		AND HUMAN SERVICES			(		APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G269	B. WING			06/	04/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	II GROUP HOME				22 HICKORY AVE SANFORD, NC 27330		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	EP Training Program CFR(s): 483.475(d) §403.748(d)(1), §44 §441.184(d)(1), §46 §483.73(d)(1), §48 §485.68(d)(1), §48 §485.727(d)(1), §48 §491.12(d)(1). *[For RNCHIs at §4 Hospitals at §482.1 at §484.102, REHs under §485.727, OF RHC/FQHCs at §48 (1) Training program the following: (i) Initial training in expolicies and proceed staff, individuals pro- arrangement, and we expected roles. (ii) Provide emergent least every 2 years. (iii) Maintain docump preparedness training (iv) Demonstrate st procedures. (v) If the emergency procedures are sign must conduct training procedures. *[For Hospices at § hospice must do all (i) Initial training in expolicies and proceed hospice employees	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 oviding services under volunteers, consistent with their ncy preparedness training at nentation of all emergency ing. aff knowledge of emergency y preparedness policies and hificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The of the following: emergency preparedness lures to all new and existing , and individuals providing	E 0	37		PRIATE	DATE
	policies and proced hospice employees	lures to all new and existing					

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 06/04/2024

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.

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		34G269	B. WING _		06	/04/2024	
NAME OF	PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZIP CODE	00	04/2024	
HICKOR	Y II GROUP HOME			322 HICKORY AVE SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
E 037	<ul> <li>(ii) Demonstrate staprocedures.</li> <li>(iii) Provide emergeleast every 2 years.</li> <li>(iv) Periodically reviemergency prepare employees (includir special emphasis pprocedures necess others.</li> <li>(v) Maintain docum preparedness trainit (vi) If the emergency procedures are sign must conduct training procedures.</li> <li>*[For PRTFs at §44 program. The PRTF (i) Initial training in epolicies and proced staff, individuals proarrangement, and vexpected roles.</li> <li>(ii) After initial training in procedures.</li> <li>(vi) Maintain docum preparedness trainit (vi) If the emergency procedures are sign must conduct training in epolicies and proced staff, individuals proarrangement, and vexpected roles.</li> <li>(ii) After initial training procedures trainit (vi) If the emergency procedures are sign must conduct training procedures are sign must conduct training procedures are sign must conduct training procedures.</li> <li>*[For PACE at §460 organization must conduct training procedures.</li> </ul>	aff knowledge of emergency ency preparedness training at ew 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 ng. by preparedness policies and inficantly updated, the hospice ing on the updated policies and 1.184(d):] (1) Training must do all of the following: emergency preparedness ures to all new and existing poiding services under rolunteers, consistent with their ing, provide emergency ing every 2 years. aff knowledge of emergency mentation of all emergency	Ε 03	37			

		AND HUMAN SERVICES				FORM	06/04/2024 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE	E SURVEY PLETED			
		34G269	B. WING			06/(	04/2024			
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
HICKOR	Y II GROUP HOME		322 HICKORY AVE SANFORD, NC 27330							
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E 037	policies and proced staff, individuals pro- arrangement, contra- volunteers, consiste (ii) Provide emerger least every 2 years. (iii) Demonstrate sta procedures, includin what to do, where to case of an emerger (iv) Maintain docum (v) If the emergence procedures are sign must conduct trainin procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in e policies and proced staff, individuals pro- arrangement, and v expected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate sta procedures.	lures to all new and existing poiding on-site services under actors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergency ing informing participants of o go, and whom to contact in ncy. The tation of all training. By preparedness policies and hificantly updated, the PACE ing 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 incy preparedness training at tentation of all emergency ing. aff knowledge of emergency as and procedures to all new ining in emergency ies and procedures to all new individuals providing services , and volunteers, consistent	EC	037						

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		AND HUMAN SERVICES				I	FORMA	06/04/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION		X3) DATE	E SURVEY PLETED
		34G269	B. WING	;			06/0	04/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
HICKORY	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD B		(X5) COMPLETION DATE
E 037	<ul> <li>(ii) Provide emergelleast every 2 years.</li> <li>(iii) Maintain docum</li> <li>(iv) Demonstrate st procedures. All new and assigned specithe CORF's emerge their first workday.</li> <li>include instruction i alarm systems and equipment.</li> <li>(v) If the emergen procedures are sign must conduct training procedures.</li> <li>*[For CAHs at §485 The CAH must do a (i) Initial training in epolicies and proced reporting and exting and where necessal personnel, and gue cooperation with firatuthorities, to all nei individuals providing and volunteers, corroles.</li> <li>(ii) Provide emerger least every 2 years.</li> <li>(iii) Maintain docum</li> <li>(iv) Demonstrate st procedures.</li> </ul>	ncy preparedness training at nentation of the training. aff knowledge of emergency w 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 ng 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	E	037				

