		AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		34G097			07/2024		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHE	RN AVENUE HOME				2001 SOUTHERN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	EP Training Progra CFR(s): 483.475(d) §403.748(d)(1), §44 §441.184(d)(1), §44 §483.73(d)(1), §483 §485.68(d)(1), §483 §485.68(d)(1), §485 §485.727(d)(1), §48 §491.12(d)(1). *[For RNCHIs at §4 Hospitals at §482.1 at §484.102, REHs under §485.727, OI RHC/FQHCs at §48 (1) Training progra the following: (i) Initial training in of policies and proced staff, individuals pro arrangement, and v expected roles. (ii) Provide emerge least every 2 years. (iii) Maintain docum preparedness trainin (iv) Demonstrate st procedures. (v) If the emergence procedures are sign	SC IDENTIFYING INFORMATION) m (1) 16.54(d)(1), §418.113(d)(1), 50.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 5.542(d)(1), §485.625(d)(1), 35.920(d)(1), §486.360(d)(1), 03.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" POs at §486.360, 91.12:] m. The [facility] must do all of emergency preparedness lures to all new and existing byiding services under volunteers, consistent with their ncy preparedness training at entation of all emergency			CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
	hospice must do all (i) Initial training in o policies and proced hospice employees	418.113(d):] (1) Training. The of the following: emergency preparedness lures to all new and existing , and individuals providing ngement, consistent with their					

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 05/08/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION	· /	TE SURVEY MPLETED	
		34G097	B. WING _		05/07/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 SOUTHERN AVENUE FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	JLD BE	(X5) COMPLETIO DATE	
E 037	 (ii) Demonstrate staprocedures. (iii) Provide emergeleast every 2 years. (iv) Periodically reviemergency prepare employees (includir special emphasis pprocedures necess others. (v) Maintain docum preparedness trainit (vi) If the emergency procedures are sign must conduct trainin procedures. *[For PRTFs at §44 program. The PRTI (i) Initial training in epolicies and proced staff, individuals proarangement, and vexpected roles. (ii) After initial training in procedures. (vi) Maintain docum preparedness trainit (vi) If the emergence procedures are sign must conduct training in epolicies and proced staff, individuals proarangement, and vexpected roles. (ii) After initial training in eporedness trainit (vi) If the emergence procedures are sign must conduct trainit preparedness trainit (vi) If the emergence procedures are sign must conduct trainit procedures are sign must conduct trainit procedures. *[For PACE at §460 organization must conduct trainit procedures. 	aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice ing nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency ing. by preparedness policies and inficantly updated, the hospice ing on the updated policies and enter the updated policies and enter the state of the following: emergency preparedness lures to all new and existing poiding services under volunteers, consistent with their ing, provide emergency ing every 2 years. aff knowledge of emergency mentation of all emergency	Ε 03	37			

If continuation sheet Page 2 of 15

		AND HUMAN SERVICES				FORM /	05/08/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
1		34G097	B. WING			05/0	07/2024
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHE	ERN AVENUE HOME				2001 SOUTHERN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	policies and proced staff, individuals pro- arrangement, contra- volunteers, consiste (ii) Provide emerger least every 2 years. (iii) Demonstrate sta procedures, includir what to do, where to case of an emerger (iv) Maintain docum (v) If the emergence procedures are sign must conduct training procedures. *[For LTC Facilities Program. The LTC - following: (i) Initial training in e policies and proced staff, individuals pro- arrangement, and v expected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate sta procedures. *[For CORFs at §48 CORF must do all co (i) Provide initial training training preparedness polici and existing staff, in	lures to all new and existing poiding on-site services under actors, participants, and ent with their expected roles. ncy preparedness training at aff knowledge of emergency ng informing participants of o go, and whom to contact in ncy. nentation of all training. cy preparedness policies and nificantly updated, the PACE ng on the updated policies and at §483.73(d):] (1) Training facility must do all of the emergency preparedness lures to all new and existing poiding services under volunteers, consistent with their ncy preparedness training at nentation of all emergency ing. aff knowledge of emergency as and procedures to all new ndividuals providing services , and volunteers, consistent	EC	037			

