PRINTED: 07/28/2023 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G070	B. WING		0.7	/26/2023	
	ROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 47 PLEASANT ACRES DRIVE IOCKSVILLE, NC 27028	1 0	12012023	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	§441.184(d)(1), §483. §483.73(d)(1), §483. §485.68(d)(1), §485. §485.727(d)(1), §485. §485.727(d)(1), §485. §491.12(d)(1). *[For RNCHIs at §402. Hospitals at §482.15, at §484.102, REHs a under §485.727, OPC RHC/FQHCs at §491 (1) Training program the following: (i) Initial training in empolicies and procedur staff, individuals provarrangement, and vol expected roles. (ii) Provide emergence least every 2 years. (iii) Maintain documer preparedness training (iv) Demonstrate staff procedures. (v) If the emergency procedures are significant training procedures. *[For Hospices at §41 hospice must do all of (i) Initial training in empolicies and procedurhospice employees, a services under arrange expected roles.	5.54(d)(1), §418.113(d)(1), 9.84(d)(1), §482.15(d)(1), 475(d)(1), §484.102(d)(1), 475(d)(1), §484.102(d)(1), 5.42(d)(1), §485.625(d)(1), 6.920(d)(1), §486.360(d)(1), 9.748, ASCs at §416.54, ICF/IIDs at §483.475, HHAs t §485.542, "Organizations" Dos at §486.360, 12:] The [facility] must do all of mergency preparedness res to all new and existing iding services under unteers, consistent with their expreparedness training at matation of all emergency preparedness training at matation of all emergency preparedness policies and cantly updated, the [facility] on the updated policies and 8.113(d):] (1) Training. The	E 037	The Qualified Professional Chairperson will in-service the EPP. This will include a emergency drill, mock drill dactivity. The Safety Chairpermonitor all EPP during the Safety Committee Meeting they are up to date; drills are completed as required and training has been completed future the Qualified Professions ensure all staff are trained demergency Preparedness Fwith required drills/tabletop	all staff on full-scale or tabletop erson will monthly to ensure e staff d. In the ional will on the Plan along	9/24/23	

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.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DISTRUCTION	(X3) DA	NO. 0938-0391 ATE SURVEY MPLETED
	- Anna Anna Anna Anna Anna Anna Anna Ann	34G070	B. WING	W-100		7/26/2023
	PROVIDER OR SUPPLIER		4471	EET ADDRESS, CITY, STATE, ZIP CODE PLEASANT ACRES DRIVE CKSVILLE, NC 27028		772072020
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	(ii) Demonstrate staff procedures. (iii) Provide emergence least every 2 years. (iv) Periodically review emergency preparedre employees (including special emphasis place procedures necessary others. (v) Maintain document preparedness training (vi) If the emergency procedures are significant tonduct training procedures. *[For PRTFs at §441.1] program. The PRTF mrogram. The PRTF mrogram. The PRTF mrogram. The procedures staff, individuals provide arrangement, and voluex expected roles. (ii) After initial training, preparedness training (iii) Demonstrate staff procedures. (iv) Maintain document preparedness training. (v) If the emergency procedures are significant emerge	knowledge of emergency by preparedness training at a and rehearse its less plan with hospice nonemployee staff), with led on carrying out the a to protect patients and station of all emergency coreparedness policies and cantly updated, the hospice on the updated policies and ling services under sergency preparedness ling services under sergency every 2 years. In consistent with their provide emergency every 2 years. In consistent with their canting of all emergency leation of all emergency every 2 years. In consistent with their can be defined and leating of the provide and leating	E 037			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G070	B. WING		07/26/2023	
	PROVIDER OR SUPPLIER		447 1	ET ADDRESS, CITY, STATE, ZIP CODE PLEASANT ACRES DRIVE CKSVILLE, NC 27028		
(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 CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
E 037	policies and procedu staff, individuals provarrangement, contract volunteers, consistent (ii) Provide emergence least every 2 years. (iii) Demonstrate staff procedures, including what to do, where to case of an emergence (iv) Maintain docume (v) If the emergency procedures are signiff must conduct training procedures. *[For LTC Facilities at Program. The LTC fa	res to all new and existing iding on-site services under ctors, participants, and it with their expected roles. By preparedness training at f knowledge of emergency informing participants of go, and whom to contact in y.	E 037			
