PRINTED: 06/14/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G064	B. WING _			06/12/2024	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG			ID PREFIX TAG	((EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		5) ETION E
E 039	CFR(s): 483.475(d)(2) §416.54(d)(2), §418.7 §460.84(d)(2), §482.1 §483.475(d)(2), §484 §485.542(d)(2), §485 §485.920(d)(2), §491 *[For ASCs at §416.5 at §485.542, OPO, "C §485.727, CMHCs at §491.12, and ESRD F (2) Testing. The [facilit to test the emergency must do all of the following to the facility of the following of the facility of the f	alta(d)(2), §441.184(d)(2), [15(d)(2), §483.73(d)(2), [102(d)(2), §485.68(d)(2), [625(d)(2), §485.727(d)(2), [12(d)(2), §494.62(d)(2). 4, CORFs at §485.68, REHs organizations" under §485.920, RHCs/FQHCs at facilities at §494.62]: alty must conduct exercises or plan annually. The [facility] owing: -scale exercise that is ery 2 years; or ity-based exercise is not a facility-based functional emergency that requires gency plan, the [facility] is go in its next required individual, facility-based llowing the onset of the onal exercise at least every 2 ear the full-scale or exercise that is individual, facility-based resercise resercise that is individual, facility-based resercise rese				(YE) DATE	

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

TITLE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		34G064	B. WING			06/12/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)	DATE	
E 039	a narrated, clinically-scenario, and a set of directed messages, of designed to challeng (iii) Analyze the [facil maintain documentate exercises, and emergifacility's] emergency *[For Hospices at 418 (2) Testing for hospic patient's home. The exercises to test the annually. The hospic (i) Participate in a furcommunity based ev (A) When a community based ev (A) When a community based ev (B) If the hospice expman-made emergency plan, engaging in its next recommunity-based exfacility-based function onset of the emerger (ii) Conduct an addit opposite the year the exercise under paragis conducted, that mato the following: (A) A second full-scar community-based or exercise; or (B) A mock disaster (C) A tabletop exercise	des a group discussion using relevant emergency for problem statements, or prepared questions ean emergency plan. Ity's] response to and ion of all drills, tabletop gency events, and revise the plan, as needed. 3.113(d):] The state provide care in the chospice must conduct emergency plan at least the must do the following: Il-scale exercise that is eary 2 years; or exity based exercise is not an individual facility based every 2 years; or exercise a natural or experiences a natural or experiences a natural or experiences a natural or experience or individual exercise following the exercise or individual exercise that is a facility based functional	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G064	B. WING _			06/12/2024
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	a narrated, clinically-r scenario, and a set of directed messages, o designed to challenge (3) Testing for hospice care directly. The hose exercises to test the eyear. The hospice midical participate in an ais community-based; (A) When a community accessible, conduct a facility-based function (B) If the hospice exp man-made emergency plan, the emergency plan is next to expect the emergency plan in the problem in the problem in the emergency plan in the problem in the problem in the emergency plan in the problem in the emergency plan in the problem in	elevant emergency i problem statements, ir prepared questions an emergency plan. es that provide inpatient spice must conduct emergency plan twice per just do the following: innual full-scale exercise that or ty-based exercise is not in annual individual ial exercise; or eriences a natural or y that requires activation of the hospice is exempt from equired full-scale community d functional exercise the emergency event. onal annual exercise that ot limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a se a group discussion using a evant emergency scenario, estatements, directed and questions designed to incy plan. ice's response to and on of all drills, tabletop ency events and revise the	EO	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G064	B. WING _			06/12/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028	·	
(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 COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	*[For PRFTs at §441. §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in an a is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the [PRTF, Hos actual natural or man requires activation of [facility] is exempt from required full-scale confacility-based function onset of the emergen (ii) Conduct an [and that may include, following: (A) A second full-scale community-based or functional exercise; on (B) A mock of (C) A tabletop exiled by a facilitator and discussion, using a nate mergency scenario, statements, directed in questions designed to plan. (iii) Analyze the [maintain documentatic conduct exercises or conduct exercis	184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must nnual full-scale exercise that or ty-based exercise is not annual individual, all exercise; or pital, CAH] experiences an emergency plan, the mengaging in its next munity based or individual, all exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based or disaster drill; or ercise or workshop that is dincludes a group exercise or prepared or challenge an emergency facility's] response to and on of all drills, tabletop tency events and revise the plan, as needed.	EC	039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLÉTION
E 039	(2) Testing. The PACE exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a community-based function (B) If the PACE exports a conduct facility-based function (B) If the PACE exports and the emergency planengaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the yexercise under parais conducted that matter following: (A) A second full-socommunity-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, cliscenario, and a set directed messages, designed to challeng (iii) Analyze the PACE is emergency *[For LTC Facilities]	E organization must conduct emergency plan at least torganization must do the annual full-scale exercise that ; or nity-based exercise is not an annual individual, onal exercise; or eriences an actual natural or recy that requires activation of the PACE is exempt from required full-scale community facility-based functional are onset of the emergency additional exercise every 2 fear the full-scale or functional graph (d)(2)(i) of this section are individual, a facility based for or drill; or cise or workshop that is led by a des a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. CE's response to and attion of all drills, tabletop regency events and revise the plan, as needed.	E 039		

