PRINTED: 02/05/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(2) MULTIPLE CONSTRUCTION BUILDING			SURVEY LETED
	34G294	B. WING _			01/	31/2024
NAME OF PROVIDER OR SUPPLIER  KONNOAK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CO 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	DE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE
S403.748(a), §416.54 §441.184(a), §460.84 §483.475(a), §484.10 §485.542(a), §485.62 §485.920(a), §486.36 §494.62(a).  The [facility] must con Federal, State and loo preparedness require develop establish and emergency preparedr requirements of this s preparedness prograr limited to, the followin (a) Emergency Plan. and maintain an emer that must be [reviewe every 2 years. The pl following:  * [For hospitals at §48 §485.625(a):] Emerge CAH] must comply wi State, and local emer requirements. The [h develop and maintain emergency preparedr requirements of this s all-hazards approach.  * [For LTC Facilities a Plan. The LTC facility	(a), §482.15(a), §483.73(a), (2(a), §485.68(a), (5(a), §485.727(a), (0(a), §491.12(a), (0	EO	TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		34G294	B. WING _		01/	31/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2901 KONNOAK DRIVE  WINSTON SALEM, NC 27127		
(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)	3E	(X5) COMPLETION DATE
E 004	* [For ESRD Facilities Plan. The ESRD facil maintain an emergen must be [evaluated], a years.  . This STANDARD is r Based on record revifailed to ensure the explan (EPP) was review biennially. The finding Review on 1/30/24 of that the facility's EPP Interview on 1/31/24 of that the facility does not he	at §494.62(a):] Emergency ity must develop and cy preparedness plan that and updated at least every 2 mot met as evidenced by: ew and interview, the facility mergency preparedness wed and/or updated at least gis:  the facility's EPP revealed was last updated 07/19.  with the qualified intellectual al (QIDP) confirmed that ave an updated EPP.  )  .54(d)(1), §418.113(d)(1), .84(d)(1), §482.15(d)(1), .920(d)(1), §485.625(d)(1), .920(d)(1), §486.360(d)(1), .920(d)(1), §486.360(d)(1), .920(d)(1), .9486.360, .12:]  . The [facility] must do all of	E	004		
	at §484.102, REHs at under §485.727, OPC RHC/FQHCs at §491 (1) Training program the following: (i) Initial training in en	§485.542, "Organizations" Os at §486.360, .12:]				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		34G294	B. WING		01/31/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2901 KONNOAK DRIVE  WINSTON SALEM, NC 27127			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION		
E 037	arrangement, and vo expected roles.  (ii) Provide emergent least every 2 years.  (iii) Maintain docume preparedness trainin (iv) Demonstrate state procedures.  (v) If the emergency procedures are signimust conduct trainin procedures.  *[For Hospices at §4 hospice must do all (i) Initial training in epolicies and procedures are very ces under arrant expected roles.  (ii) Demonstrate state procedures.  (iii) Demonstrate state procedures.  (iii) Provide emerger least every 2 years.  (iv) Periodically revise emergency prepared employees (including special emphasis play procedures necessate others.  (v) Maintain docume preparedness trainin (vi) If the emergency procedures are significations.	viding services under blunteers, consistent with their cy preparedness training at entation of all emergency ag.  Iff knowledge of emergency preparedness policies and ifficantly updated, the [facility] g on the updated policies and and the following: mergency preparedness ures to all new and existing and individuals providing and individuals providing agement, consistent with their for knowledge of emergency preparedness training at ew and rehearse its dness plan with hospice g nonemployee staff), with acced on carrying out the ry to protect patients and entation of all emergency	E 03	7			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		34G294	B. WING _			01/31/2024
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE  2901 KONNOAK DRIVE  WINSTON SALEM, NC 27127		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 037	program. The PRTI (i) Initial training in policies and proced staff, individuals pro arrangement, and vexpected roles. (ii) After initial training preparedness training (iii) Demonstrate stoprocedures. (iv) Maintain documpreparedness training (v) If the emergency procedures are signing must conduct training procedures.  *[For PACE at §460 organization must of (i) Initial training in policies and procedures arrangement, contrivolunteers, consiste (ii) Provide emerge least every 2 years (iii) Demonstrate stoprocedures, including what to do, where to case of an emerger (iv) Maintain documprocedures are signing must conduct training procedures.	1.184(d):] (1) Training  F must do all of the following: emergency preparedness dures to all new and existing oviding services under volunteers, consistent with their  Ing, provide emergency Ing every 2 years. In aff knowledge of emergency Ing. In a preparedness policies and Indicantly updated, the PRTF Ing on the updated policies and Indicantly up	EO	37		

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		34G294	B. WING	·····	0	1/31/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
