| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 004 | Develop EP Plan, Review and Update Annually<br>CFR(s): 483.475(a)<br><br>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).<br><br>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:<br><br>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:<br><br>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.<br><br>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. | E 004 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 004 | Continued From page 1<br>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.<br><br>.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to review and update their emergency preparedness (EP) plan at least every 2 years. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:<br><br>Review on 6/5/24 of the facility's EP revealed a completion date of 5/15/22. Further review revealed no evidence the plan had been updated in the past 2 years.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was unable to provide any additional information that the EP had been updated. | E 004 | | |
| E 006 | Plan Based on All Hazards Risk Assessment<br>CFR(s): 483.475(a)(1)-(2)<br><br>§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan | E 006 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 006 | Continued From page 2<br>that must be reviewed, and updated at least every 2 years. The plan must do the following:]<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*<br><br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.<br>(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.<br><br>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>*[For ICF/IIDs at §483.475(a):] Emergency Plan. | E 006 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 006 | Continued From page 3<br>The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to develop an all-hazards risk assessment that was facility and community based for their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:<br><br>Review on 6/5/24 of the facility's EP dated 5/15/22 revealed there we no details for a risk assessment.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was unable to provide any additional information regarding the facility's risk assessment. | E 006 | | |
| E 018 | Procedures for Tracking of Staff and Patients<br>CFR(s): 483.475(b)(2)<br><br>§403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness | E 018 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 018 | Continued From page 4<br>policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.<br><br>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.<br><br>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.<br>(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. | E 018 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 018 | Continued From page 5<br>(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.<br><br>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.<br><br>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.<br><br>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to develop a system to track clients and staff in the event, their emergency preparedness (EP) plan had to be implemented. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:<br><br>Review on 6/5/24 of the facility's EP plan dated 5/15/22 revealed there we no details for the clients residing in the home and current staff. | E 018 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 018 | Continued From page 6<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was unable to provide any additional information regarding tracking clients and staff during an emergency. | E 018 | | |
| E 022 | Policies/Procedures for Sheltering in Place<br>CFR(s): 483.475(b)(4)<br><br>§403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3).<br><br>(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>[(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].<br><br>*[For Inpatient Hospices at §418.113(b):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br>(i) A means to shelter in place for patients, | E 022 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 022 | Continued From page 7<br>hospice employees who remain in the hospice. This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to develop a shelter in place policy for their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:<br><br>Review on 6/5/24 of the facility's EP plan dated 5/15/22 revealed there we no details to identify a shelter in place policy and procedures.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was unable to provide any additional information regarding a shelter in place policy. | E 022 | | |
| E 023 | Policies/Procedures for Medical Documentation<br>CFR(s): 483.475(b)(5)<br><br>§403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.542(b)(5), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] | E 023 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 023 | Continued From page 8<br><br>[(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.<br><br>*[For RNHCIs at §403.748(b) and REHs at §485.542(b):] Policies and procedures. (5) A system of care documentation that does the following:<br>(i) Preserves patient information.<br>(ii) Protects confidentiality of patient information.<br>(iii) Secures and maintains the availability of records.<br><br>*[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to develop an emergency medical records storage system, as part of their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:<br><br>Review on 6/5/24 of the facility's EP plan dated 5/15/22 revealed there we no details that listed the clients' medical diagnoses, physician's orders and medications to be dispensed during an emergency.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was unable to provide any additional information regarding the facility's emergency medical | E 023 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 023 | Continued From page 9<br>storage system. | E 023 | | |
| E 030 | Names and Contact Information<br>CFR(s): 483.475(c)(1)<br><br>§403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).<br><br>[(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:]<br><br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians<br>(iv) Other [facilities].<br>(v) Volunteers.<br><br>*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians<br>(iv) Other [hospitals and CAHs].<br>(v) Volunteers. | E 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 030 | Continued From page 10<br>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Next of kin, guardian, or custodian.<br>(iv) Other RNHCIs.<br>(v) Volunteers.<br><br>*[For ASCs at §416.45(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Volunteers.<br><br>*[For Hospices at §418.113(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Hospice employees.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Other hospices.<br><br>*[For HHAs at §484.102(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Volunteers. | E 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 030 | Continued From page 11<br><br>*[For OPOs at §486.360(c):] The communication plan must include all of the following:<br>(2) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Volunteers.<br>(iv) Other OPOs.<br>(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to develop a system to identify clients and guardians in their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:<br><br>Review on 6/5/24 of the facility's EP plan dated 5/15/22 revealed there we no details that listed the names of all clients and the contact information of their guardians. Further, the facility had admitted one new client (#3) since their policy was written.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was unable to provide any additional information regarding contact information for clients and guardians for their EP plan. | E 030 | | |
| E 039 | EP Testing Requirements<br>CFR(s): 483.475(d)(2)<br><br>§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), | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 039 | Continued From page 12<br>§485.920(d)(2), §491.12(d)(2), §494.62(d)(2).<br><br>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(B) If the [facility] 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 community-based or individual, facility-based functional exercise following the onset of the actual event.<br>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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. | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 039 | Continued From page 13<br>(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.<br><br>*[For Hospices at 418.113(d):]<br>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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. | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 039 | Continued From page 14<br>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 039 | Continued From page 15 | E 039 | | |