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 34G269 B. WING 06/04/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 322 HICKORY AVE **HICKORY II GROUP HOME** SANFORD, NC 27330 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 037 Continued From page 4 E 037 \*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on interview and review of the facility's emergency preparedness (EP) plan, the facility failed to develop an EP training and testing program for staff. The finding is: Review on 6/3/24 of the EP plan revealed no record of training for direct care staff on the facility EP plan. Interview on 6/4/24 with staff B revealed she doesn't recall a training on the EP plan. Interview on 6/4/24 with the program manager revealed that a training was completed but she was unable to produce documentation of completion. E 039 EP Testing Requirements E 039 CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). \*[For ASCs at §416.54, CORFs at §485.68, REHs

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Facility ID: 931971

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/04/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G269	B. WING			06/0	04/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				22 HICKORY AVE ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	<ul> <li>§485.727, CMHCs</li> <li>§491.12, and ESRE</li> <li>(2) Testing. The [fact to test the emergen must do all of the foce of the emergen must do all of the foce of the emergen must do all of the foce of the emergen must do all of the foce of the emergen must do all of the foce of the emergen of the</li></ul>	"Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]: cility] must conduct exercises cy plan annually. The [facility] ollowing: ull-scale exercise that is every 2 years; or unity-based exercise is not t a facility-based functional ars; or y] experiences an actual le emergency that requires ergency plan, the [facility] is ing in its next required or individual, facility-based following the onset of the tional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: ale exercise that is or individual, facility-based or	E	039			

Facility ID: 931971

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		AND HUMAN SERVICES				FORM	06/04/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G269	B. WING			06/0	04/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330		
(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	[facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based e (A) When a commu- accessible, conduct functional exercise (B) If the hospice ex- man-made emerge- the emergency plan engaging in its next community-based function onset of the emerged (ii) Conduct an add opposite the year the exercise under para- is conducted, that in to the following: (A) A second full-sec community-based of exercise; or (B) A mock disasted (C) A tabletop exer- a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (3) Testing for hosp care directly. The hosp	cy plan, as needed. 18.113(d):] bices 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 a required full scale exercise or individual onal exercise following the ency event. ditional exercise every 2 years, he 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			

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 34G269 B. WING 06/04/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 322 HICKORY AVE **HICKORY II GROUP HOME** SANFORD, NC 27330 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 7 E 039 year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise: or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated. clinically-relevant emergency scenario. and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. \*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G269 B. WING 06/04/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 322 HICKORY AVE **HICKORY II GROUP HOME** SANFORD, NC 27330 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 8 E 039 (A) When a community-based exercise is not accessible, conduct an annual individual. facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise: or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared guestions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. \*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES				FORM	06/04/2024 APPROVED 0938-0391
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HICKOR	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330		
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E 039	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 y exercise under para is conducted that m the following: (A) A second full-sec 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 emer PACE's emergency '*[For LTC Facilities (2) The [LTC facility test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu	onal exercise; or periences an actual natural or ncy that requires activation of n, 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):] of 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		039			

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		AND HUMAN SERVICES				FORM	06/04/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	l` í		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		34G269	B. WING	}		06/(	04/2024
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	facility-based function (B) If the [LTC facility actual natural or marequires activation of LTC facility is exem- required a full-scale individual, facility-based following the onset of (ii) Conduct an add may include, but is in (A) A second full-so community-based of functional exercise; (B) A mock disaste (C) A tabletop exer- a facilitator includes narrated, clinically-rr and a set of problem messages, or prepa- challenge an emerge (iii) Analyze the [LT and maintain docum exercises, and eme [LTC facility] facility/ *[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergen The ICF/IID must do (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based function (B) If the ICF/IID ex- man-made emergen	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. TC facility] facility's response to mentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises hoy 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, onal exercise; or. cperiences an actual natural or ncy that requires activation of h, the ICF/IID is exempt from	E	039	9		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G269 B. WING 06/04/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 322 HICKORY AVE **HICKORY II GROUP HOME** SANFORD, NC 27330 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 11 E 039 community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. \*[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years,