E 037	following: (i) Initial training in er policies and procedu staff, individuals provarrangement, and vo expected role. (ii) Provide emergence least annually. (iii) Maintain docume preparedness trainin (iv) Demonstrate state procedures.  *[For CORFs at §485 CORF must do all of (i) Provide initial train preparedness policie and existing staff, incurder arrangement, with their expected roughleast every 2 years. (iii) Provide emergence (iv) Demonstrate state procedures. All new and assigned specification the CORF's emerger their first workday. The conduct instruction in alarm systems and sequipment. (v) If the emergency procedures are significated instruction in alarm systems and sequipment.	mergency preparedness res to all new and existing riding services under lunteers, consistent with their cy preparedness training at ntation of all emergency g. If knowledge of emergency s.68(d):](1) Training. The the following: hing in emergency s and procedures to all new dividuals providing services and volunteers, consistent	E 03				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G294	B. WING		01/31/2024
KONNOAK GROUP HOME  (X4) ID PREFIX TAG  Continued From page 5 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,			STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	,	
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
E 037	The CAH must do a (i) Initial training in a policies and proced reporting and exting and where necessa personnel, and gue- cooperation with fire authorities, to all ne individuals providing and volunteers, con roles. (ii) Provide emerger least every 2 years. (iii) Maintain docum (iv) Demonstrate sta procedures. (v) If the emergen procedures are sign must conduct trainin procedures.  *[For CMHCs at §46 CMHC must provide preparedness polici and existing staff, ir under arrangement, with their expected documentation of th demonstrate staff ki procedures. Therea emergency prepare years. This STANDARD is Based on record re failed to provide and annual staff training Preparedness (EP)	all of the following: emergency preparedness ures, including prompt guishing of fires, protection, ry, evacuation of patients, sts, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, sistent with their expected ancy preparedness training at entation of the training. aff knowledge of emergency cy preparedness policies and difficantly updated, the CAH and on the updated policies and as and procedures to all new andividuals providing services and volunteers, consistent roles, and maintain the training. The CMHC must mowledge of emergency after, the CMHC must provide dness training at least every 2 as not met as evidenced by: eview and interview, the facility d maintain documentation of	E 037		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G294	B. WING _			01/31/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127			
(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 COR  ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 037	training. Continued retraining was conducted.  Interview on 1/31/24 disabilities profession	ntation of the annual staff eview revealed the last	E	037			
E 039	EP Testing Requirem CFR(s): 483.475(d)(2) §416.54(d)(2), §418.2 §460.84(d)(2), §482.3 §483.475(d)(2), §484 §485.542(d)(2), §491 *[For ASCs at §416.5 at §485.542, OPO, "C §485.727, CMHCs at §491.12, and ESRD If (2) Testing. The [facilit to test the emergency must do all of the following to the following to the following the facility of the emergency of the e	113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .625(d)(2), §494.62(d)(2).  4, CORFs at §485.68, REHs Organizations" under §485.920, RHCs/FQHCs at Facilities at §494.62]:  ity] must conduct exercises or plan annually. The [facility] owing:  -scale exercise that is ery 2 years; or ity-based exercise is not a facility-based functional ers; or experiences an actual emergency that requires regency plan, the [facility] is	E	039			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G294	B. WING			01/	31/2024
	ROVIDER OR SUPPLIER		•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 KONNOAK DRIVE WINSTON SALEM, NC 27127		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	years, opposite the year functional exercise unthis section is conduct not limited to the follo (A) A second full-scal community-based or functional exercise; o (B) A mock disaster of (C) A tabletop exercise a facilitator and include a narrated, clinically-rescenario, and a set of directed messages, of designed to challenge (iii) Analyze the [facility maintain documentatic exercises, and emerging [facility's] emergency  *[For Hospices at 418* (2) Testing for hospice patient's home. The leavercises to test the exanually. The hospic (i) Participate in a full community based every (A) When a community community based every (B) If the hospice expense man-made emergency plan, the emergency plan, the emergency plan, the emergency plan, the emergency of the emergency	conal exercise at least every 2 cear the full-scale or order paragraph (d)(2)(i) of oted, that may include, but is wing: e exercise that is individual, facility-based r irill; or se or workshop that is led by des a group discussion using relevant emergency f problem statements, or prepared questions e an emergency plan. ty's] response to and ion of all drills, tabletop pency events, and revise the plan, as needed.  3.113(d):] ses that provide care in the chospice must conduct cemergency plan at least e must do the following: I-scale exercise that is ery 2 years; or ty based exercise is not an individual facility based overy 2 years; or eriences a natural or by that requires activation of the hospital is exempt from equired full scale ercise or individual hal exercise following the	E	039			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G294	B. WING		01/31/2024	
	ROVIDER OR SUPPLIER	•	:	STREET ADDRESS, CITY, STATE, ZIP CODE  2901 KONNOAK DRIVE  WINSTON SALEM, NC 27127		