	policies and procedur staff, individuals provide arrangement, and volexpected role. (ii) Provide emergence least annually. (iii) Maintain documer preparedness training (iv) Demonstrate staff procedures. *[For CORFs at §485. CORF must do all of (i) Provide initial training preparedness policies and existing staff, individuals provided in the context of the conte	unteers, consistent with their y preparedness training at ntation of all emergency knowledge of emergency 68(d):](1) Training. The following: ng in emergency and procedures to all new viduals providing services and volunteers, consistent				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		34G070	B. WING			7/26/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREETADDRESS, CITY, STATE, ZIP CODE 447 PLEASANT ACRES DRIVE MOCKSVILLE, NC 27028			
(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)	SHOULD BE	(X5) COMPLETION DATE	
E 037	(ii) Provide emergence least every 2 years. (iii) Maintain docume (iv) Demonstrate staff procedures. All new pand assigned specific the CORF's emergent their first workday. Trinclude instruction in alarm systems and siequipment. (v) If the emergency procedures are signiff must conduct training procedures. *[For CAHs at §485.6] The CAH must do all (i) Initial training in empolicies and procedure reporting and extinguland where necessary personnel, and guest cooperation with fireficial authorities, to all new individuals providing and volunteers, consiroles. (ii) Provide emergence least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. (v) If the emergency procedures are significations.	ey preparedness training at intation of the training. If knowledge of emergency personnel must be oriented to responsibilities regarding to plan within 2 weeks of the training program must the location and use of gnals and firefighting If preparedness policies and identify updated, the CORF on the updated policies and of the following: Interpretation of patients, including prompt ishing of fires, protection, including prompt ishing and disaster and existing staff, services under arrangement, stent with their expected by preparedness training at	E 03				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		34G070	B. WING			07/	26/2023
NAME OF PE	ROVIDER OR SUPPLIER T ACRES			44	TREET ADDRESS, CITY, STATE, ZIP CODE 47 PLEASANT ACRES DRIVE IOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	2177	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	Contract of the Contract of th	(X5) COMPLETION DATE
E 039	CMHC must provide in preparedness policies and existing staff, ind under arrangement, a with their expected ro documentation of the demonstrate staff knot procedures. Thereaft emergency prepared ryears. This STANDARD is robusted in the facility's Emergency failed to ensure direct the facility's Emergent (EPP). The finding is: Review of the facility's was reviewed by the form the facility of 2023. Continued revidence of initial or be emergency prepared for existing staff were EP Testing Requirem CFR(s): 483.475(d)(2), §485.542(d)(2), §	initial training in emergency is and procedures to all new ividuals providing services and volunteers, consistent ales, and maintain training. The CMHC must award of emergency ter, the CMHC must provide the energy of the complete of emergency ter, the CMHC must provide the energy of the complete of emergency ter, the complete of emergency		037			9/24/23
	9465,727, CMHCs at	§485.920, RHCs/FQHCs at					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		TE SURVEY MPLETED	
		34G070	B. WING		0	7/26/2023
NAME OF PE	ROVIDER OR SUPPLIER T ACRES		447 1	ET ADDRESS, CITY, STATE, ZIP CODE PLEASANT ACRES DRIVE CKSVILLE, NC 27028		
(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	(X5) COMPLETION DATE
E 039	(2) Testing. The [fact to test the emergen must do all of the formust do accessible, conduct exercise every 2 ye (B) If the [facilit natural or man-mad activation of the emexempt from engage community-based of functional exercise this section is conduct an additive years, opposite the functional exercise this section is conduct in the fol (A) A second full-socommunity-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclitation and a set directed messages, designed to challen (iii) Analyze the [fact maintain document exercises, and emergent designed to challen (iii) Analyze the [fact maintain document exercises, and emergent designed to all the fact maintain document exercises, and emergent designed to all the fact maintain document exercises, and emergent designed to all the fact maintain document exercises, and emergent designed to all the fact maintain document exercises, and emergent designed to all the fact maintain document exercises, and emergent designed to all the fact maintain document exercises, and emergent designed to all the fact maintain document exercises, and emergent designed to all the fact maintain document exercises, and emergent designed to all the fact maintain document exercises, and emergent designed to all the fact maintain document exercises, and emergent designed the fact maintain designed the fact maint	Distriction Facilities at §494.62]: Distriction Facilities at §494.62]: Distriction Facilities at §494.62]: Distriction Facilities at Facility F	E 039			

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A, BUILDING		
