		AND HUMAN SERVICES			0	-	APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>′</i>		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
		34G296	B. WING			02/14/2024		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•		
STONER	IDGE				22 UNION HEIGHTS BOULEVARD ALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 037	CFR(s): 483.475(d) §403.748(d)(1), §44 §441.184(d)(1), §44 §483.73(d)(1), §48 §485.68(d)(1), §48 §485.68(d)(1), §48 §485.727(d)(1), §48 §491.12(d)(1). *[For RNCHIs at §44 Hospitals at §482.1 at §484.102, REHs under §485.727, OI RHC/FQHCs at §49 (1) Training prograther the following: (i) Initial training in opolicies and proced staff, individuals pro- arrangement, and vexpected roles. (ii) Provide emerge- least every 2 years. (iii) Maintain documpreparedness training (iv) Demonstrate stoprocedures. (v) If the emergence procedures are sign must conduct training procedures. *[For Hospices at § hospice must do all (i) Initial training in opolicies and procedures services under array	<ul> <li>(1)</li> <li>16.54(d)(1), §418.113(d)(1),</li> <li>60.84(d)(1), §482.15(d)(1),</li> <li>3.475(d)(1), §484.102(d)(1),</li> <li>5.542(d)(1), §485.625(d)(1),</li> <li>35.920(d)(1), §486.360(d)(1),</li> <li>403.748, ASCs at §416.54,</li> <li>5, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations"</li> <li>POs at §486.360,</li> <li>91.12:]</li> <li>m. The [facility] must do all of</li> <li>emergency preparedness lures to all new and existing oviding services under volunteers, consistent with their</li> <li>ncy preparedness training at the intation of all emergency at the intation of all emergency ing.</li> <li>aff knowledge of emergency ing.</li> <li>aff knowledge of emergency ing on the updated policies and hificantly updated, the [facility] ing on the updated policies and</li> <li>418.113(d):] (1) Training. The</li> </ul>	EO	37	DEFICIENCY)			
	expected roles.							

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 02/15/2024

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		34G296	B. WING		02/14/2024		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
STONER	IDGE			222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
E 037	procedures. (iii) Provide emerge least every 2 years (iv) Periodically rev emergency prepare employees (includir special emphasis p procedures necess others. (v) Maintain docum preparedness traini (vi) If the emergence procedures are sign must conduct traini procedures are sign must conduct traini procedures. *[For PRTFs at §44 program. The PRTF (i) Initial training in policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) After initial traini preparedness traini (iii) Demonstrate st procedures. (iv) Maintain docum preparedness traini (v) If the emergenc procedures are sign must conduct traini procedures. *[For PACE at §460 organization must of	aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice ng nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency ing. by preparedness policies and nificantly updated, the hospice ng on the updated policies and enter do all of the following: emergency preparedness lures to all new and existing by ing services under volunteers, consistent with their ing, provide emergency ing every 2 years. aff knowledge of emergency mentation of all emergency	EO	37			

If continuation sheet Page 2 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G296	B. WING			02/ <sup>,</sup>	14/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STONER	IDGE				222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	policies and proced staff, individuals pro- arrangement, contra- volunteers, consiste (ii) Provide emerger least every 2 years. (iii) Demonstrate sta procedures, includin what to do, where to case of an emerger (iv) Maintain docum (v) If the emergence procedures are sign must conduct trainin procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in e policies and proced staff, individuals pro- arrangement, and v expected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate sta procedures. *[For CORFs at §48 CORF must do all o (i) Provide initial tra preparedness polici and existing staff, in	ures to all new and existing oviding on-site services under actors, participants, and ent with their expected roles. hey preparedness training at aff knowledge of emergency ng informing participants of o go, and whom to contact in ney. entation of all training. by preparedness policies and hificantly updated, the PACE ng on the updated policies and at §483.73(d):] (1) Training facility must do all of the emergency preparedness ures to all new and existing oviding services under olunteers, consistent with their ney preparedness training at entation of all emergency ng. aff knowledge of emergency sing in emergency es and procedures to all new ndividuals providing services , and volunteers, consistent	E	037			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G296	B. WING			02/ <sup>.</sup>	14/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
STONER	IDGE				22 UNION HEIGHTS BOULEVARD GALISBURY, NC 28144		
(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	least every 2 years. (iii) Maintain docum (iv) Demonstrate st procedures. All new and assigned speci the CORF's emerge their first workday. include instruction i alarm systems and equipment. (v) If the emergen procedures are sign must conduct training procedures. *[For CAHs at §485 The CAH must do a (i) Initial training in e policies and proced reporting and exting and where necessa 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	hey preparedness training at entation of the training. aff knowledge of emergency / personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must in the location and use of signals and firefighting cy preparedness policies and hificantly updated, the CORF ing on the updated policies and 6.625(d):] (1) Training program. all of the following: emergency preparedness ures, including prompt guishing of fires, protection, iry, evacuation of patients, sts, fire prevention, and efighting and disaster w and existing staff, g services under arrangement, isistent with their expected incy preparedness training at	E	037			