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		AND HUMAN SERVICES					FORM	05/08/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	0	(X3) DATE	E SURVEY PLETED
		34G097	B. WING	i			05/0	07/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
SOUTHE	RN AVENUE HOME				2001 SOUTHERN AVENUE FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
E 037	 (ii) Provide emerger least every 2 years. (iii) Maintain docum (iv) Demonstrate stap procedures. All new and assigned speci the CORF's emerger their first workday. include instruction in alarm systems and equipment. (v) If the emergen procedures are sign must conduct training procedures. *[For CAHs at §485 The CAH must do at (i) Initial training in e policies and proced reporting and exting and where necessan personnel, and gue cooperation with fire authorities, to all ne individuals providing and volunteers, corr roles. (ii) Provide emerger least every 2 years. (iii) Maintain docum (iv) Demonstrate stap procedures. (v) If the emergen procedures are sign 	ncy preparedness training at mentation of the training. aff knowledge of emergency of personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must n the location and use of signals and firefighting cy preparedness policies and hificantly updated, the CORF ing on the updated policies and 5.625(d):] (1) Training program. all of the following: emergency preparedness lures, including prompt guishing of fires, protection, ary, evacuation of patients, sts, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, hisistent with their expected ncy preparedness training at	EC	037				

Facility ID: 944882

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		AND HUMAN SERVICES				l	FORM /	05/08/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION		X3) DATE	E SURVEY PLETED
		34G097	B. WING				05/0)7/2024
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP COD			
SOUTHE	RN AVENUE HOME				2001 SOUTHERN AVENUE FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD B		(X5) COMPLETION DATE
E 037	CMHC must provid preparedness polici and existing staff, ir under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on document facility failed to ensu- adequately trained preparedness (EP) Review on 5/6/24 o dated April 2024 did about a previous tra- staff. During an interview confirmed there wa annual training for t During an interview intellectual disabiliti there was no inform concerning annual EP Testing Require CFR(s): 483.475(d) §416.54(d)(2), §418	 85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new ndividuals providing services, and volunteers, consistent roles, and maintain the training. The CMHC must nowledge of emergency after, the CMHC must provide edness training at least every 2 s not met as evidenced by: Int review and interview, the ure direct care staff were on the facility's emergency plan. The finding is: f the facility's EP manual d not include any information aining or annual training for f on 5/6/24, the home manager s no information concerning the staff. f on 5/7/24, the qualified es professional confirmed nation included in the EP training for the staff. ments (2) 8.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2),)37	7			
	§485.542(d)(2), §48	34.102(d)(2), §485.68(d)(2), 35.625(d)(2), §485.727(d)(2), 91.12(d)(2), §494.62(d)(2).						

Facility ID: 944882

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		AND HUMAN SERVICES				FORM	05/08/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G097	B. WING			05/	07/2024
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHE	RN AVENUE HOME				001 SOUTHERN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	Continued From pa	ge 5	E)39			
	at §485.542, OPO, §485.727, CMHCs §491.12, and ESRE (2) Testing. The [fact to test the emergen must do all of the for (i) Participate in a fu community-based et (A) When a commu- accessible, conduct exercise every 2 ye (B) If the [facilit natural or man-mact activation of the em- exempt from engag community-based of functional exercise actual event. (ii) Conduct an addi years, opposite the functional exercise this section is cond not limited to the for (A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise; a facilitator and incl a narrated, clinically scenario, and a set directed messages designed to challen	ull-scale exercise that is every 2 years; or unity-based exercise is not t a facility-based functional ears; or y] experiences an actual de emergency that requires hergency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: cale exercise that is or individual, facility-based or					

Facility ID: 944882

If continuation sheet Page 6 of 15

		AND HUMAN SERVICES				FORM	05/08/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G097	B. WING			05/	07/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SOUTHE	RN AVENUE HOME				001 SOUTHERN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	maintain document exercises, and eme [facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. Th exercises to test the annually. The hosp (i) Participate in a f community based ef (A) When a commu accessible, conduct functional exercise (B) If the hospice ex man-made emerge the emergency plar engaging in its next community-based function onset of the emerge (ii) Conduct an add opposite the year th exercise under para is conducted, that in to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaster (C) A tabletop exer a facilitator and incl a narrated, clinically scenario, and a set directed messages designed to challen	ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] pices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not t an individual facility based every 2 years; or xperiences a natural or ncy that requires activation of n, the hospital is exempt from t required full scale exercise or individual onal exercise following the ency event. ditional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	E	039			