		34G070	B. WING		07	//26/2023
NAME OF PI	ROVIDER OR SUPPLIER		447 1	EET ADDRESS, CITY, STATE, ZIP CO PLEASANT ACRES DRIVE CKSVILLE, NC 27028	DDE	
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 039	*[For Hospices at 41 (2) Testing for hospi patient's home. The exercises to test the annually. The hospi (i) Participate in a fu community based ev (A) When a commun accessible, conduct functional exercise e (B) If the hospice ex man-made emergen the emergency plan, engaging in its next community-based ev facility-based functio onset of the emerge (ii) Conduct an addi opposite the year the exercise under para is conducted, that m to the following: (A) A second full-se community-based or exercise; or (B) A mock disaster (C) A tabletop exerc a facilitator and inclu a narrated, clinically scenario, and a set directed messages, designed to challeng (3) Testing for hospi care directly. The h exercises to test the year. The hospice r	8.113(d):] ces that provide care in the hospice must conduct emergency plan at least ce must do the following: ill-scale exercise that is very 2 years; or hity based exercise is not an individual facility based every 2 years; or periences a natural or cy that requires activation of the hospital is exempt from required full scale exercise or individual anal exercise following the not event. It in a continuation of the hospital is exempt from required full scale exercise or individual anal exercise following the not event. It in a continuation of the hospital is exempt from required full scale exercise every 2 years, a full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited alle exercise that is	E 039			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G070	B. WING				07/26/2023
NAME OF PI	ROVIDER OR SUPPLIER			447 P	ET ADDRESS, CITY, STATE, ZIP CODE PLEASANT ACRES DRIVE KSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
E 039	is community-based; (A) When a communicaccessible, conduct a facility-based function (B) If the hospice expression and a set of facility-based or facility-based or facility-based following the onset of (ii) Conduct an addit may include, but is not (A) A second full-sca community-based or exercise; or (B) A mock disaster (C) A tabletop exercise; facilitator that include narrated, clinically-reand a set of problem messages, or preparatellenge an emerged (iii) Analyze the hospicallenge and emergency exercises, and emergency exercises, and emergency exercises, and emergency exercises. *[For PRFTs at §441 §482.15(d), CAHs at (2) Testing. The [PR conduct exercises to twice per year. The do the following:	or ity-based exercise is not an annual individual hal exercise; or periences a natural or by that requires activation of the hospice is exempt from required full-scale community and functional exercise of the emergency event. ional annual exercise that not limited to the following: ale exercise that is a facility based functional drill; or ise or workshop led by a as a group discussion using a alevant emergency scenario, statements, directed red questions designed to ency plan. pice's response to and tion of all drills, tabletop gency events and revise the y plan, as needed.	E	039			
	is community-based (A) When a commun						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		34G070	B. WING			0	7/26/2023	
NAME OF P	ROVIDER OR SUPPLIER			447 PLEA	ADDRESS, CITY, STATE, ZIP CODE ASANT ACRES DRIVE VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 039	facility-based functio (B) if the [PRTF, Hos actual natural or mar requires activation of [facility] is exempt for required full-scale co facility-based functio onset of the emerger (ii) Conduct an and that may include following: (A) A second full-scale community-based or functional exercise; (B) A mock (C) A tabletop eled by a facilitator and discussion, using a remergency scenario statements, directed questions designed to glan. (iii) Analyze the maintain documental 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 community-based (A) When a community-based function accessible, conduct facility-based function.	nal exercise; or spital, CAH] experiences an n-made emergency that if the emergency plan, the om engaging in its next emmunity based or individual, nal exercise following the ney event. [additional] annual exercise or e, but is not limited to the ale exercise that is individual, a facility-based or disaster drill; or exercise or workshop that is individual, a group harrated, clinically-relevant in and a set of problem messages, or prepared to challenge an emergency [facility's] response to and tion of all drills, tabletop gency events and revise the plan, as needed. 84(d):] E organization must conduct emergency plan at least organization must do the annual full-scale exercise that conduct of the plan in the plan	E	039				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		34G070	B. WING_		0	7/26/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (447 PLEASANT ACRES DRIVE MOCKSVILLE, NC 27028	CODE		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