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 [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 questions 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 039 | Continued From page 16 | E 039 | | |

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 PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE 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 opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted 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 questions designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 039 | Continued From page 17<br>is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator 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.<br>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(B) If the ICF/IID experiences an actual natural or | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 039 | Continued From page 18 | E 039 | | |

man-made emergency that requires activation of the emergency plan, the ICF/IID 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 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 039 | Continued From page 19 | E 039 | | |

functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:
(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise 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. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 039 | Continued From page 20<br>following the onset of the emergency event.<br>(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.<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(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.<br>(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.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to conduct a full-scale exercise to test their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is:<br><br>Review on 6/5/24 of the facility's EP dated 5/15/22 revealed the facility conducted tabletop and mock drill exercises for their EP plan. There was no evidence of a full-scale exercise.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was not aware a full-scale exercise was required. | E 039 | | |
| W 104 | GOVERNING BODY<br>CFR(s): 483.410(a)(1) | W 104 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 104 | Continued From page 21<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br>This STANDARD is not met as evidenced by:<br>Based on observations and interview, the facility failed to furnish dining room chairs in good repair. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6).<br>The finding is:<br><br>Observations in the home during 6/4/24 and 6/5/24 revealed 6-8 dark teal stackable fabric covered dining room chairs that clients used to sit on during all meals. The chairs were heavily stained; and some had torn fabric that exposed foam cushion or shredded strings and fabrics, hanging off the chair.<br><br>Interview on 6/5/24 with the home manager revealed there were plans made three weeks ago to switch out the chairs with some of their other group homes.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was not aware of any work order to replace the chairs. The QIDP revealed the chairs had been recently donated from the church of client #6's guardian. | W 104 | | |
| W 148 | COMMUNICATION WITH CLIENTS, PARENTS &<br>CFR(s): 483.420(c)(6)<br><br>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.<br>This STANDARD is not met as evidenced by: | W 148 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 148 | Continued From page 22<br>Based on record review and interview, the facility failed to notify 1 of 3 audit clients (#1) guardian of a significant change in condition. The finding is:<br><br>Review on 6/4/24 of client #1's nursing notes revealed on 10/28/23 a discoloration of unusual texture was first noticed on his right buttocks that was determined to be an abscess. On 11/28/23, new physician's orders revealed to apply a protective cream to buttocks twice a day. On 6/5/24, client #1 returned from a doctor's appointment with a consultant report that diagnosed him as having a stage II pressure ulcer on right buttocks. There was no documentation in the chart that his guardian had been notified of his skin breakdown.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed on 6/1/24, he received a call from staff who was concerned about skin breakdown on client #1's right buttocks and sent a photograph to the QIDP. The QIDP revealed the buttock appeared to have a hole and he was worried that client #1 developed a pressure ulcer and made immediate arrangements to get an appointment for client #1 to see the doctor soon. The QIDP acknowledged that he did not think to contact the nurse or the guardian to notify of client #1's skin condition. | W 148 | | |
| W 153 | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(2)<br><br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. | W 153 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 153 | Continued From page 23<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to notify law enforcement for allegation for physical abuse for 1 of 3 audit clients (#3). The finding is:<br><br>Review on 6/5/24 of an abuse investigation from 4/29/24 revealed at 4:30pm, client #3 had a behavior in the front yard after getting off the van, falling to the ground and would not get up when prompted by Staff F. A camera installed outside the home, recorded Staff F dragging client #3, 10-15' up the wooden wheelchair ramp leading to the side door of the home, while client #3 was on his backside. Client #3's pants came down while dragged and caused abrasions to his buttocks. The incident was not reported by another staff until 4/30/24. An investigation was launched by the qualified intellectual disabilities professional (QIDP) who interviewed staff, in-serviced staff on their abuse policy, contacted Department of Social Services (DSS), but did not contact law enforcement. Staff F was terminated as an employee after the investigation concluded.<br><br>Interview on 6/6/24 with the QIDP revealed he did not know he was required to contact law enforcement if he contacted DSS. | W 153 | | |
| W 159 | QIDP<br>CFR(s): 483.430(a)<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who-<br>This STANDARD is not met as evidenced by:<br>Based on record reviews and interview, the facility failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) completed the | W 159 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 159 | Continued From page 24 | W 159 | | |