Facility ID: 944370

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2024 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION		E SURVEY PLETED
		34G296	B. WING			02/1	14/2024
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
STONER	RIDGE				22 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	*[For CMHCs at §4. CMHC must provid preparedness polic and existing staff, ir under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on record re failed to ensure dire the facility's Emerge (EPP) at least bient Review of the facilit was reviewed by the 6/2023. Continued to of initial or biennial Interview with the p confirmed that initia current staff has no EP Testing Require CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §448 §485.542(d)(2), §448 §485.542(d)(2), §448 §485.542, OPO, §485.727, CMHCs	85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new ndividuals providing services , and volunteers, consistent roles, and maintain ne training. The CMHC must nowledge of emergency after, the CMHC must provide idness training at least every 2 s not met as evidenced by: eview and interview, the facility ect care staff were trained on ency Preparedness Plan nially. The finding is: y's EPP on 2/13/24 revealed it e facility administrator on review revealed no evidence staff training on the EPP. rogram manager on 2/14/23 I and biennial training for t been completed. ments		037			

Facility ID: 944370

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		AND HUMAN SERVICES				FORM	02/15/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		34G296	B. WING			02/*	14/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
STONER	IDGE				22 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	Continued From pa	ge 5	E (	)39			
	to test the emergen must do all of the for (i) Participate in a fu community-based e (A) When a commu- accessible, conduct exercise every 2 ye (B) If the [facilit natural or man-mac activation of the em- exempt from engag community-based of functional exercise actual event. (ii) Conduct an addi years, opposite the functional exercise this section is cond not limited to the for (A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise; a facilitator and incl a narrated, clinically scenario, and a set directed messages designed to challen (iii) Analyze the [fac maintain document	ull-scale exercise that is every 2 years; or unity-based exercise is not t a facility-based functional ears; or y] experiences an actual de emergency that requires hergency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: cale exercise that is or individual, facility-based for r drill; or cise or workshop that is led by udes 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.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G296	B. WING			02/	14/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STONER	IDGE				22 UNION HEIGHTS BOULEVARD ALISBURY, NC 28144		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based e (A) When a commu accessible, conduct functional exercise (B) If the hospice ex- man-made emerge the emergency plan engaging in its next community-based e facility-based function 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 disaste (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 h exercises to test the year. The hospice	bices that provide care in the e hospice must conduct e emergency plan at least ice must do the following: ull-scale exercise that is very 2 years; or nity based exercise is not an individual facility based every 2 years; or operiences a natural or ney that requires activation of a, the hospital is exempt from required full scale exercise or individual onal exercise following the ency event. itional exercise every 2 years, e full-scale 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. ices that provide inpatient tospice must conduct e emergency plan twice per- must do the following: annual full-scale exercise that	E	039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G296	B. WING			02/	14/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STONER	IDGE				22 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144		
(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	accessible, conduct facility-based functi (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 community-based of exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the hose maintain documents exercises, and emerge (iii) Analyze the hose maintain documents exercises, and emerge (iii) Analyze the hose maintain documents exercises, and emerge (iii) Analyze the hose maintain documents exercises and emerge (iii) Conduct exercises to twice per year. The do the following: (i) Participate in an is community-based (A) When a commu	inity-based exercise is not t an annual individual onal exercise; or experiences a natural or ncy that requires activation of n, the hospice is exempt from required full-scale community sed functional exercise of the emergency event. litional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or cise or workshop led by a des a group discussion using a elevant emergency scenario, n statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed. 1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must o 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,	EC	039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G296	B. WING			02/	14/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STONER	IDGE				222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144		
(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	actual natural or ma requires activation of [facility] is exempt for required full-scale of facility-based function onset of the emerge (ii) Conduct an and that may includ following: (A) A second full-sc community-based of functional exercise; (B) A mock (C) A tabletop e led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the maintain documents exercises, and eme [facility's] emergency *[For PACE at §460 (2) Testing. The PACE following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the PACE exp	<ul> <li>bspital, 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.</li> <li>[additional] annual exercise or e, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is not includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency</li> <li>[facility's] response to and ation of all drills, tabletop regency events and revise the cy plan, as needed.</li> <li>a.84(d):]</li> <li>CE organization must conduct e emergency plan at least e organization must do the annual full-scale exercise is not tan annual individual,</li> </ul>	E	039			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G296	B. WING			<b>02</b> / <sup>,</sup>	14/2024
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STONER	IDGE				222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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	the emergency plar engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the exercise under para is conducted that m the following: (A) A second full-sec community-based of functional exercise; (B) A mock disaster (C) A tabletop exer a facilitator and incl using a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the PA maintain documents 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	a, the PACE is exempt from required full-scale community facility-based functional ne onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section ay include, but is not limited to cale exercise that is or individual, a facility based or r drill; or cise or workshop that is led by 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 regency 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,	EC	039			