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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NAME OF PI	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 89 FAIRMONT DRIVE MOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	including unannounce emergency procedure ICF/IID] must do the finance in an analysis community-based; (A) When a community accessible, conduct a facility-based function (B) If the [LTC facility] actual natural or man requires activation of LTC facility is exempt required a full-scale of individual, facility-base following the onset of (ii) Conduct an additionary include, but is not (A) A second full-scale community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercial facilitator includes a narrated, clinically-reland a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerge [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/IID must document in the incommunity in in the i	lan at least twice per year, ed staff drills using the es. The [LTC facility, following: Innual full-scale exercise that or ty-based exercise is not an annual individual, facility experiences an emade emergency that the emergency plan, the from engaging its next formunity-based or ed functional exercise that emergency event. Individual, facility based or ed functional exercise that is an individual, facility based or exercise that is en individual, facility based or exercise that exercise that exercise that is led by a group discussion, using a event emergency scenario, estatements, directed exercise decidency plan. If acility is response to entation of all drills, tabletop tency events, and revise the emergency plan, as needed. 3.475(d): ID must conduct exercises or plan at least twice per year.	E	039			

AND DUAN OF CORRECTION IN IMPER-		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G064	B. WING _			06/	12/2024
NAME OF PI	ROVIDER OR SUPPLIER		·	189	EET ADDRESS, CITY, STATE, ZIP CODE FAIRMONT DRIVE CKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	accessible, conduct facility-based function (B) If the ICF/IID exproman-made emergency the emergency plan, engaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an additional include, but is not (A) A second full-scat community-based or functional exercise; (B) A mock disaster (C) A tabletop exercity a facilitator and inclusing a narrated, clinscenario, and a set of directed messages, and emergically designed to challeng (iii) Analyze the ICF/IID's emergency *[For HHAs at §484. (d)(2) Testing. The Hoto test the emergency least annually. The Formunity-based; or (A) When a compaccessible, conduct and conduct and compact in the compa	or ity-based exercise is not an annual individual, nal exercise; or. eriences an actual natural or cy that requires activation of the ICF/IID is exempt from required full-scale individual, facility-based ollowing the onset of the onal annual exercise that ot limited to the following: le exercise that is an individual, facility-based or drill; or se or workshop that is led by des a group discussion, ically-relevant emergency of problem statements, or prepared questions e an emergency plan. IID's response to and ion of all drills, tabletop gency events, and revise the plan, as needed. IO2] HA must conduct exercises y plan at HHA must do the following: Il-scale exercise that is munity-based exercise is not	E	039			