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E 039	exercise under paragis conducted, that m to the following:  (A) A second full-so community-based or exercise; or  (B) A mock disaster (C) A tabletop exercise facilitator and inclusion an arrated, clinically-scenario, and a set of directed messages, designed to challeng (3) Testing for hospic care directly. The hospic exercises to test the year. The hospice in an is community-based (A) When a community-based (A) When a community-based function (B) If the hospice eximan-made emergen the emergency plan, engaging in its next based or facility-base following the onset of (ii) Conduct an addimay include, but is m (A) A second full-so community-based or exercise; or  (B) A mock disaster (C) A tabletop exercise.	e full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited ale exercise that is a facility based functional drill; or sise or workshop that is led by des a group discussion using relevant emergency of problem statements, or prepared questions are an emergency plan.  The state provide inpatient obspice must conduct emergency plan twice per must do the following: annual full-scale exercise that are annual individual nal exercise; or periences a natural or cy that requires activation of the hospice is exempt from required full-scale community ed functional exercise that to tlimited to the following: ale exercise that is a facility based functional	E 039			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G294	B. WING		01/31/2024	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE  2901 KONNOAK DRIVE  WINSTON SALEM, NC 27127		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION	
E 039	and a set of problen messages, or prepa challenge an emerg (iii) Analyze the hos maintain documenta exercises, and eme hospice's emergence	elevant emergency scenario, in statements, directed red questions designed to ency plan. Spice's response to and attion of all drills, tabletop regency events and revise the by plan, as needed.	E 03	9		
	§482.15(d), CAHs a (2) Testing. The [PR conduct exercises to twice per year. The do the following: (i) Participate in an is community-based (A) When a community-based function (B) If the [PRTF, Ho actual natural or ma requires activation of [facility] is exempt for required full-scale of facility-based function (ii) Conduct an and that may includ following: (A) A second full-so community-based of functional exercise; (B) A mock (C) A tabletop of led by a facilitator and	extremental to test the emergency plan [PRTF, Hospital, CAH] must annual full-scale exercise that annual full-scale exercise that an annual individual, and exercise; or spital, CAH] experiences an an-made emergency that of the emergency plan, the omengaging in its next annual exercise following the ency event.  [additional] annual exercise or e, but is not limited to the exercise that is a rindividual, a facility-based or a disaster drill; or exercise or workshop that is				

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G294	B. WING		01/31/2024	
	ROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE  2901 KONNOAK DRIVE  WINSTON SALEM, NC 27127		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION	
E 039	statements, directed questions designed plan.  (iii) Analyze the maintain documenta exercises, and emer [facility's] emergency  *[For PACE at §460. (2) Testing. The PACE following: (i) Participate in an is community-based (A) When a communaccessible, conduct facility-based function (B) If the PACE experman-made emergenthe emergency plantenessing in its next based or individual, exercise following the event.  (ii) Conduct an ayears opposite the yexercise under parais conducted that mathe following: (A) A second full-secommunity-based or functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and included.	facility's] response to and tion of all drills, tabletop gency events and revise the y plan, as needed.  84(d):] E organization must conduct emergency plan at least organization must do the annual full-scale exercise that; or nity-based exercise is not an annual individual, anal exercise; or eriences an actual natural or cy that requires activation of the PACE is exempt from required full-scale community facility-based functional e onset of the emergency additional exercise every 2 ear the full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited to alle exercise that is individual, a facility based or	E 039			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	, , , , , , , , , , , , , , , , , , , ,
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E 039	directed messages, designed to challeng (iii) Analyze the PAI maintain documenta exercises, and emel PACE's emergency  *[For LTC Facilities of (2) The [LTC facility) test the emergency including unannounce emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the [LTC facility actual natural or ma requires activation of LTC facility is exemprequired a full-scale individual, facility-bafollowing the onset (ii) Conduct an add may include, but is represented (A) A second full-scale functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator includes narrated, clinically-reand a set of problem	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):] I must conduct exercises to plan at least twice per year, ced staff drills using the res. The [LTC facility, following: annual full-scale exercise that contain annual individual, anal exercise.  by facility experiences an in-made emergency plan, the form engaging its next community-based or sed functional exercise for the emergency event. It it is an individual, facility based or contain annual exercise that is an individual, facility based or statements, directed red questions designed to	E 03	9	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED			