E 039	man-made emerge the emergency platengaging in its next based or individual exercise following the event. (ii) Conduct any years opposite the exercise under parties conducted that in the following: (A) A second full-scommunity-based functional exercise (B) A mock disasts (C) A tabletop exercise (B) A mock disasts (C) A tabletop exercise a facilitator and including a narrated, conscipled to challet (iii) Analyze the Primaintain document exercises, and emergency and emergency procedured including unannout emergency procedured in a scommunity-base (A) When a community-base (A) When a community-based functions in the emergency procedured in a scommunity-based functions and the emergency procedured in a scommunity-based functions are serviced in a scommunity-based functions are s	ney that requires activation of in, the PACE is exempt from a required full-scale community facility-based functional he onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited to cale exercise that is or individual, a facility based or or drill; or recise or workshop that is led by ludes a group discussion, linically-relevant emergency of of problem statements, or or prepared questions and eation of all drills, tabletop ergency events and revise the plan, as needed. Seat §483.73(d):] by must conduct exercises to by plan at least twice per year, inced staff drills using the lures. The [LTC facility, ine following: in annual full-scale exercise is not ct an annual individual,	EO	39			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G070	B. WING		0	7/26/2023
NAME OF PI	ROVIDER OR SUPPLIER		44	REET ADDRESS, CITY, STATE, ZIP CODE 7 PLEASANT ACRES DRIVE OCKSVILLE, NC 27028		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
E 039	actual natural or m requires activation LTC facility is exem required a full-scalindividual, facility-b following the onset (ii) Conduct an admay include, but is (A) A second full-scommunity-based functional exercise (B) A mock disastr (C) A tabletop exe a facilitator include narrated, clinically-and a set of proble messages, or prep challenge an emer (iii) Analyze the [L and maintain docu exercises, and em [LTC facility] facility *[For ICF/IIDs at § (2) Testing. The IC to test the emerge The ICF/IID must (i) Participate in an is community-based (A) When a commaccessible, conduction facility-based function (B) If the ICF/IID eman-made emerging in its necommunity-based community-based function in the ICF/IID eman-made emerging in its necommunity-based	an-made emergency that of the emergency plan, the not from engaging its next e community-based or lased functional exercise of the emergency event. ditional annual exercise that not limited to the following: locale exercise that is or an individual, facility based or or drill; or recise or workshop that is led by s a group discussion, using a relevant emergency scenario, m statements, directed lared questions designed to gency plan. TC facility] facility's response to mentation of all drills, tabletop lergency events, and revise the lev's emergency plan, as needed. 483.475(d)]: F/IID must conduct exercises local the following: leanual full-scale exercise that	E 039			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G070	B, WING		07	/26/2023
NAME OF PI	ROVIDER OR SUPPLIER		447 F	ET ADDRESS, CITY, STATE, ZIP CODE PLEASANT ACRES DRIVE CKSVILLE, NC 27028		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 039	emergency event. (ii) Conduct an additimal may include, but is not (A) A second full-scale community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and inclusing a narrated, clin scenario, and a set of directed messages, of designed to challeng (iii) Analyze the ICF/I maintain documental exercises, and emergic ICF/IID's emergency exercises and emergic east annually. The Hoto test the emergency least annually. The Hoto test the emergency exercises for man-made emergic of the emergency place engaging in its next a community-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the	onal annual exercise that of limited to the following: le exercise that is an individual, facility-based or drill; or se or workshop that is led by des a group discussion, ically-relevant emergency of problem statements, or prepared questions an emergency plan. ID's response to and ion of all drills, tabletop gency events, and revise the plan, as needed. IO2] HA must conduct exercises by plan at the must do the following: lescale exercise that is remunity-based exercise is not an annual individual, nal exercise every 2 years; experiences an actual natural ency that requires activation and the HHA is exempt from required full-scale individual, facility based onlowing the onset of the tonal exercise every 2 years,	E 039			

Event ID: IV9N11

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G070	B. WING			07/	26/2023