initial Individual Program Plan (IPP) meeting, revised goals that had been met, coordinated annual nutritional assessments, completed comprehensive functional assessments, monitored data collection for all identified programs. This affected 3 of 3 audit clients (#1, #2 and #3). The findings are:

A. Record review on 6/5/24 of client #3's record revealed he was admitted to the home on 8/23/23. Further review revealed client #3 had a partially completed IPP that was dated 5/15/24.

During an interview on 6/5/24 , the QIDP revealed he did not follow up on scheduling assessments with clinicians for client #3's initial IPP.

B. Review on 6/4/24 of client #1's record revealed he met his goal to walk up stairs independently.

During an interview on 6/5/24, the QIDP revealed he had not realized client #1 had already achieved his walking goal when he revised it on 2/14/24 for continuation.

C. Record review on 6/5/24 of client #1's goals: to turn off a light independently with 100% accuracy, unhook his pants independently with 100% accuracy, walk up stairs independently with 100% accuracy, and to use his silverware and napkin at mealtimes appropriately for 80% revealed each goal only received one day of documented training this year.

Record review on 6/5/24 of client #2's goals: to put placemats on table independently, learn to put folded clothes in drawer independently, wash hands with 100% accuracy and to use silverware

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 159 | Continued From page 25<br>and napkin at mealtimes with 80% accuracy revealed each goal only received one day of documented training this year.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional revealed he did not have any additional documents for review.<br><br>D. Record review on 6/5/24 of the audited clients (#1, #2 and #3) Adaptive Behavioral Instrument (ABI) assessments revealed there was no annual review. Client #1's ABI was completed on 5/6/22; client #2's ABI was completed on 5/22/22 and client #3's, who was admitted on 8/23/23, ABI was never done.<br><br>Interview on 6/5/24, with the qualified intellectual disabilities professional (QIDP) revealed the ABI's should be updated annually. The QIDP acknowledged the ABI's have not been done for the current review period. | W 159 | | |
| W 210 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)<br><br>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure initial assessments were done for 1 of 3 audit clients (#3) that was newly admitted to the home. The finding is:<br><br>Record review on 6/5/24 of client #3 was admitted to the facility on 8/23/23 and his individual program plan (IPP) dated 5/15/24 only | W 210 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 210 | Continued From page 26<br>had the qualified intellectual disabilities professional (QIDP) and guardian participating. The current IPP did not have assessments from nutrition, speech, auditory, physical or occupational therapy clinicians, despite a referral from the doctor in August 2023 to get them scheduled.<br><br>Interview on 6/5/24 with the QIDP revealed he was using the IPP dated 7/20/23 from client #3's former group home. The QIDP revealed the physician examined client #3 and made recommendations to refer him to contract clinicians for his assessments. The QIDP acknowledged it was his responsibility to schedule these appointments and it was not done. | W 210 | | |
| W 217 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)(v)<br><br>The comprehensive functional assessment must include nutritional status.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 3 of 3 audit clients (#1, #2 and #3) received annual nutritional evaluations. The findings are:<br><br>A. Record review on 6/4/24 of client #1's nutritional review revealed the last assessment was done on 4/19/23.<br><br>B. Record review on 6/4/24 of client #2's nutritional review revealed the last assessment was done on 4/19/23.<br><br>C. Record review on 6/5/24 of client #3's nutritional review revealed an absence of a | W 217 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 217 | Continued From page 27<br>nutritional assessment since his admission to the home on 8/21/23.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed they have not had a registered dietician since a year ago. The QIDP revealed they were using the dietary orders that client #3 was on from his last group home. | W 217 | | |
| W 252 | PROGRAM DOCUMENTATION<br>CFR(s): 483.440(e)(1)<br><br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 2 of 3 audit clients (#1 and #2) data for their goals were documented. The findings are:<br><br>A. Record review on 6/5/24 of client #1's goals:<br>1. To turn off a light independently with 100% accuracy had one data collection on 5/4/24.<br>2. To unhook his pants independently with 100% accuracy had one data collection on 6/2/24.<br>3. To walk up stairs indepently with 100% accuracy had one data collected on 5/3/24.<br>4. To use his silverware and napkin at mealtimes appropriately for 80% had one data collection on 5/3/24.<br>There was one blank behavior data sheet from November, 2023 and no other months. | W 252 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 252 | Continued From page 28<br>B. Record review on 6/5/24 of client #2's goals:<br>1. To put placemats on table independently had one data collection on 5/3/24.<br>2. To learn to put folded clothes in drawer independently had one data collection on 5/3/24.<br>3. To wash hands with 100% accuracy did not have data recorded.<br>4. To use silverware and napkin at mealtimes with 80% accuracy had one data collection on 5/3/24.<br>There was one behavior data sheet from June, 2023 with multiple entries.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional revealed he did not have any additional documents for review. | W 252 | | |