		34G294	B. WING _			01/31/2024
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127		
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E 039	(iii) Analyze the [LTC and maintain docume exercises, and emerg [LTC facility] facility's  *[For ICF/IIDs at §48. (2) Testing. The ICF/It to test the emergency The ICF/IID must do (i) Participate in an ais community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID expense and an another emergency plan, engaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an additional include, but is not (A) A second full-scat community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and includusing a narrated, clin scenario, and a set of directed messages, of designed to challenge (iii) Analyze the ICF/I maintain documentated.	c facility] facility's response to entation of all drills, tabletop gency events, and revise the emergency plan, as needed.  3.475(d)]:  IID must conduct exercises y plan at least twice per year. the following: nnual full-scale exercise that or ty-based exercise is not an annual individual, nal exercise; or. eriences an actual natural or by that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based illowing the onset of the conal annual exercise that of limited to the following: le exercise that is an individual, facility-based or drill; or see or workshop that is led by des a group discussion, ically-relevant emergency f problem statements, or prepared questions ean emergency plan.  ID's response to and ion of all drills, tabletop gency events, and revise the	E	039		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X4) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X4) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PLAN OF CORRECTION (X6) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/		, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	,	<del>- 11 - 1</del> - 1
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 039	to test the emergence least annually. The (i) Participate in a furcommunity-based; of (A) When a correct accessible, conduct facility-based function.  (B) If the HHA or man-made emergency plengaging in its next community-based of functional exercise fremergency event.  (ii) Conduct an additional exercise under parais conducted, the limited to the following (A) A second furcommunity-based of functional exercise;  (B) A mock disassional exercise;  (B) A mock disassion, using a emergency scenarios statements, directed questions designed plan.  (iii) Analyze the HHZ documentation of all	HHA must conduct exercises by plan at HHA must do the following: Ill-scale exercise that is or inmunity-based exercise is not an annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation an, the HHA is exempt from required full-scale individual, facility based following the onset of the stional exercise every 2 years, individual, facility based following the onset of the stional exercise every 2 years, individual, facility based following the onset of the stional exercise every 2 years, individual, facility-based for an individual, facility-based for exercise exercise that is individual, facility-based for exercise or workshop that is individues a group formatted, clinically-relevant to an a set of problem in messages, or prepared to challenge an emergency. A's response to and maintain individus, tabletop exercises, and and revise the HHA's	E 03	9		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G294	B. WING		01/31/2024
	ROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 901 KONNOAK DRIVE VINSTON SALEM, NC 27127	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
E 039	to test the emergent following: (i) Conduct a paperworkshop at least alled by a facilitator and discussion, using a emergency scenario statements, directed questions designed plan. If the OPO expanan-made emerger the emergency plan engaging in its next following the onset of (ii) Analyze the OPO documentation of all emergency events, OPO's] emergency *[RNCHIs at §403.7 (d)(2) Testing. The flexercises to test the must do the followin (i) Conduct a paperleast annually. A table discussion led by a clinically-relevant er of problem statement prepared questions emergency plan. (ii) Analyze the RNI-maintain documental and emergency evenemergency plan, as This STANDARD is Based on record residusing a service of the statement of the st	DPO must conduct exercises by plan. The OPO must do the sebased, tabletop exercise or annually. A tabletop exercise is and includes a group marrated, clinically relevant or, and a set of problem of messages, or prepared to challenge an emergency periences an actual natural or not that requires activation of the OPO is exempt from required testing exercise of the emergency event. D's response to and maintain all tabletop exercises, and and revise the [RNHCl's and plan, as needed.  TAB]:  RNHCl must conduct the emergency plan. The RNHCl g:  Based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, mergency scenario, and a set onts, directed messages, or designed to challenge an all cl's response to and ation of all tabletop exercises, and revise the RNHCl's	E 039		

	MENT OF DEFICIENCIES LAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING  (X3)		` '	X3) DATE SURVEY COMPLETED			
		34G294	B. WING _			01/	31/2024