Facility ID: 944370

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		AND HUMAN SERVICES				FORM	02/15/2024 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED			
		34G296	B. WING	i		02/1	14/2024			
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•				
STONER	IDGE		222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
E 039	requires activation of LTC facility is exem required a full-scale individual, facility-ba following the onset (ii) Conduct an add 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 and a set of probler messages, or prepa challenge an emerge (iii) Analyze the [LT and maintain docum exercises, and emerge [LTC facility] facility' *[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 exer engaging in its next community-based of	of the emergency plan, the pt from engaging its next e community-based or ased functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based or er drill; or rcise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. C facility] facility's response to mentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises noy plan at least twice per year. o the following: annual full-scale exercise is not t an annual individual, onal exercise; or. cperiences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from	EC	039						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G296	B. WING	i		02/ <sup>,</sup>	14/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STONER	IDGE				222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	<ul> <li>(ii) Conduct an addi may include, but is</li> <li>(A) A second full-sc community-based of functional exercise;</li> <li>(B) A mock disaster</li> <li>(C) A tabletop exerce</li> <li>a facilitator and inclusing a narrated, clusing a narrate</li></ul>	tional annual exercise that not limited to the following: ale exercise that is or an individual, facility-based or drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. /IID's response to and ation of all drills, tabletop orgency events, and revise the 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 an actual natural gency that requires activation lan, the HHA is exempt from	E	039			

Facility ID: 944370

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2024 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		```		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		34G296	B. WING			02/14/2024				
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
STONERIDGE			222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE			
E 039	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, documentation of a emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The 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 plar engaging in its next following the onset (ii) Analyze the OPO	ing: II-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 to challenge an emergency A's response to and maintain II drills, tabletop exercises, and and revise the HHA's a needed. 3.360] OPO must conduct exercises cy plan. The OPO must do the -based, tabletop exercise or nnually. 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 a, the OPO is exempt from required testing exercise of the emergency event. D's response to and maintain II tabletop exercises, and and revise the [RNHCI's and	E	039						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2024 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G296	B. WING	·		02/14/2024		
NAME OF PRO	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
STONERID	GE				222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
* (4 e n (i l e d c o p e (i n a e T f f f f f f f f f W 227 W 227 U C T o a	exercises to test the nust do the followir i) Conduct a paper- east annually. A tak liscussion led by a slinically-relevant er of problem stateme prepared questions emergency plan. ii) Analyze the RNH naintain documenta and emergency ever emergency plan, as This STANDARD is Based on record re ailed to conduct bie Emergency Prepare inding is: Review of the facilit to evidence of a ful acility-based emergency nock drill or table to neterview with the pre- confirmed the facilit scale community ar lrill, or an additiona exercise. NDIVIDUAL PROG CFR(s): 483.440(c) The individual progro- bjectives necessar is identified by the	748]: RNHCI must conduct e emergency plan. The RNHCI ag: -based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set nts, directed messages, or designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's needed. a not met as evidenced by: eview and interview, the facility eview and interview, the facility's edness Plan (EPP). The y's EPP on 2/13/24 revealed I scale community and/or gency drill, or an additional op exercise. rogram manager on 2/14/24 y has not conducted a full ad/or facility-based emergency I mock drill or table top GRAM PLAN	E (	227				