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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	or man-made emergory plengaging in its next community-based of functional exercise if emergency event. (ii) Conduct an addit opposite the year the exercise under parais conducted, the limited to the following (A) A second for community-based of functional exercise; (B) A mock disaid (C) A tabletop of led by a facilitator and discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HHA documentation of all emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The off to test the emergency workshop at least and led by a facilitator and discussion, using a emergency scenario discussion, using a emergency scenario	experiences an actual natural gency that requires activation an, the HHA is exempt from required full-scale r individual, facility based following the onset of the stional exercise every 2 years, e full-scale or functional graph (d)(2)(i) of this section at may include, but is not ng: Ill-scale exercise that is r an individual, facility-based or exercise or workshop that is not includes a group narrated, clinically-relevant or, and a set of problem it messages, or prepared to challenge an emergency A's response to and maintain it drills, tabletop exercises, and and revise the HHA's needed. 360] DPO must conduct exercises cy plan. The OPO must do the chased, tabletop exercise is	EC	39		

Facility ID: 952779

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G064	B. WING			06/	/12/2024
NAME OF PI	ROVIDER OR SUPPLIER			189 F	ET ADDRESS, CITY, STATE, ZIP CODE FAIRMONT DRIVE CKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	plan. If the OPO exp man-made emergen the emergency plan, engaging in its next following the onset of (ii) Analyze the OPO documentation of all emergency events, a OPO's] emergency poor *[RNCHIs at §403.7 (d)(2) Testing. The Fexercises to test the must do the following (i) Conduct a paper-least annually. A tab discussion led by a folinically-relevant emof problem statement prepared questions of emergency plan. (ii) Analyze the RNH maintain documenta and emergency even emergency plan, as This STANDARD is Based on record review of the facility failed to conduct emergency prepared which effects all client #4, #5 and #6). The Review of facility docrevealed an EPP dar review of the facility' evidence of a full-sca	to challenge an emergency eriences an actual natural or cy that requires activation of the OPO is exempt from required testing exercise of the emergency event. It is response to and maintain tabletop exercises, and and revise the [RNHCl's and olan, as needed. 48]: RNHCl must conduct emergency plan. The RNHCl g: based, tabletop exercise at letop exercise is a group facilitator, using a narrated, hergency scenario, and a set tts, directed messages, or designed to challenge an CI's response to and tion of all tabletop exercises, and revise the RNHCl's needed. not met as evidenced by: view and interviews, the facility (#1, #2, #3, finding is: cumentation on 6/12/24 ted 3/28/24. Continued	E	039			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		34G064	B. WING			06/	12/2024
NAME OF PE	ROVIDER OR SUPPLIER			18	TREET ADDRESS, CITY, STATE, ZIP CODE 39 FAIRMONT DRIVE OCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	professional (QIDP) of tabletop exercise was however, evidence of facility-based exercise not completed. Intervious manager (PM) and Q a copy of the facility to full-scale exercise shemergency operation PROGRAM IMPLEM CFR(s): 483.440(d)(1). As soon as the interdeformulated a client's it each client must receive treatment program conterventions and ser and frequency to sup	alified intellectual disabilities on 6/12/24 revealed a scompleted on 3/5/24; f a full-scale community, e, or tabletop exercise was iew with the program IIDP on 6/12/24 verified that abletop, mock drill, and/or ould be stored in the splan manual. ENTATION isciplinary team has ndividual program plan, sive a continuous active		2249			
	Based on observation interviews, the facility continuous active treat of needed intervention identified in the person of 3 sampled clients (Observations on 6/11 staff to prompt client prepare for dinner. Corevealed client #1 to and serve his plate at	not met as evidenced by: ons, record review and of failed to ensure that a fatment program consisting ons were implemented as on-centered plan (PCP) for 1 #1). The finding is: /24 at 5:15 PM revealed #1 to wash his hands and ontinued observations sit at the dining room table and participate in the dinner ing the observation did staff					