	ROVIDER OR SUPPLIER			29	TREET ADDRESS, CITY, STATE, ZIP CODE 901 KONNOAK DRIVE VINSTON SALEM, NC 27127		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	is:  Review on 1/30/24 of no evidence of a full-sfacility-based training scale-community or famock drill, or a tableto Interview on 1/31/24 of disabilities profession facility has not conductor facility-based training scale-community or famock drill, or a tableto PROTECTION OF CLOFR(s): 483.420(a)(7)  The facility must ensurate for this STANDARD is in Based on observation failed to ensure private of personal needs for findings is:  Observations in the graining signal of the client's bed Interview with the horn 1/30/24 revealed the client's bed	the facility's EPP revealed scale community or a second full acility-based training or op exercise.  with the qualified intellectual al (QIDP) confirmed the cted a full-scale community ing, a second full acility-based training or op exercise.  LIENTS RIGHTS  are the rights of all clients. must ensure privacy during personal needs. The facility cy during treatment and care and interviews, the facility cy during treatment and care and interviews, the facility cy during treatment and care and interviews (#4). The roup home during the rey revealed client #4 to be in his room with the door servations revealed client we window coverings. The room from the outside.  The manager (HM) on	W	130			

	XTEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		34G294	B. WING _			01/	31/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	Ē		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
W 130	decided not to put up attempt to decrease to pulling them down. Could have a behavior plan and to window tinting, however permission to do so of HUD home. Further in revealed the client has from the client's wind providing privacy while or personal care.  Review of client's #4 support plan (BSP) do review of the BSP review of the BSP review of the BSP review of the BSP distriction, self injurit toileting, and seeking review of the BSP distriction, self injurit toileting, and seeking review of the BSP distriction. Interview with the quaprofessional (QIDP) of was not made aware window covering in his privacy. Continued in revealed the client shall and the support of the pure window covering in his privacy. Continued in revealed the client shall and the support of the pure window covering in his privacy. Continued in revealed the client shall and the pure window covering in his privacy.	window and the facility any window coverings in the he chances of the client ontinued interview with the mation is listed in the client' hat the facility did consider wer the facility did not have ue to the home being a hterview with the HM is a fence a few feet away ow which helps with he receiving treatment and/  record revealed a behavior ated 4/13/23. Continued realed the following targeted tural abuse, physical ion difficulty, property ous behavior, inappropriate pornography. Further I not address strategies of having window covering  halified intellectual disabilities on 1/31/24 revealed that she of client #4 not having	W	130			
W 247	care in his bedroom. INDIVIDUAL PROGR CFR(s): 483.440(c)(6  The individual progra opportunities for clien	)(vi) m plan must include	W 2	247			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 247	Based on observation interviews, the faciliar clients were given of self-management with dining. The finding is considered the place servings of for plate, napkin, and for before clients entered observation revealed opportunity to make preferences, choice second helpings. Fullients appear capa passing dishes, and kitchen. Continued or removing dishes from the dining table, was mopping the dining from the clients.  Record review on 1/2 individual program plass a meal prep good	s not met as evidenced by: ions, record review and ty failed to ensure that 6 of 6 apportunities for choice and ith respect to family-style s: group home during the dinner d the breakfast meal on e staff to prepare all food, od into bowls, and place each ork on the dining room table ed the room. Continued d clients were not offered the e choices with respect to food of utensils, condiments or urther observation revealed all ble of serving themselves, I taking their dishes to the observations revealed staff m the dining table, cleaning shing the dishes, and room floor with no assistance  //31/24 revealed current olan (IPPs) and each client al. Continued record review to have at least some level of g self-care, home	W2	247		
	professional (QIDP) staff were trained or preparation. QIDP of	ualified intellectual disabilities on 1/31/24 confirmed that n family style dining and meal confirmed that each client has endence and can participate				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		34G294	B. WING		01/31/2024
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W 249	formulated a client's each client must rec treatment program c interventions and se and frequency to su	1) disciplinary team has individual program plan, eive a continuous active	W 24	9	
	Based on observati interviews, the facilit clients (#2, #3, and a active treatment pro interventions and se	not met as evidenced by: ons, record reviews and ry failed to ensure 3 of 3 audit #4) received a continuous gram consisting of needed rvices as identified in the rlan (ISP) relative to meal dings are:			
	PM until 6:15 PM ar 7:55 AM, revealed S meal and the home prepare the breakfar no point during obse	rvations on 1/30/24 from 4:30 and 1/31/24 from 6:00 AM until Staff C to prepare the dinner manager was observed to st meal and wash dishes. At ervations were any clients with meal preparation.			