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		AND HUMAN SERVICES				FORM	06/04/2024 APPROVED 0938-0391
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		34G269	B. WING	i		06/	04/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HICKOR	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	opposite the year th exercise under para is conducted, tha limited to the followin (A) A second functional exercise; (B) A mock disa (C) A tabletop end led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HHA documentation of a emergency events, emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The of to test the emergen following: (i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. If the OPO eximan-made emergen the emergency plan engaging in its next following the onset (ii) Analyze the OPO	he full-scale or functional agraph (d)(2)(i) of this section it may include, but is not ing: ill-scale exercise that is or an individual, facility-based or aster drill; or exercise or workshop that is ind includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared t o challenge an emergency A's response to and maintain II drills, tabletop exercises, and and revise the HHA's is needed.	EC	039			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G269 B. WING 06/04/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 322 HICKORY AVE **HICKORY II GROUP HOME** SANFORD, NC 27330 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 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 followina: (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 interview, the facility failed to ensure facility community-based, mock disaster drill or tabletop exercises to test their emergency Preparedness (EP) plan were conducted. The finding is: Review on 6/3/24 of the facility's EP plan did not include a full-scale community-based or tabletop exercise. Interview on 6/4/24, the Program Manager revealed there was no documentation to confirm a community-based or tabletop exercise was completed. W 125 PROTECTION OF CLIENTS RIGHTS W 125 CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		34G269	B. WING		06/(	04/2024
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME			322 HICKORY AVE SANFORD, NC 27330		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 125 W 249	individual clients to of the facility, and a including the right to to due process. This STANDARD is Based on observat failed to ensure clie regarding the use of affected 1 of 4 audi During observations 4:40pm, client #3 w wheelchair with an him visible to every Interview on 6/4/24 disabilities profession incontinence pads a wheelchair from be with the QIDP confi pads in the manner dignity issue. PROGRAM IMPLE CFR(s): 483.440(d) As soon as the inter formulated a client each client must re- treatment program interventions and so and frequency to su objectives identified plan.	exercise their rights as clients as citizens of the United States, o file complaints, and the right s not met as evidenced by: tions and interviews, the facility ents' had the right to dignity of incontinence padding. This it clients (#3). The finding is: s in the home on 6/3/24 at vas observed to be sitting in a incontinence pad underneath one in the home. with the qualified intellectual onal (QIDP) revealed the are used to protect client #3's ing soiled. Further interview irmed use of the incontinence r described is a respect and MENTATION	W 12			

		AND HUMAN SERVICES				FORM	06/04/2024 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G269	B. WING			06/0	04/2024
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				22 HICKORY AVE ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	interviews, the facil clients (#5) receiver consisting of needer identified in the Indi the area of program is: During observations through 6/4/24, clie outside smoking for time, was client #5 any activity or intera was observed going #5 approximately 2 survey. Record review on 6 4/24/24 revealed for achieving personal management, medi taking out the trash client #5 observed of activity or completin Interview on 6/4/24 client #5 was transf The QIDP confirme attend the day prog revealed he should confirmed that clien more meaningful at the day. PROGRAM MONIT CFR(s): 483.440(f) The committee sho monitor individual p	ity failed to ensure 1 of 4 audit d active treatment program of interventions and services ividual Program Plan (IPP) in in implementation. The finding is in the home on 6/3/24 nt #5 was observed to be r majority of the survey. At no observed to be participating in acting with peers or staff. Staff g outside to engage with client or 3 times throughout the i/3/24 of client #5's IPP dated rmal training objectives for goals, oral hygiene, money ication administration and . However, at no time was engaging in a structured ing training objectives. with the QIDP revealed that ferred to the facilty on 4/29/24. I that client #5 does not ram as of yet. However, she be starting soon. The QIDP it #5 should be involved in ind structured activities during TORING & CHANGE	W 2				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G269 B. WING 06/04/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 322 HICKORY AVE **HICKORY II GROUP HOME** SANFORD, NC 27330 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) W 262 Continued From page 16 W 262 in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 1 of 4 audit clients (#6) was reviewed and monitored by the human rights committee (HRC). The finding is: Review on 6/3/24 of client #6's Behavior Support Plan (BSP) dated 5/14/24 revealed target behaviors consisting of property destruction, physical aggression, noncompliance, disrobing and elopement. Further review on 6/4/24 of clients #6's BSP revealed no written consent by the HRC. Interview on 6/4/24 with the program manager confirmed that client #6 did not have written consent by HRC. The program manager revealed that written consent should be obtained by HRC. W 263 **PROGRAM MONITORING & CHANGE** W 263 CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 4 audit clients (#6). The finding is: Record review on 6/3/24 of client #6's behavior support plan (BSP) dated 5/14/24 revealed target behaviors of property destruction, physical

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**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G269 B. WING 06/04/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 322 HICKORY AVE **HICKORY II GROUP HOME** SANFORD, NC 27330 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 DEFICIENCY) W 263 Continued From page 17 W 263 aggression, noncompliance, disrobing, and elopement. The medications were listed on the BSP with no signed informed consent of a legal quardian. Record review on 6/4/24 of client #6 physician's orders signed 2/14/24 revealed orders for Aripiprazole, Benztropine, Clonidine, Lybalvi and Melatonin. Interview on 6/4/24 with the program manager confirmed there was no written informed consent for client #6's medications. W 312 DRUG USAGE W 312 CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure drugs used to control inappropriate behaviors for 1 of 4 audit clients (#6) were only used as an integral part of the clients behavior support (BSP). The finding is: Review on 6/3/24 of client #6's individual program plan (IPP) dated 8/23/23 revealed his target behaviors of property destruction, physical aggression, noncompliance, disrobing and elopement. Further review of client #6's physician orders dated 2/14/24 he receives aripiprazole for agitation, benztropine for aims, clonidine for impulsivity, lybalvi for psychiatric management

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and melatonin for insomnia.