Facility ID: 944370

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION			E SURVEY IPLETED
		34G296	B. WING			02/14/2024	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE	-	
STONERIDGE				222 UNION HEIGH SALISBURY, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE RY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				) BE	(X5) COMPLETION DATE
W 227	This STANDARD is Based on observation interview, the facility objectives necessal clients (#2). The fin Observation in the g 2/13-14/24 survey of most of the time situ unengaged by staff 4:20 PM to 5:20 PM living room unengat from 6:23 AM to 7:0 in the living room une survey observations assist with meal pre- chores. Further obs survey revealed clies instructions when p Review of client #2' a person-centered p which indicated clies coins with 75% acc less prompts, impro- with a verbal promp accuracy, and bath Continued review of dated 5/12/22 which "1" (no independen preparation and how Interview with the p revealed client #2 hobjectives to suppo preparation or hous interview confirmed	s not met as evidenced by: ions, record review and y failed to ensure specific ry to meet the needs for 1 of 6 dings is: group home throughout the revealed client #2 to spend ting in the living room, . Observation on 2/13/24 from 1 revealed client #2 to sit in the ged. Observation on 2/14/24 00 AM revealed client #2 to sit nengaged. At no time during s was client #2 prompted to eparation or housekeeping servations throughout the ent #2 to follow staff rompted. s record on 2/14/24 revealed plan (PCP) dated 5/18/23 nt's goals to include identifying uracy, handwashing with 2 or ove eating skills/table manners ot, brush front teeth with 80% e with 90% accuracy. f the record revealed an ABI n indicated the client to be a ce) relative to meal	W 2:	27			

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## PRINTED: 02/15/2024 FORM APPROVED

		AND HUMAN SERVICES				FORM	02/15/2024 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		34G296	B. WING			02/14/2024				
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
STONERIDGE			222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144							
(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			
W 249	PROGRAM IMPLE CFR(s): 483.440(d)		W 2	249						
	formulated a client's each client must rea treatment program interventions and se and frequency to su	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program								
	Based on observat interview, the facility (#2) received a con program consisting	s not met as evidenced by: tions, record review and y failed to ensure 1 of 6 clients tinuous active treatment of needed interventions as son-centered plan (PCP). The								
	2/14/24 revealed st plate at the dining ta bedroom instead of	g mealtimes on 2/13/24 and aff to prompt client #2 to fix his able, then eat each meal in his f the dining table. Continued led staff to monitor the client in e mealtimes.								
	a PCP dated 5/18/2 goals to include ide accuracy, handwas improve eating skill	s record on 2/14/24 revealed 23 which indicated program ntifying coins with 75% hing with 2 or less prompts, s/table manners with a verbal teeth with 80% accuracy, and curacy.								
	confirmed client #2	rogram manager on 2/14/24 's goals are current. Continued I staff cannot support client #2								

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	FIPLE CC		NO. 0938-039 DATE SURVEY			
AND PLAN C	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	NG		COMPLETED			
		34G296	B. WING				02/14/2024		
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP				
STONER	IDGE				NION HEIGHTS BOULEVARD SBURY, NC 28144				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE		
W 249	Continued From pa	age 16	W 2	49					
	instructing him to e								
W 287	MGMT OF INAPPE BEHAVIOR CFR(s): 483.450(b	ROPRIATE CLIENT )(3)	W 2	87					
	behavior must neve of staff. This STANDARD is Based on observa interview, the facilit to manage inappro	age inappropriate client er be used for the convenience is not met as evidenced by: tion, record review and ty failed to ensure techniques priate client behavior for 1 of 6 ot used for the convenience of ::							
	2/14/24 revealed st plate at the dining t bedroom instead o	g mealtimes on 2/13/24 and taff to prompt client #2 to fix his table, then eat each meal in his f the dining table. Continued alled staff to monitor the client in the mealtimes.							
	a behavior support which indicated tar physical aggression destruction, and se Continued review of revealed no instruct	's record on 2/14/24 revealed plan (BSP) dated 1/24/24 get behaviors to include n, verbal disruption, property lf-injurious behaviors. of the BSP and the record ctions or approval to restrict room during mealtimes.							
	will often become a while sitting with his revealed staff have bedroom "for a whi	on 2/13/24 revealed client #2 aggressive at the dining table s peers. Continued interview e prompted client to eat in his le now." Interview with on 2/14/24 confirmed there is							

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/15/2024 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	34G296		B. WING	i		02/14/2024	
NAME OF F	PROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE		
STONER	IDGE				22 UNION HEIGHTS BOULEVARD ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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
W 287	Continued From pa	age 17	W 2	287			
		to restrict the client #2 to his					
W 440	EVACUATION DRI	bedroom during mealtimes. EVACUATION DRILLS CFR(s): 483.470(i)(1)		440			
	This STANDARD is Based on record re failed to ensure eva- least quarterly for e finding is: Review of the facilit revealed missing se fire drills for the rev revealed no first sh second quarter and conducted in the th	or each shift of personnel. s not met as evidenced by: eview and interview, the facility acuation drills were held at each shift of personnel. The ties fire drill reports on 2/13/24 econd, third, and fourth quarter view period. Continued review ift drill conducted in the d no second or third shift drill ird and fourth quarter. ram manager on 2/14/24 should have been conducted shift of personnel.					

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