	Observations at the 4:30 PM - 5:20 PM r closet, fold clothes a while in his room. Co	to support client #2 with meal ample: group home on 1/30/24 from revealed client #2 to clean his and complete a puzzle activity continued observations at 5:30 #2 to participate in dinner,			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		34G294	B. WING		01/31/2024	4
	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLI	ETION
W 249	client #2 prompted preparation.  Morning observation revealed client #2 to participate in the bridishes to the sink. 66:20 AM revealed of watching Barney or exited the home at observation was cliented preparation.  Review of client #2' an individual service Continued review of the areas of exercise brush teeth and mer Further review reverseal preparation 70 consecutive months to prepare, select it item in proper pot/pfrom the menu.  Interview on 1/31/2 disabilities profession #2 training objective have been prompted preparation.	ne during observations was to assist with meal  ns on 1/31/24 at 6:00 AM of come out of his room, eakfast meal, then take his continued observations at lient #2 to sit in the livingroom in the television until surveyors 7:55 AM. At no time during ent #2 prompted to assist with served on 1/31/24 revealed the plan (ISP) dated 1/3/24. If the ISP revealed training in the ise, meal preparation, shower, dication administration. The includes selecting item the includes selecting item the mem from the cabinet. Place and name item needed  4 with the qualified intellectual conal (QIDP) confirmed client are current and should do participate in meal	W 2-4	,		
	Observations at the 4:30 PM until 6:15 I a table in the activit	group home on 1/30/24 from PM revealed client #3 to sit at y room, coloring in a book. ions revealed to sit in the				

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3)	(X3) DATE SURVEY COMPLETED		
		34G294	B. WING _			01/31/2024		
	ROVIDER OR SUPPLIER  K GROUP HOME	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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) COMPLETION DATE		
W 249	livingroom at 5:20 Pl until prompted for dir observation was clie meal preparation.  Morning observation revealed client #3 to and participate in the observations at 6:25 client #3 to the bathr revealed client #3 to room, coloring in a b home at 7:55 AM. At was client #3 prompt preparation.  Review of client #3's an individual service Continued review of the areas of laundry, brush teeth and med Further review reveameal preparation 70' consecutive months to prepare, select ite item in proper pot/pafrom the menu.  Interview on 1/31/24 client #3 should have engaged in other act Continued interview	M to 5:40 PM falling asleep oner. At no time during on #3 prompted to assist with as on 1/31/24 from 6:00 AM come out of the bathroom one breakfast meal. Continued AM revealed staff to escort oom. Further observations sit at a table in the activity ook until surveyors exited the continued to assist with meal arecord on 1/31/24 revealed plan (ISP) dated 2/24/23. The ISP revealed training in meal preparation, shower, lication administration. This includes selecting item of the form the cabinet, place on, and name item needed with the QIDP confirmed to been prompted and divies than coloring. The preparation as the	W 2	49				
	C. The facility failed preparation.	to support client #4 with meal						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
W 249	4:30 PM until 6:15 P bedroom cleaning hi observations betwee client #4 moving to a activity room. Furthe 5:40 PM until prompi sitting in the living ro observation was clie meal preparation.  Morning observation revealed client #4 to participate in the bre observations reveale sitting in the living ro television with anoth the home at 7:55 AM observation was clie meal preparation.  Review of client #4's an individual service Continued review of the areas of laundry, brush teeth and med Further review revea meal preparation 100 consecutive months, items to prepare from	group home on 1/30/24 from M revealed client #4 in his is room. Continued in 5:20 PM-5:40 PM revealed and from his bedroom and ir observations reveal from ited for dinner, client #4 was om. At no time during in the prompted to assist with as on 1/31/24 from 6:00 AM come out of his room and akfast meal. Further ited at 6:18 AM client #4 was om watching Barney on the er peer until surveyors exited in the prompted to assist with a som watching in the prompted to assist with a som watching in the during in meal preparation, shower, ication administration. Ited client #4 will assist with the individual in the menu, select item from in proper pot/pan, and	W 24	,				
	Interview on 1/31/24 client #4 should have engaged in other act	with the QIDP confirmed be been prompted and ivities than sitting watching his room. Continued						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G294	B. WING			01/	31/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
W 249 W 371	Continued From page participated in meal p objectives are current DRUG ADMINISTRA' CFR(s): 483.460(k)(4	reparation as the training t. TION	W	249 371			
	The system for drug a that clients are taught medications if the interest determines that self-a is an appropriate object does not specify other This STANDARD is represent the system failed to assure 1 of 60 provided the opporture medication self-admirt teaching relative to not a self-admirt teaching relative to not self-admire the self-admirest teaching relative to not self-admirest teaching relative teaching relative to not self-admirest teaching relative te	administration must assure t to administer their own erdisciplinary team administration of medications ective, and if the physician rwise. not met as evidenced by: n, record review and for drug administration of clients (client #1) were nity to participate in					