13454650000000000000000000000000000000000	ROVIDER OR SUPPLIER			44	REET ADDRESS, CITY, STATE, ZIP CODE 7 PLEASANT ACRES DRIVE DCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	is conducted, tha limited to the following (A) A second full-community-based or of functional exercise; or (B) A mock disas (C) A tabletop ex led by a facilitator and discussion, using a nate emergency scenario, statements, directed requestions designed to plan. (iii) Analyze the HHA's documentation of all demergency events, are emergency plan, as not emergency plan, as not emergency events, are emergency plan, as not emergency plan, as not entered in the emergency following: (i) Conduct a paper-based workshop at least annuled by a facilitator and discussion, using a nate emergency scenario, statements, directed in questions designed to plan. If the OPO experiments are emergency plan, the emergency plan, the emergency plan, the emergency plan, the emergency of all the opolism of the opolism o	t may include, but is not g: scale exercise that is an individual, facility-based fer drill; or ercise or workshop that is includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency is response to and maintain fills, tabletop exercises, and ind revise the HHA's eeded. 60] PO must conduct exercises plan. The OPO must do the ased, tabletop exercise or ually. A tabletop exercise is includes a group arrated, clinically relevant and a set of problem messages, or prepared a challenge an emergency riences an actual natural or y that requires activation of the OPO is exempt from required testing exercise the emergency event. The response to and maintain abletop exercises, and and revise the [RNHCI's and	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A, BUILDING	(X3) DATE SURVEY COMPLETED	
		34G070	B, WING		07/26/2023
NAME OF PROVIDER OR SUPPLIER PLEASANT ACRES			447 P	ET ADDRESS, CITY, STATE, ZIP CODE LEASANT ACRES DRIVE KSVILLE, NC 27028	
(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 COMPLETIO
E 039	Continued From page	ge 13	E 039		
	exercises to test the must do the followin (i) Conduct a paper-least annually. A tat discussion led by a clinically-relevant er of problem statement prepared questions emergency plan. (ii) Analyze the RNH maintain documents and emergency everemergency plan, as This STANDARD is Based on record refailed to conduct bis	RNHCI must conduct remergency plan. The RNHCI g: based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, nergency scenario, and a set nts, directed messages, or designed to challenge an HCI's response to and ation of all tabletop exercises, ints, and revise the RNHCI's			
	reveal evidence of facility-based emery mock drill or table to				
	confirmed the facility	rogram manager on 7/26/23 y has not conducted a full nd/or facility-based emergency al mock drill or table top			
W 130	PROTECTION OF CFR(s): 483.420(a		W 130		
	Therefore, the facil	nsure the rights of all clients. ity must ensure privacy during of personal needs.			The second state of the se

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		34G070	B. WING	1	07/	26/2023
PLEASAN	ROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 47 PLEASANT ACRES DRIVE IOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 130	Based on observation failed to ensure privalent failed to ensure privalent failed to ensure privalent failed to ensure privalent failed to ensure failed fai	s not met as evidenced by: iion and interviews, the facility vacy during treatment and care or 1 of 6 clients (#3). The entry to the group on 7/26/23 at lient #3 to be in the th the door open. Continued ad client #6 to be sitting ion room watching as client dication from staff. acility nurse on 7/26/23 ald offer privacy during tration.	W 130	W130 The Qualified Professional will in-service staff on clients' right to privacy during personal care and medication administration. The team will monitor through Intera Assessments two times a week month and then on routine basis ensure clients are provided privibuting personal care and medical administration. In the future the Qualified Professional will ensure trained to ensure clients are provided privacy during personal and medication administration.	d clinical ction for one s to acy ation	9/24/23
	formulated a client's each client must red treatment program of interventions and se and frequency to su objectives identified plan. This STANDARD is Based on observation review, the facility factive treatment prointerventions relative	rdisciplinary team has a individual program plan, belive a continuous active consisting of needed ervices in sufficient number apport the achievement of the in the individual program and met as evidenced by: ion, interviews and recordabled to ensure a continuous agram consisting of needed e to communication were intified in the person-centered		The Qualified Professional will in-service staff on client #6 communication objective. The cleam will monitor through Intera Assessments two times a week one month and then on a routine basis to ensure client #6 communication program is being implemented. In the future the Qualified Professional will ensur staff are trained to implement traobjectives as written in the Person-Centered Plan.	etion for e	9/24/23