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
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(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE	
allow client #1 to predinner meal. Review of the record dated 4/6/23 which in the following program hands, initiate an ass beverage for dinner. Interview with the quaprofessional (QIDP) of client #1's goals winterview with the QID (PM) revealed that st follow client #1's proglevel of independence PM and QIDP revealed client #1's dinner goal PROGRAM MONITO CFR(s): 483.440(f)(3). The committee should monitor individual program in the opinion of the collient protection and the protection and the protection and the protection of the collient protection and the prote	for client #1 revealed a PCP dicated that the client has a goals: exercise, wash his igned task and prepare a salified intellectual disabilities on 6/12/24 revealed that all ere current. Continued DP and program manager aff have been trained to gram goals to increase his e. Further interview with the ed staff should implement I as prescribed. RING & CHANGE (i) d review, approve, and grams designed to manage or and other programs that, committee, involve risks to rights. not met as evidenced by: ns, record review and failed to ensure that		249	NCY)		
reviewed annually by (HRC) for 6 of 6 clien #6). The findings are: Observations through period from 6/11/24 - surrounding the group	the human rights committee ts (#1, #2, #3, #4 #5 and nout the recertification survey 6/12/24 revealed a fence o with a carabineer at the					
	Continued From page allow client #1 to pregation for some with the quaprofessional (QIDP) of client #1's goals we interview with the QID (PM) revealed that strollow client #1's proglevel of independence PM and QIDP revealed client #1's dinner goal PROGRAM MONITO CFR(s): 483.440(f)(3). The committee should monitor individual programment in the opinion of the colient protection and in the opinion of the colient protection a	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 allow client #1 to prepare a beverage for the dinner meal. Review of the record for client #1 revealed a PCP dated 4/6/23 which indicated that the client has the following program goals: exercise, wash his hands, initiate an assigned task and prepare a	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 allow client #1 to prepare a beverage for the dinner meal. Review of the record for client #1 revealed a PCP dated 4/6/23 which indicated that the client has the following program goals: exercise, wash his hands, initiate an assigned task and prepare a beverage for dinner. Interview with the qualified intellectual disabilities professional (QIDP) on 6/12/24 revealed that all of client #1's goals were current. Continued interview with the QIDP and program manager (PM) revealed that staff have been trained to follow client #1's program goals to increase his level of independence. Further interview with the PM and QIDP revealed staff should implement client #1's dinner goal as prescribed. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) 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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of 6 clients (#1, #2, #3, #4 #5 and #6). The findings are: Observations throughout the recertification survey period from 6/11/24 - 6/12/24 revealed a fence surrounding the group with a carabineer at the	ROVIDER OR SUPPLIER 34G064 34G064 34G064 34G064 34G064 34G064 34G066 SUNING STREET ADDRESS, CITY, STATE, ZII 139 FAIRMONT DRIVE MOCKSVILLE, NC 27028 PROVIDERS PLAN- (EACH DEFICIENCY MUST BE PRECEDED BY PLIL REGULATORY OR LSC IDENTIFYING INFORMATION) REQULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 10 allow client #1 to prepare a beverage for the dinner meal. Review of the record for client #1 revealed a PCP dated 4/6/23 which indicated that the client has the following program goals: exercise, wash his hands, initiate an assigned task and prepare a beverage for dinner. Interview with the QIDP and program manager (PM) revealed that staff have been trained to follow client #1's program goals to increase his level of independence. Further interview with the PM and QIDP revaled staff should implement client #1's dinner goal as prescribed. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) 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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of 6 clients (#1, #2, #3, #4 #5 and #6). The findings are: Observations throughout the recertification survey period from 6/11/24 - 6/12/24 revealed a fence surrounding the group with a carabineer at the	ROWIDER OR SUPPLIER 34G064 34G064 34G064 34G064 3 WING STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO DENTIFYING INFORMATION) Continued From page 10 allow client #1 to prepare a beverage for the dinner meal. Review of the record for client #1 revealed a PCP dated 4/6/23 which indicated that the client has the following program goals: exercise, wash his hands, initiate an assigned task and prepare a beverage for dinner. Interview with the qualified intellectual disabilities professional (QIDP) on 6/12/24 revealed that all of client #1's goals were current. Continued interview with the DP and program manager (PM) revealed that staff have been trained to follow client #1's program goals to increase his level of independence. Further interview with the PM and QIDP revealed staff should implement client #1's dinner goal as prescribed. PREFIX PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) 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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of clients (#1, #2, #3, #4 #5 and #6). The findings are: Observations throughout the recertification survey period from 6/11/24 - 6/12/24 revealed a fence surrounding the group with a carabineer at the	