Facility ID: 944882

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/08/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G097	B. WING			05/	07/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHE	RN AVENUE HOME				2001 SOUTHERN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	exercises to test the year. The hospice i (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functii (B) If the hospice ex- man-made emerge the emergency plar engaging in its next based or facility-base following the onset (ii) Conduct an add may include, but is (A) A second full-se community-based of exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerg (iii) Analyze the hos- maintain document exercises, and emerg hospice's emergend *[For PRFTs at §44 §482.15(d), CAHs a (2) Testing. The [PF conduct exercises the set of the set of the set of the conduct exercises the set of the set of the set of the set of the conduct exercises the set of the set	in the product of the emergency plan twice per must do the following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual onal exercise; or operiences a natural or ncy that requires activation of n, the hospice is exempt from required full-scale community sed functional exercise of the emergency event. litional annual exercise that not limited to the following: cale exercise that is or a facility based functional r drill; or cise or workshop led by a des a group discussion using a elevant emergency scenario, n statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop orgency events and revise the cy plan, as needed. 1.184(d), Hospitals at	E)39			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/08/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G097	B. WING			05/	07/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHE	RN AVENUE HOME						
				г	FAYETTEVILLE, NC 28301		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	 (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the [PRTF, Hore actual natural or marequires activation of [facility] is exempt for required full-scale of facility-based function onset of the emerge (ii) Conduct an and that may includ following: (A) A second full-scale of functional exercise; (B) A mock (C) A tabletop end by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the maintain documenta exercises, and emergency *[For PACE at §460 (2) Testing. The PACE following: 	annual full-scale exercise that d; or inity-based exercise is not a annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or e, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency [facility's] response to and ation of all drills, tabletop ergency events and revise the ey plan, as needed. .84(d):] CE organization must conduct e emergency plan at least organization must do the	EC	039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/08/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G097	B. WING	·		05/	07/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHE	RN AVENUE HOME				2001 SOUTHERN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	accessible, conduct facility-based functi (B) If the PACE exp man-made emerge the emergency plar engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the exercise under para is conducted that m the following: (A) A second full-se community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator and incl using a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the PA maintain document exercises, and eme PACE's emergency '*[For LTC Facilities (2) The [LTC facility test the emergency including unannoun emergency procedu ICF/IID] must do the	inity-based exercise is not t an annual individual, onal exercise; or periences an actual natural or ncy that requires activation of h, the PACE is exempt from 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 hay include, but is not limited to cale exercise that is or individual, a facility based or er drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. CE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed. at §483.73(d):]] must conduct exercises to plan at least twice per year, iced staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that	EC	039			

		AND HUMAN SERVICES				FORM	05/08/2024 APPROVED 0938-0391
STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		34G097	B. WING			05/0	07/2024
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SOUTHE	ERN AVENUE HOME				001 SOUTHERN AVENUE AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	 (A) When a communication of the image of the ima	unity-based exercise is not t an annual individual, onal exercise. ty] facility experiences an an-made emergency that of the emergency plan, the upt from engaging its next e community-based or ased functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based for er drill; or rcise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. C facility] facility's response to nentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. 483.475(d)]: F/IID must conduct exercises not plan at least twice per year. o the following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual,	ΕO	39			

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		AND HUMAN SERVICES				FORM	05/08/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G097	B. WING	i		05/	07/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
SOUTHE	RN AVENUE HOME				2001 SOUTHERN AVENUE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	the emergency plan engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exerce a facilitator and incl using a narrated, cli scenario, and a set directed messages, designed to challen (iii) Analyze the ICF maintain documents exercises, and emer ICF/IID's emergenc '[For HHAs at §484 (d)(2) Testing. The to test the emergen least annually. The (i) Participate in a fu community-based; of (A) When a cor accessible, conduct facility-based function or. (B) If the HHA or man-made emer of the emergency p engaging in its next community-based of	a, the ICF/IID is exempt from t required full-scale or individual, facility-based following the onset of the itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based or r drill; or cise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan. F/IID's response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. I.102] HHA must conduct exercises hey plan at HHA must do the following: ull-scale exercise that is or mmunity-based exercise is not t an annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation lan, the HHA is exempt from	EC	039			

	FORM	05/08/2024 APPROVED 0938-0391						
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G097	B. WING			05/07/2024		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SOUTHERN AVENUE HOME					001 SOUTHERN AVENUE AYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			FIX (EACH CORRECTIVE ACTION SHOU		D BE COMPLETION		
E 039	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		E 039					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G097 B. WING 05/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2001 SOUTHERN AVENUE SOUTHERN AVENUE HOME FAYETTEVILLE, NC 28301 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 039 Continued From page 13 E 039 (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure facility community-based, mock disaster drill or tabletop exercises to test their emergency Preparedness (EP) plan were conducted. This potentially affected audited clients (#1, #2, #3, #4, #5 and #6). This finding is: Review on 5/6/24 of the facility's EP plan did not included a full-scale community-based or tabletop exercise. Interview on 5/6/24, the home manager confirmed there was no community-based or tabletop exercise completed. Interview on 5/7/24, the gualified intellectual disabilities professional revealed there was no documentation to confirm a community-based or

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
34G097			B. WING			05/07/2024		
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE			
SOUTHERN AVENUE HOME					001 SOUTHERN AVENUE AYETTEVILLE, NC 28301			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 039	Continued From page 14		E 0)39				
W 125	tabletop exercise was completed. PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)			125				

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