| W 255 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(1)(i)<br><br>The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to ensure a review at least by the qualified intellectual intellectual disability professional (QIDP) in which the client has successfully completed an objective was not continued after it was completed. This affected 1 of 3 audit clients (#1). The finding is:<br><br>During observations in the home on 6/4/24 at 6:10pm, client #1 walked independently to the kitchen, carrying his dinner dishes, intentionally skipped the first step and landed with a steady gait on the second step. An additional observation | W 255 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 255 | Continued From page 29<br>on 6/5/24 at 7:40am, client #1 walked independently to the kitchen, carrying his breakfast dishes, intentionally skipped the first step and landed with a steady gait on the second step.<br><br>Review on 6/5/24 of his individual program plan (IPP) last revised on 2/16/24, revealed a continuation of the goal for client #1 to walk up the stairs independently.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP), he acknowledged he would consider discontinuing the goal if the objective had been met. | W 255 | | |
| W 259 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(2)<br><br>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure the comprehensive functional assessments were updated as needed. This affected 3 of 3 audit clients (#1, #2 and #3). The findings are:<br><br>A. Record review on 6/5/24 of client #1's Adaptive Behavioral Instrument (ABI) revealed it was reviewed on 5/6/22 and did not have updates.<br><br>B. Record review on 5/22/24 of client #2's ABI revealed it was reviewed on 5/22/22 and did not have updates.<br><br>C. Record review on 4/22/24 of client #4's chart, | W 259 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 259 | Continued From page 30<br>revealed the ABI was not completed after his admission on 8/23/23.<br><br>Interview on 6/5/24, with the qualified intellectual disabilities professional (QIDP) revealed the ABI's should be updated annually. The QIDP acknowledged the ABI's have not been done for the current review period. | W 259 | | |
| W 262 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)(i)<br><br>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure techniques used to manage behaviors were reviewed and monitored by the Human Rights Committee (HRC) for 3 of 3 audit clients (#1, #2 and #3) on behavior support plans (BSP). The findings are:<br><br>A. Record review on 6/4/24 of client #1's BSP from 5/5/23 revealed a goal to decrease episodes of inappropriate behaviors to 15 per month for during the review period. Inappropriate targeted behaviors were defined as non-compliance, aggression, self-injurious behaviors, public masturbation and taking food that does not belong to him. Medications used to treat his behaviors were Fluvoxamine Mal and Quetiapine Fumarate. There was no record that client #1's BSP had been reviewed and approved by the facility's HRC.<br><br>B. Record review on 6/4/24 of client #2's BSP | W 262 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 262 | Continued From page 31<br>from 6/1/23 revealed a goal to decrease episodes of inappropriate behavior to 15 or fewer per month. Inappropriate behaviors were defined as hitting, kicking, attacking staff when redirected, self-wetting, PICA, sexually inappropriate behaviors, loud vocalizations, taking food that did not belong to her and public masturbation. Medications to treat her behaviors included Citalopram, Clonidine, Fanapt, Topiramate, Hydroxyzine, Trazadone, Celexa, Zyprexa and Diazepam prn. There was no record that client #2's BSP had been reviewed and approved by the facility's HRC.<br><br>C. Record review on 6/5/24 of client #3's BSP revealed the facility had incorporated behavioral guidelines from his previous placement. Client #3's target behaviors were defined as threatening self-harm, verbal aggression, self-injurious behaviors, property destruction, noncompliance, physical aggression, attempted AWOL and making untrue statements. Medications used to treat his behaviors were Risperidone ER bi-monthly injections, Clonazepam, Lithium Carb and Gabapentin. There was no record that client #3's BSP had been reviewed and approved by the facility's HRC.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed the facility did not have a Human Rights Committee. | W 262 | | |
| W 263 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)(ii)<br><br>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. | W 263 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 263 | Continued From page 32<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure a restrictive Behavior Support Plan (BSP) used to administer behavioral medications and behavior techniques, had the written consent of the guardian. This affected 1 of 3 audit clients (#1). The finding is:<br><br>Record review on 6/4/24 of client #1's BSP from 5/5/23 revealed a goal to decrease episodes of inappropriate behaviors to 15 per month for during the review period. Inappropriate targeted behaviors were defined as non-compliance, aggression, self-injurious behaviors, public masturbation and taking food that does not belong to him. Medications used to treat his behaviors were Fluvoxamine Mal and Quetiapine Fumarate. The last consent to authorize the BSP was signed by the guardian on 8/2/22.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed the consents for the BSP's should be updated annually. | W 263 | | |
| W 289 | MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br>CFR(s): 483.450(b)(4)<br><br>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure the use of physical interventions to manage 1 of 3 audit clients (#3) inappropriate behaviors were incorporated into | W 289 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 289 | Continued From page 33 | W 289 | | |