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DAT	E SURVEY PLETED
		34G070	B. WING	**************************************	0:	7/26/2023
NAME OF P	ROVIDER OR SUPPLIER		447 F	ET ADDRESS, CITY, STATE, ZIP CODE PLEASANT ACRES DRIVE CKSVILLE, NC 27028		
(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 CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	3:45 PM through 5: participate in a leist observation revealed dinner meal, fix his and take his dishest observation revealed room. Subsequent verbally prompt clie activity to another. It did staff implement training objective. Observation in the 6:30 AM through 8: participate in a leist observation revealed Further observation participate in the brocereal, pour his drift the kitchen. Subsectient #6 to return to observation did state communication trained Review of records revealed a person 8/8/22. Further reviewealed training of manners, oral hygin TEACCH schedule communication trained pendence as proutine skills, staff Rather, during time "client #6 go check read the item, check and the item, check the schedule read the item of the schedule read the item of the schedule read the item of the schedule read the schedule read the item of the schedul	group home on 7/25/23 from 15 PM revealed client #6 to ure activity. Continued ad client #6 to participate in the dinner plate, pour his drinks to the kitchen. Further ad client #6 to return to his observation revealed staff to ent #6 to transition from one At no time during observation client #6's communication group home on 7/26/23 from 00 AM revealed client #6 to ure activity. Continued ad client #6 to set the table. In revealed client #6 to reakfast meal, fix a bowl of nks, eat and take his dishes to equent observation revealed to his room. At no time during ff implement client #6's	W 249			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		34G070	B. WING _			07	//26/2023
NAME OF PE	ROVIDER OR SUPPLIER	,		44	REET ADDRESS, CITY, STATE, ZIP CODE 7 PLEASANT ACRES DRIVE DCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	100	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 249	consecutive months. Interview with the quiprofessional (QIDP) on 7/26/23 revealed current for client #6. QIDP and PM verifier	Implementation date 2/2/23. alified intellectual disabilities and program manager (PM) all training objectives are Further interview with the d client #6 communication implemented as written to	W:	249			
W 262	CFR(s): 483,440(f)(3) The committee should monitor individual profinappropriate behavior in the opinion of the client protection and This STANDARD is Based on observation interview, the facility updated, written informan rights comming ated fence and exterior clients (#2, #4 and #4) Observations in the survey period from 7 gated fence surround observations revealed upon staff and survey facility. Review of client recorded in the committee of t	d review, approve, and orgams designed to manage or and other programs that, committee, involve risks to rights. not met as evidenced by: on, record review and failed to ensure that remed consent from the tee (HRC) was secured for a perior door alarms for 3 of 6	W	262	The Qualified Professional and Behavior Analysist will review obtain necessary consents from guardians and HCR gate and a on doors. The Qualified Profes will monitor during quarterly Qingeviews to ensure all consent rights limitations are in place. If tuture the Qualified Profession ensure consents from guardiat HRC are obtained for all rights restrictions.	and m alarms ssional P s for In the nal will ns and	9/24/23

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G070	B. WING		07/26/2023
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 PLEASANT ACRES DRIVE MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
W 262	guardian consent da review the clients' re written informed con HRC relative to a ga alarms. Interview with the querofessional (QIDP) on 7/26/23 revealed human rights conserver, 44, and #5 could survey. Continued in PM verified HRC limedients should be upland legal guardian a DRUG ADMINISTR/CFR(s): 483.460(k)() The system for drug that all drugs, including self-administered, and This STANDARD is Based on observation interview, the facility drugs, including those were administered with the following including the conservation in the grown for medication observation revealed following medication Sertraline 100 mg, Control of the client for the conservation revealed following medication sertraline 100 mg, Control of the client following medication sertraline 100 mg, Control of the client following medication sertraline 100 mg, Control of the client following medication sertraline 100 mg, Control of the client following medication of the client foll	ted 8/11/21. Subsequent cord did not reveal updated sents from guardians and ted fence or exterior door salified intellectual disabilities