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G269	B. WING			06/0	04/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HICKORY	II GROUP HOME				22 HICKORY AVE ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 312	Continued From pa	ge 18	W 3	312			
W 340	confirmed client #6 in place at this time	ES	W 3	340			
	other members of t appropriate protect measures that inclu- training clients and health and hygiene This STANDARD is Based on observat interviews, the facili- staff were sufficient administration and	ust include implementing with he interdisciplinary team, ive and preventive health ide, but are not limited to staff as needed in appropriate methods. s not met as evidenced by: tions, record review and ity failed to ensure nursing ly trained in medication health and hygiene. This t clients (#1 and #6). The					
	staff B assisted clie medications from th #6 consumed the m	e home on 6/4/24 at 6:36am, nt #6 with punching his ne bubble packs. After client nedication, staff B scanned the e Electronic Medication					
	medication adminis assisted client #1 w from the bubble page	is in the home on 6/4/24 of the tration at 6:55am, staff B rith punching his medications cks. After client #1 consumed ff B scanned the medications					
		with staff B revealed that she acceptable to scan the					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/04/2024 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G269	B. WING			06/0	04/2024	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
HICKORY	( II GROUP HOME				22 HICKORY AVE ANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 340	pass. Interview on 6/4/24 that staff should sca administration in an nurse confirmed that the medication befor ingest them. B. Observations in a fingernails were obs appropriate length. Review on 6/4/24 of home/life assessme -to maintain approp physical assistance C. Observations in fingernails were obs appropriate length. Review on 6/4/24 of home/life assessme maintain appropriate physical assistance Interview on 6/4/24 should be complete shower. Nail care s clients program book	me during the medication wit the facility nurse revealed an the medication prior to reffort to prevent errors. The at staff B should have scanned ore allowing the clients to the home on 6/3-4/24 client #1 served not maintained at an of client #1's community ent dated 12/26/23 revealed riate length of fingernails need the home on 6/3-4/24 client #1 served not maintained at an of client #6's community ent dated 8/23/23 revealed -to e length of fingernails need with staff B revealed nail care ed on second shift after clients hould be documented in the oks. the qualified intellectual onal (QIDP) revealed she hat clients nails needed to be	W 3	340				
W 368	cut on 6/3/24 after o DRUG ADMINISTR		W 3	868				

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		AND HUMAN SERVICES				FORM	: 06/04/2024 APPROVED : 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G269	B. WING	·		06/04/2024		
NAME OF F	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
HICKORY II GROUP HOME			322 HICKORY AVE SANFORD, NC 27330					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 368	Continued From page 20 CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 of 4 audit clients (#1). The finding is:		w :	368				
	6/4/24 at 6:55am, s	servations in the home on taff B was observed prazole to client #1.						
	disabilities professi	with the qualified intellectual onal revealed that client #1 oreakfast prior to medication						
	orders signed 2/14/ "Omeprazole Caps	24 of client #1's physician's 24 revealed an order for ule 40mg. Take 1 capsule ninutes before breakfast".						
W 460	confirmed client #1 Omeprazole before	TION SERVICES	W 4	460				
	Each client must re well-balanced diet i specially-prescribed	ncluding modified and						
	This STANDARD is	s not met as evidenced by:						

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DEPAR <sup>-</sup> CENTEI	RINTED: 06/04/2024 FORM APPROVED MB NO. 0938-0391							
STATEMENT OF DEFICIENCIES (X1) P		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G269	B. WING	;		06/04/2024		
NAME OF	PROVIDER OR SUPPLIER		L		STREET ADDRESS, CITY, STATE, ZIP CODE			
HICKOR	Y II GROUP HOME		322 HICKORY AVE SANFORD, NC 27330					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 460	Based on observation interview, the facilitic clients (#1) receiver as indicated. The fill Observations in the approximately 4:30 kitchen table for dirichicken with a grav was a shredded corrice. Record review of clidated 12/7/23 reveation coarsely chopped review on 6/4/24 revealed the chicker was a shredded corrice.	tions, record review and y failed to ensure 1 of 4 audit d the specially prescribed diet		460				

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