the client's individual program plan (IPP). The finding is:

During observations in the home on 6/5/24 at 7:15am, client #3 was not at the dining room table having breakfast with the other clients. Client #3 remained in his bedroom during the meal.

Interview on 6/5/24 with Staff D and Staff E revealed client #3 had a behavior earlier, was non-compliant with requests and refused his meal.

Record review on 6/5/24 of a behavior data sheet from third shift on 6/5/24 revealed Staff E recorded client #3 "had to be carried to his room due to refusing to listen to verbal commands."

Record review on 6/5/24 of an Incident Response Improvement System (IRIS) revealed the qualified intellectual disabilities professional (QIDP) had investigated an abuse incident on client #3 that took place on 4/29/24 involving terminated Staff F. On 5/3/24, the QIDP conducted an in-service with staff. Staff were retrained on client #3's behavior support plan and not to use restrictive techniques.

Interview on 6/5/24 with Staff E revealed client #3 was verbally aggressive toward staff this morning, engaged in self-injurious behaviors, had flopped down and refused breakfast.

Interview on 6/5/24 with the QIDP revealed he was not aware of the incident this morning with client #3 and needing to be carried back to his room. The QIDP revealed he was able to view video footage from the hallway this morning and it revealed client #3 was having a behavior leaving

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 289 | Continued From page 34<br>the medication room at 12:07am and was escorted out by Staff C using a manual touch on the elbow to supervise client #3. Minutes later, client #3 was observed on the video, falling to the floor in front of his door (behavior from non-compliance) and was seen lifted off the floor by Staff C and carried to inside the room. The QIDP revealed carrying client #3 was not the proper technique to use when he is non-compliant and will not get up from floor. | W 289 | | |
| W 331 | NURSING SERVICES<br>CFR(s): 483.460(c)<br><br>The facility must provide clients with nursing services in accordance with their needs.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure 2 of 3 audit clients (#1 and #3) received the necessary ongoing nursing services to prevent declines in skin conditions. The findings are:<br><br>A. Review on 6/4/24 of client #1's nursing notes revealed on 10/28/23 a discoloration of unusual texture was first noticed on his right buttocks that was determined to be an abscess. On 11/28/23, new physician's orders revealed to apply a protective cream to buttocks twice a day. There was no documentation on the chart the abscess was still being treated or had worsened. On 6/5/24, client #1 returned from a doctor's appointment with a consultant report that diagnosed him as having a stage II pressure ulcer on right buttocks.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed there was no nurse working in the home but there was | W 331 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 331 | Continued From page 35 | W 331 | | |

a contract nurse who came to the home every month. The QIDP acknowledged, staff have been trained to contact him for nursing concerns. On 6/1/24, he received a call from staff who was concerned about skin breakdown on client #1's right buttocks and sent a photograph to the QIDP. The QIDP revealed the buttock appeared to have a hole and he was worried that client #1 developed a pressure ulcer and made immediate arrangements to get an appointment for client #1 to see the doctor. The QIDP acknowledged the nurse was notified on 6/5/24 of client #1's pressure ulcer on buttocks.