and program manager (PM) that current guardian and intellectual disabilities and program manager (PM) that current guardian and intellectual disabilities and program manager (PM) that current guardian and intellectual diamonal forms for clients and the located during the interview with the QIDP and diation consent forms for all dated and signed by the HRC innually. ATION 2) administration must assure ing those that are readministered without error, not met as evidenced by: on, record review and if alled to ensure that all se that are self-administered, without error for 1 of 6 clients aroup home on 7/26/23 at 6:32 for the client to receive the institution. Continued the client to receive the institution D3 50 mcg, Dyster Shell 500 mg, Levothyroxin 50 mcg, and	W 262		9/24/23
	Review of client #6's	s record on 7/26/23 revealed		No	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	THE PERSON NAMED IN COLUMN TO SERVICE AND ADDRESS OF THE PERSON NAMED IN COLUMN TO SE			(3) DATE SURVEY COMPLETED	
		34G070	B. WING		07/	26/2023	
	ROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 47 PLEASANT ACRES DRIVE IOCKSVILLE, NC 27028	1 077.	20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 369	physician's orders remorning medication except the Docusate AM. Continued review Docusate prescription interview with the faconfirmed client #6's current. Continued is medications should	dated 11/2/22. Review of the evealed all the client's are ordered for 7:00 AM, e which is ordered for 8:00 ew revealed the client's on was added on 7/6/23. dicility nurse on 7/26/23 as medication orders are interview confirmed client #6 be given as prescribed. ATION	W 369	W371 A and B		9/24/23	
	The system for drug that clients are taug medications if the in determines that self-is an appropriate obdoes not specify oth This STANDARD is Based on observati interview, the system failed to ensure 2 of observed during me provided the opportunedication self-adm. A. The system for drassure client #5 was participate in medication self-in medication in the game and the system for drassure client #7 own for medication observation revealed.	administration must assure that to administer their own terdisciplinary team -administration of medications jective, and if the physician erwise. not met as evidenced by: ons, record review and in for drug administration 2 clients (#5 and #6) dication administration were unity to participate in inistration. The findings are: rug administration failed to a provided the opportunity to ation self-administration. For		The nurse will retrain staff on participation and independence during medication administration. The clinical team will monitor the Medication Administration. Assessments two times a week one month and then on a routine basis to ensure clients are affore the opportunity for independence during medication administration the future nursing will ensure state trained to allow and encouraindependence during medication administration per their Person-Centered Plan.	for e ded e n. In		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		STRUCTION		OATE SURVEY OMPLETED		
		34G070	B. WING				07/26/2023
NAME OF P	ROVIDER OR SUPPLIER			447 PL	TADDRESS, CITY, STATE, ZIP CODE LEASANT ACRES DRIVE (SVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 371	a glass of water. Fur education or identific medication. Review of records for revealed a person-or 11/10/22. Review of prompted client #5 comedications are for a pack. Interview with the far confirmed staff shou allow the opportunity who are capable. B. The system for drassure client #6 was participate in medications prepare client with a glass of revealed no education observation revealed medications. Review of records for revealed a person-of 8/8/22. Review of the needs assistance was appropriately. He can to the medication cups. He can dication cups. He can dication cups. He	ther observation revealed no cation of the client's or client #5 on 7/26/23 entered plan (PCP) dated the PCP indicated when can tell you what his and can punch pills form the cility nurse on 7/26/23 and provide education and of the participation to all clients for participation to all clients are gaministration failed to a provided the opportunity to action self-administration. For a provided the medication administration. Continued distaff to have six and in a cup and hand to the fewater. Further observation on or identification of the	W	371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		MEDICAID SERVICES		The second of th	OWR M	0. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	TE SURVEY MPLETED	
		34G070	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	1 07	26/2023	
				PLEASANT ACRES DRIVE			
PLEASAN	T ACRES		1	CKSVILLE, NC 27028			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION		
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
W 371	Continued From pag	e 20	W 371				
	confirmed staff shou	cility nurse on 7/26/23 ld provide education and of for participation to all clients					