CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE C	(X3) DAT	OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	NG		COMP	
		34G168	B. WING			0	7/16/2024
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	• • •	
NORTHBA	Y GROUP HOME				7 NORTHBAY DRIVE OWN SUMMIT, NC 27214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
E 039	EP Testing Requirem CFR(s): 483.475(d)(2		E	039			
	§460.84(d)(2), §482. §483.475(d)(2), §484 §485.542(d)(2), §485	113(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).					
	at §485.542, OPO, "O	§485.920, RHCs/FQHCs at					
		ity] must conduct exercises / plan annually. The [facility] owing:					
	community-based eve (A) When a commun accessible, conduct a exercise every 2 year (B) If the [facility]	ity-based exercise is not a facility-based functional rs; or experiences an actual					
	activation of the emer exempt from engagin community-based or	emergency that requires rgency plan, the [facility] is g in its next required individual, facility-based llowing the onset of the					
	years, opposite the ye functional exercise un this section is conduct not limited to the follo	nder paragraph (d)(2)(i) of sted, that may include, but is wing:					
	functional exercise; o (B) A mock disaster of	individual, facility-based r Irill; or					
	(C) A tabletop exercis	se or workshop that is led by					

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/17/2024

FORM APPROVED

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/17/2024 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		34G168	B. WING			07/	16/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHBAY GROUP HOME					907 NORTHBAY DRIVE BROWN SUMMIT, NC 27214		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	a facilitator and includ a narrated, clinically-r scenario, and a set of directed messages, o designed to challenge (iii) Analyze the [facilit maintain documentati exercises, and emerg [facility's] emergency *[For Hospices at 418 (2) Testing for hospic patient's home. The f exercises to test the e annually. The hospic (i) Participate in a full community based eve (A) When a communit accessible, conduct a functional exercise ev (B) If the hospice exp man-made emergenc the emergency plan, t engaging in its next re community-based function onset of the emergen (ii) Conduct an additi opposite the year the exercise under paragi is conducted, that ma to the following: (A) A second full-sca community-based or a exercise; or (B) A mock disaster o (C) A tabletop exercise	des a group discussion using relevant emergency f problem statements, or prepared questions e an emergency plan. ty's] response to and ton of all drills, tabletop gency events, and revise the plan, as needed. 3.113(d):] tess that provide care in the hospice must conduct emergency plan at least e must do the following: I-scale exercise that is ery 2 years; or ty based exercise is not in individual facility based very 2 years; or eriences a natural or by that requires activation of the hospital is exempt from equired full scale ercise or individual hal exercise following the cy event. onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section by include, but is not limited le exercise that is a facility based functional	E	039			

If continuation sheet Page 2 of 12

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G168 B. WING 07/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1907 NORTHBAY DRIVE** NORTHBAY GROUP HOME **BROWN SUMMIT, NC 27214** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 039 Continued From page 2 E 039 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 922774

If continuation sheet Page 3 of 12

PRINTED: 07/17/2024

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G168 B. WING 07/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1907 NORTHBAY DRIVE** NORTHBAY GROUP HOME **BROWN SUMMIT, NC 27214** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 039 Continued From page 3 E 039 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the followina: (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 followina: (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):]

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 07/17/2024

		MEDICAID SERVICES					<u>O. 0938-03</u>
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,		CONSTRUCTION	· · ·	E SURVEY IPLETED	
		34G168	B. WING			07	7/16/2024
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NORTHBAY GROUP HOME					07 NORTHBAY DRIVE ROWN SUMMIT, NC 27214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
E 039	Continued From page	9 4	E	039			
		E organization must conduct					
		emergency plan at least					
	annually. The PACE of following:						
	(i) Participate in an a						
	is community-based;						
	(A) When a communi accessible, conduct a						
	facility-based function						
	(B) If the PACE exper						
	man-made emergence						
	the emergency plan,						
		equired full-scale community					
		acility-based functional					
	event.	e onset of the emergency					
		dditional exercise every 2					
		ar the full-scale or functional					
	exercise under parag	raph (d)(2)(i) of this section					
		y include, but is not limited to					
	the following:						
	(A) A second full-sca						
	functional exercise; o	individual, a facility based r					
	(B) A mock disaster						
	· · /	se or workshop that is led by					
		les a group discussion,					
		cally-relevant emergency					
	scenario, and a set of						
	directed messages, o						
	designed to challenge (iii) Analyze the PAC						
	. , .	ion of all drills, tabletop					
		jency events and revise the					
	PACE's emergency p						
	*[For LTC Facilities at	t \$483.73(d):1					

