	
		34G166	B. WING		0	9/07/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
YADKIN II	& III			3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
W 227	Continued From page 16		W 22	77			
** 221			VV 22				
	0 1	folding chair he was sitting					
		all to the floor and land on					
		ent observations revealed client's underarms from both					
	-	t to assist the client from off					
	the floor to the medic						
	Review of client #2's	record on 9/7/23 revealed a					
		(PCP) dated 9/14/22.					
	Continued review of t	. ,					
	-	ectives: wash body parts					
		ng, attend a task VOC, meal					
		ng. Further review of the					
		evealed adaptive equipment					
		plate, nonskid mat and mug					
		bsequent review of the					
		reveal the use of a gait belt.					
	Interview with the fac on 9/7/23 revealed cli	ility nurse and QA Manager					
		as a history of seizures and view with the QA Manager					
		id a significant increase in					
		ew months and the team					
		s to better support the client					
	-	as agreed that staff would					
		ait belt if or when the client					
		Further interview with the					
		d that the team agreed that					
		e utilized while other options					
	-	Subsequent interview with					
		aled there were no updated					
	-	evaluations, team meeting					
	notes, inservice traini	ngs or prescribed orders for					
		Additional interview with the					
		ed there is an identified need					
		uld benefit from wearing the					
	gait belt and should b	e included in his training					

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/12/2023 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		E CONSTRUCTION		(X3) DATE	
		34G166	B. WING				09/	07/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
YADKIN II	& III				3220 & 3224 US HWY 21 HAMPTONVILLE, NC 2	7020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	PROGRAM IMPLEM CFR(s): 483.440(d)(1		w	249				
	each client must rece treatment program co interventions and serv and frequency to supp	ndividual program plan, ive a continuous active						
	Based on observation review, the facility fail active treatment program interventions were im the person-centered p	7 relative to a						
	from 9/6/23-9/7/23 rev participate in meaning activity, looking at pic watching tv, making th mealtimes, personal of administration. At no	gful activities such as a color tures in a magazine, heir bed, participating in care and medication point during the observation #7 to use a communication						
	the following program	for client #7 on 9/7/23 d 5/12/23 which indicated goals: toothbrush goal, eating goal, meaningful						

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	-	ID HUMAN SERVICES			FOR	D: 09/12/2023 MAPPROVED	
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		34G166	B. WING		09	0/07/2023	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD	E		
YADKIN II	& III		-	20 & 3224 US HWY 21 MPTONVILLE, NC 27020			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
W 249	activities throughout t goal. Continued revier revealed a habilitation dated 8/1/23 which in continue the client's c to make choices. Interview with the qua professional (QIDP) a 9/7/23 revealed that c and objectives are cu with the habilitation sp non-verbal and staff s communication album communication skills. administrator on 9/7/2 been trained to follow interventions for client B. The facility failed to objectives relative to a for client #8. For exan Observations through 9/6/23-9/7/23 revealer various activities such with dolls, preparing h administration and me during the observation choose activities by u picture book. Review of the record f revealed a PCP dateo following program goa objects, communication	he day and communication w of the record for client #7 in specialist progress note dicated that staff should communication picture album alified intellectual disabilities and habilitation specialist on client #7's program goals rrent. Continued interview pecialist revealed client #7 is should utilize the in to improve the client's Interview with the facility 23 revealed that staff have in the program objectives and t #7 as prescribed. b implement program a communication program inple: nout the survey from d client #8 to participate in in as a color activity, playing her plate, medication ealtime activities. At no point in was client #8 prompted to asing a communication for client #8 on 9/7/23 d 8/2/21 which indicated the als: laundry goal, sort two on goal, choose a se a napkin to wipe mouth to wipe herself during toileting	W 249				

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI F	CONSTRUCTION	(X3) TAT	OMB NO. 0938-039 (X3) DATE SURVEY	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING		COMPLETED	
		B. WING		0	09/07/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
YADKIN II	& III			220 & 3224 US HWY 21 IAMPTONVILLE, NC 27020		
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
W 249	Continued From page 19 communication goal also indicated the picture book should be used for client #8 to choose activities when presented with picture choices and a question prompt. Continued review of the 8/2/21 PCP also indicated that the communication book for client #8 should be used during the vocational program and leisure time at the group home. Subsequent review of the record for client #8 revealed a habilitation evaluation dated 8/29/23 which indicated that client #8 should be provided a picture book for desired activities.		W 249			
W 260	9/7/23 revealed that of staff should use the of client to improve com Continued interview of habilitation specialist program goals and of Interview with the QII	vith the QA Manager and verified that all of client #8's ojectives are current. OP also revealed that staff use client #8's program as prescribed. RING & CHANGE	W 260			
	At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to show evidence that person- centered plans (PCPs) and/or behavior support plans (BSPs) for five of six sampled clients (#3, #7, #8, #9, #10, and #11) were revised and updated at least annually. The findings are:					

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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 34G166 B. WING 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 YADKIN II & III HAMPTONVILLE, NC 27020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 260 Continued From page 20 W 260 and/or BSPs for the review year for clients at Yadkin III home. For example: Review of the record for client #7 on 9/7/23 revealed a behavior support plan (BSP) dated 6/23/22. Review of the record for client #9 revealed a BSP dated 6/23/22. Continued review of the record did not reveal current BSPs for clients #7 and #9 for the 2023 review year. Review of the record for client #8 revealed a PCP dated 8/2/21. Continued review of the record for client #8 did not reveal a current PCP for the 2022 and 2023 review year. Review of the record for client #10 revealed a PCP dated 5/25/22. Continued review of client #10's record did not reveal a PCP for the current review year. Review of the record for client #11 revealed a PCP dated 4/5/22. Continued review of the record for client #11 revealed a BSP dated 6/23/22. Further review of the record for client #11 did not reveal a current PCP or BSP for the 2023 review year. Interview with the gualified intellectual disabilities professional (QIDP) and QA Manager on 9/7/23 revealed that the current PCPs and/or BSPs for clients #7, #8, #9, #10, and #11 could not be located during the survey. Continued interview with the QA Manager revealed the PCP plan team meetings for clients #8, #10, and #11 had not been completed. Interview with the QA Manager and facility administrator verified all clients should have an updated PCP review and updated BSPs at least annually. B. The facility failed to provide a current PCP for

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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 **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G166 B. WING 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 YADKIN II & III HAMPTONVILLE, NC 27020 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 260 Continued From page 21 W 260 review year for client #2 at Yadkin II home. For example: Review of the record for client #2 on 9/7/23 revealed a PCP dated 5/18/22. Continued review of the record for client #2 did not reveal a current PCP for the 2023 review year. Interview with the QIDP and QA Manager on 9/7/23 revealed that the current PCP for client #2 could not be located during the survey. Continued interview with the QA Manager revealed the PCP plan team meeting for client #2 had not been completed. Interview with the QA Manager and facility administrator verified all clients should have an updated PCP in the client record. Further interview with the facility administrator and QA Manager verified all PCPs should be reviewed and updated annually. W 262 **PROGRAM MONITORING & CHANGE** W 262 CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that updated, written informed consents from the human rights committee (HRC) was secured for exterior door chimes for 8 of 11 clients (#1, #2, #3, #4, #5, #6, #9 and #10). The finding is: Observations at Yadkin II and Yadkin III group homes during the survey period from 9/6/23 -9/7/23 revealed exterior door alarms to ring upon

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB 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					
	34G166		B. WING			09/07/2023				
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•				
YADKIN II	& III				3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
W 262	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W	262	2					

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