B. During observations in the home on 6/4/24 at 5:45pm, client #1 wore an surgical shoe on his right foot.

Record review on 6/4/24 revealed on 5/1/24, client #3 was evaluated for right foot pain, was picking the skin on the great toe and received an x-ray and ultrasound. Client #3 was diagnosed with soft tissue injury and was noted to have displaced soft tissue flap on the tip of his right great toe. No fracture was detected from tests. Client #3 was placed on antibiotic for an infection to great toe. On 5/30/24, client #3 was sent to the emergency room due to the fat layer on great toe exposed. Client #3 was diagnosed with a right haliuz ulcer on toe. Client #3's dressing should be changed daily, with antibiotic ointment applied, covered with bandage and he should continue to wear surgical shoe. Client #3 needs to follow-up with his podiatrist in 4 weeks.

Interview on 6/5/24 with Staff A revealed client #1 would remove the bandage on great toe and did not always like to wear the surgical shoe. Staff A acknowledged she passed medications on day

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 331 | Continued From page 36<br>shift and was cleaning the wound on great toe that originated from a hang nail for client #3. Staff A revealed she was not told client #3's toe injury had worsened to an ulcer.<br><br>Interview on 6/5/24 with the QIDP revealed the nurse was contracted and did not spend a lot of time in the home. | W 331 | | |
| W 454 | INFECTION CONTROL<br>CFR(s): 483.470(l)(1)<br><br>The facility must provide a sanitary environment to avoid sources and transmission of infections.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to maintain furniture in sanitary condition. This had the potential to effect all clients in the home (#1, #2, #3, #4, #5 and #6). The finding is:<br><br>During observations in the home on 6/4/24 at 12:48pm, client #1 got up from leather loveseat and walked toward Staff A in the kitchen. Staff A immediately noticed that client #1 was incontinent and the back of his pants were wet with a large oval stain. Staff A told client #1 that she was taking him to his room to change pants and give him a shower. When client #1 returned to the living room he sat in the same spot on the loveseat. No one was observed to sanitize the loveseat after he had a toileting accident.<br><br>Interview on 6/5/24 with the home manager revealed once staff becomes aware that the furniture has been soiled, staff should wipe it down with a sanitary wipe. The home manager also advised staff should wait for the sanitized | W 454 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 454 | Continued From page 37<br>furnishing dries before clients use it again.<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed if the furniture becomes contaminated, staff should clean it "as best they can" and notify the QIDP. The QIDP revealed he can state if the furniture needs to be cleaned professionally. | W 454 | | |
| W 487 | DINING AREAS AND SERVICE<br>CFR(s): 483.480(d)(4)<br><br>The facility must assure that each client receives enough food.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure adequate nutrition for 1 of 3 audit clients (#3) who refuses meals. The finding is:<br><br>During observations in the home on 6/4/24 from 5:30pm-6:15 pm, client #3 refused to eat spaghetti, green beans or mandarin oranges for dinner. The home manager was observed to tell client #3 his plate would be reserved for later, in case he changed his mind. An additional observation on 6/5/24 from 7:15am-7:45am, client #3 refused to come to the dining room to eat breakfast. Dietary orders from 2/14/24 were taped to the dining room wall and revealed client #3 was on a regular diet and could receive 2nd helpings of fruits and vegetables. There were no instructions for meal replacement or substitutions if he refused meals.<br><br>Record review on 6/5/24 of a behavior note revealed client #3 refused dinner and evening medications. An additional behavior note on 6/5/24 revealed client #3 refused breakfast. | W 487 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G239 | A. BUILDING _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THOMAS S DECATUR HOME | 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 487 | Continued From page 38<br><br>Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed the facility has not had a registered dietician since May 2023. | W 487 | | |