	AM revealed client #1 room and the home in the following medicati L-Carnitine 500mg, Li Divalproex 250mg, Di Clobazam 20mg. Cor HM to prompt client # small cup from blister questioned the HM at and the HM did not revealed client #1 to twater. Client #1 was a training during medical beyond receiving medical	ivalproex ER 250mg, and attinued observation revealed it to pop medications into a packet. Client #1 cout one of his medications expond. Further observations take all pills with a cup of not observed to receive any ation pass or to participate					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
W 371	should have participal administration with state teaching of name of medications, and a single revealed client #1 harms.	on 1/31/24 verified client #1 Ited in the medication aff providing the basic medications, reason for the Ide effect. QIDP also ving a goal for medication as capable of participating.	W 3				
	This STANDARD is a Based on record rev facility failed to ensur conducted at least que finding is:  Review of the facility 1/2023-12/2023 reveal Quarter 1: Jan 23 (1/2 (none) Mar 23 (none) Quarter 2: April 23 (4 (none), June 23 (none) Quarter 3: Jul 23 (none) 23(9/21/23 1st shift) Quarter 4: Oct 23 (10 (11/20/23 3rd shift), East of the continued interview of the continued interview of the continued interview of the system and continued interview of the continued interview of	each shift of personnel. not met as evidenced by: iew and interviews, the e fire evacuation drills were larterly on each shift. The  fire drills on 01/30/24 from aled the following:  9/23 3rd shift), Feb 23  1/5/23 2nd shift), May 23  e) ne), Aug 23 (none) Sept  1/25/23 2nd shift), Nov 23  2ec 23 (12/2/23 1st shift)  I with the home manager were no additional fire drills if n the fire drill book.  with the HM revealed the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		34G294	B. WING _		01/31/2024	
NAME OF PROVIDER OR SUPPLIER  KONNOAK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127		·	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
W 440		e 24 uarterly for each shift of	W 4	40		
W 454	personnel. INFECTION CONTF CFR(s): 483.470(I)(1		W 4	54		
		vide a sanitary environment I transmission of infections.				
	Based on observation pantry and emergen	not met as evidenced by: on of the facility's refrigerator, cy supplies food storage, the food in a sanitary manner for nding is:				
	pantry and emergen 4:30 PM - 6:15 PM r condiments, and mil revealed over 32 ext 2019. Further observations several canned good the expiration date b was also noted that opened box of pance	roup home refrigerator, cy supply closet on 1/30/24 at evealed expired cans of food, k. Continued observations bired food cans dated back to vations in the pantry revealed ds and premium crackers with each to 3/2021 and 8/2023. It the pantry contained one ake mix, open box of instant prevent attraction of insects in the pantry.				
	revealed a used gall Additional observation	ntions in the refrigerator on of milk dated 1/9/24. ons revealed several frigerator with the expiration				
	1/31/24 revealed he can goods, milk and	ome manager (HM) on was not aware of the expired condiments. Continued alified intellectual disabilities				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	1 ' '	
		34G294	B. WING _		01/31/202	24	
NAME OF PROVIDER OR SUPPLIER  KONNOAK GROUP HOME			•	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127			
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W 454	foods should be dispersive expiration date.	ge 25 on 1/31/24 confirmed expired posed of or used before the	W 4				
W 473	This STANDARD is Based on observati interviews, the facilit served at appropriat potentially affected \$\frac{2}{2}\$, #3, #5, and #6).  During dinner observation of the vegetable mix of vegetable mix in a lakitchen counter steat clients were seated vegetable mix was pfamily-style serving temperatures check sitting at the dining to eat, and surveyor temperature. Furthe the food temperature degrees. Observed mix back into the kith cooled down and shable.  Review of dining probook revealed that for 135 degrees and not 1/30/24.	d at appropriate temperature. not met as evidenced by: ons, record reviews and y failed to ensure foods were e temperature. This of 6 clients in the home (#1,	W	473			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G294	B. WING _			01/:	31/2024
NAME OF PROVIDER OR SUPPLIER  KONNOAK GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORE  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE AF  DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