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 262	clients and surveyor group home. A. Review of client revealed a signed or legal guardian for th door alarms. Continuous ents were revieed. B. Review of client 2 revealed a signed or legal guardian for th door alarms. Continuous ents were revieed. C. Review of client 3 reveal a consent signed or consents were revieed. Continued review direviewed or approved. D. Review of client 4 revealed a signed or legal guardian for the door alarms. Continuous ents were revieed. E. Review of client 5 revealed a signed or legal guardian for the door alarms. Continuous ents were revieed. F. Review of client 6 revealed a signed or legal guardian for the door alarms. Continuous ents were revieed. F. Review of client 6 revealed a signed or legal guardian for the door alarms. Continuous ents were revieed.	or alarms to chime as staff, is entered and exited the discrete and exited the discrete and exited the discrete and exited the discrete and exited review did not reveal wed or approved by the HRC. Discrete and exited for exited for exited and exited for	W 26				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G064	B. WING _			06/	12/2024
NAME OF PROVIDER OR SUPPLIER TWINBROOKS			•	18	TREET ADDRESS, CITY, STATE, ZIP CODE B9 FAIRMONT DRIVE IOCKSVILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 262	Continued From page	alified intellectual	w:	262			
W 263	confirmed that update were not reviewed or Continued interview r	revealed HRC limitation clients will be updated and nnually. RING & CHANGE	W	263			
	are conducted only w consent of the client, minor) or legal guard This STANDARD is Based on observation interviews, the facility restrictive techniques	not met as evidenced by: who, record review and refailed to ensure that were monitored and the legal guardian for 1 of 6					
	period from 6/11/24 - surrounding the grou side gate entrance. C revealed exterior doo	nout the recertification survey 6/12/24 revealed a fence p with a carabineer at the continued observations or alarms to chime as staff, a entered and exited the					
	reveal a consent sign the fence, carabineer Interview with the qua developmental profes confirmed that update	ecords on 6/12/24 did not need by the legal guardian for and exit door alarms. alified intellectual esional (QIDP) on 6/12/24 ed signed consent form for a located during the survey.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G064	B. WING			06/	12/2024
NAME OF PROVIDER OR SUPPLIER TWINBROOKS				STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
W 263	Continued interview revealed limitation consent forms for all clients will be updated and signed by the legal guardian annually.		w:				
W 474	forms for all clients will be updated and signed by the legal guardian annually.		W	474			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDE IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	PLE CONSTRUCTION G	(X3) DA	(X3) DATE SURVEY COMPLETED		
		34G064	B. WING _			06/12/2024		
NAME OF PROVIDER OR SUPPLIER TWINBROOKS				STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
W 474	on 6/12/24 revealed to follow client #4's d Continued interview verified that client #4' Further interview with	chat staff have been trained let consistency as ordered. with the PM and QIDP is prescribed diet is current. In the PM revealed that all clients' diet consistency as	W 4'	74				