W 475	went into the kitchen dining book, and she temperature range. Stemperature must real exceed 165 degrees. 189.5 was too hot.  Interview on 1/31/24 disabilities profession food temperature sho prior to consumption. MEAL SERVICES CFR(s): 483.480(b)(2)  Food must be served This STANDARD is real Based on observation interview, the facility of clients were provided allow each client to expossible. The findings Afternoon observation 1/30/24 at 5:45 PM readining table to prepare dinner meal consisted green beans and corrobservations revealed except client #3 with a participated in the din provided with a spoor observations revealed dinner utilizing the the concerns. At no point period were clients of	to find the protocol in the located the food staff C stated that the food staff C stated that the food school staff C stated that the food school staff C stated that the food school staff C confirmed that with the qualified intellectual hal (QIDP) confirmed that hal (QIDP) conf	W 2	173			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  KONNOAK GROUP HOME			•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 KONNOAK DRIVE WINSTON SALEM, NC 27127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 475	revealed all clients to prepare for the break meal consisted of the milk. Continued obse provide clients with a participated in the break meals. Continued into clients should have be setting including a for meals. Continued into that all clients should setting to promote incomealtimes.  MENUS  CFR(s): 483.480(c)(1)  Menus must provide meal.  This STANDARD is a Based on observation interviews, the facility residing in the home foods listed on the michigant of green beans and conservations revealed one fish fillet for dinner indicated banana split	s on 1/31/24 at 6:55 AM sit at the dining table to fast meal. The breakfast following: cereal, juice and rivations revealed staff to spoon only as the clients eakfast meal.  alified intellectual disabilities on 1/31/24 revealed all een offered a full place rk, knife and spoon during all erview with the QIDP verified be provided a full place dependence during  (iii)  a variety of foods at each not met as evidenced by: ons, document review and of failed to assure clients were offered the variety of enu. This affected 6 of 6 : group home on 1/30/24 ting fish fillets and a mixture corn for dinner. Further d some clients to receive er. Continued observations its for the clients' dessert. At ints offered a desert or any		475			
	Review on 1/30/24 of	f the facility's menu book for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		34G294	B. WING	·····	01/31/2024
NAME OF PROVIDER OR SUPPLIER  KONNOAK GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2901 KONNOAK DRIVE WINSTON SALEM, NC 27127	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
W 478	banana split, 2% milk dinner.  Observations on 1/3 manager to prepare a crunch cereal for all opreferred juice or mil offered additional sid Additional observationand wheat bread recrefrigerator.  Review on 1/31/24 of fall/winter week IV re	vealed hotdog, bun, ion rings, tomato, salad, and beverage of choice for al/24 revealed the home a bowl of toasted cinnamon clients and asked if they are with their breakfast meal. In the revealed there were eggs ently purchased in the all the facility's menu book for vealed cereal, egg of choice,	W 4	78	
W 483	1/31/24 revealed the toast were optional for interview revealed the on diabetic diets. Fur qualified intellectual of (QIDP) on 1/31/24 co have been offered a meals according to the DINING AREAS AND CFR(s): 483.480(d)(2). The facility must providents who can and of clients in wheelchairs This STANDARD is Based on observation interviews the facility	me manager (HM) on egg of choice and wheat or all clients. Continued ere are three clients currently ther interview with the disabilities professional onfirmed the clients should variety of food during all neir prescribed diets.  2 SERVICE  2)  vide table service for all will eat at a table, including	W 48	33	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G294	B. WING	<del></del>	0.	1/31/2024
NAME OF PROVIDER OR SUPPLIER  KONNOAK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  2901 KONNOAK DRIVE  WINSTON SALEM, NC 27127			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 483	PM revealed client the dining room for the dining room and to a short sideboard a fork and napkin. (from the dining table Continued observationing table. Further having to eat his din not facing his plate encourage client #2 room table.  Observation on 1/3 AM revealed client from the table and short sideboard cate eating his breakfast his body not facing observation revealed dining room table for encourage client #2 room table.  Record review on 1 support plan (BSP) any target behavior room table with permealtimes.  Interview with the him 1/31/24 revealed the sideboard cabinet of #4 doesn't like sitting the sideboard cabinet of the sideboard cabinet of #4 doesn't like sitting the sideboard cabinet of the sideboard cabinet of #4 doesn't like sitting the sideboard cabinet of the sideboard cabine	ge 29  20/24 between 5:47 PM- 6:13  #4 was prompted to come to dinner. Client #4 walked into a was told to have a seat next a cabinet that staff had placed client #4 was positioned away are near the back wall. Sion revealed the other five the home to be seated at the probservation reveal client #4 the problem of the join his peers at the dining at a poinet. Observed client #4 while the problem of the join his peers at the dining to the side of the join his peers at the dining at a poinet. Observed client #4 while the join his peers at the dining at the join his peers at the dining are or isolation during the join his peers at the dining are or isolation during the join his peers at the dining at the dining table with his pat staff does not encourage	W 48	33		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		34G294	B. WING _		01/31/2024
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W 483	him to sit at the dining the sideboard table. (Interview with the quaprofessional (QIDP) of client #4 should have dining table with peer was unaware that client.	e 30 g table because he prefers Client #4 is non-verbal.  alified intellectual disabilities on 1/31/24 revealed that been asked to sit at the rs first. QIDP stated that she ent # 4 was sitting alone at a d that was inappropriate	W 4		