Facility ID: 922774

If continuation sheet Page 5 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/17/2024 APPROVED . 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED		
		34G168	B. WING			07/1	16/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE			
NORTHBA	Y GROUP HOME			1907 NORTHBAY DRIVE BROWN SUMMIT, NC	27214			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 039	test the emergency pl including unannounce emergency procedure ICF/IID] must do the f (i) Participate in an ar- is community-based; ((A) When a communit 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 c individual, facility-base following the onset of (ii) Conduct an addition may include, but is no (A) A second full-scale community-based or a functional exercise; on (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-rele and a set of problem s messages, or prepare challenge an emerger (iii) Analyze the [LTC and maintain docume exercises, and emerg [LTC facility] facility's of *[For ICF/IIDs at §483 (2) Testing. The ICF/II to test the emergency The ICF/IID must do t	an at least twice per year, ed staff drills using the es. The [LTC facility, following: nnual full-scale exercise that or ty-based exercise is not n annual individual, al exercise. facility experiences an -made emergency that the emergency plan, the from engaging its next ommunity-based or ed functional exercise the emergency event. onal annual exercise that of limited to the following: le exercise that is an individual, facility based r drill; or se or workshop that is led by a group discussion, using a evant emergency scenario, statements, directed ed questions designed to ncy plan. facility] facility's response to intation of all drills, tabletop ency events, and revise the emergency plan, as needed. 3.475(d)]: ID must conduct exercises plan at least twice per year.	E 03	39				

Facility ID: 922774

If continuation sheet Page 6 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/17/2024 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE		
		34G168	B. WING				07/	16/2024
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE	E, ZIP CODE		
NORTHBAY GROUP HOME					1907 NORTHBAY DRIVE BROWN SUMMIT, NC 272′	14		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
E 039	is community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID exper man-made emergency the emergency plan, t engaging in its next re community-based or if functional exercise fol emergency event. (ii) Conduct an addition may include, but is not (A) A second full-scale community-based or a functional exercise; of (B) A mock disaster d (C) A tabletop exercise a facilitator and include using a narrated, clini scenario, and a set of directed messages, o designed to challenge (iii) Analyze the ICF/II maintain documentati exercises, and emerg ICF/IID's emergency f *[For HHAs at §484.1 (d)(2) Testing. The HH to test the emergency least annually. The H (i) Participate in a full- community-based; or (A) When a comm	or ty-based exercise is not in annual individual, hal exercise; or. eriences an actual natural or by that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based llowing the onset of the onal annual exercise that bit limited to the following: e exercise that is an individual, facility-based r rill; or se or workshop that is led by des a group discussion, cally-relevant emergency f problem statements, r prepared questions e an emergency plan. ID's response to and on of all drills, tabletop uency events, and revise the plan, as needed. 02] HA must conduct exercises r plan at HA must do the following: -scale exercise that is munity-based exercise is not	E	039				

Facility ID: 922774

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/17/2024 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	· <i>`</i>		E CONSTRUCTION	(X3) DATE SU COMPLET	
		34G168	B. WING			07/	/16/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				15	907 NORTHBAY DRIVE		
NORTHBA	AY GROUP HOME			В	BROWN SUMMIT, NC 27214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	 (B) If the HHA exon man-made emergers of the emergency planengaging in its next recommunity-based or if functional exercise following exercise under paragers event. (ii) Conduct an additional exercise following exercise under paragers event. (iii) Conduct an additional exercise under paragers exercise under paragers exercise under paragers is conducted, that limited to the following (A) A second full-community-based or a functional exercise; or (B) A mock disas (C) A tabletop exon (B) A mock discussion, using a maximum exon (B) A mock discussion (B) A	 xperiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based llowing the onset of the conal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section t may include, but is not g: -scale exercise that is an individual, facility-based r -scale exercise that is an individual, facility-based r -ster drill; or -ercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared to challenge an emergency s response to and maintain drills, tabletop exercises, and ind revise the HHA's needed. 360] PO must conduct exercises is a proup arrated, tabletop exercise or must do the ased, tabletop exercise or must do the ased, tabletop exercise is d includes a group arrated, clinically relevant 	E	039			

Event ID: WGT811

Facility ID: 922774

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/17/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	
		34G168	B. WING		_	07/	16/2024
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
NORTHBA	Y GROUP HOME			907 NORTHBAY DRIVE ROWN SUMMIT, NC 2	7214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	questions designed to plan. If the OPO exper man-made emergency the emergency plan, the engaging in its next re- following the onset of (ii) Analyze the OPO's documentation of all the emergency events, and OPO's] emergency plan. *[RNCHIs at §403.74 (d)(2) Testing. The RM exercises to test the e- must do the following (i) Conduct a paper-b- least annually. A table discussion led by a far clinically-relevant emergency plan. (ii) Analyze the RNHC maintain documentati and emergency event emergency plan, as in This STANDARD is r Based on record revit failed to conduct bien emergency prepared is: Review on 7/15/24-7/ revealed no evidence community-based or features.	 b challenge an emergency eriences an actual natural or cy that requires activation of the OPO is exempt from equired testing exercise the emergency event. c response to and maintain tabletop exercises, and nd revise the [RNHCI's and an, as needed. 48]: NHCI must conduct emergency plan. The RNHCI emergency plan. The RNHCI is ased, tabletop exercise at etop exercise is a group to cilitator, using a narrated, ergency scenario, and a set is, directed messages, or esigned to challenge an CI's response to and on of all tabletop exercises, ts, and revise the RNHCI's the RNHCI's the end of the facility's the facility is plan. The finding 16/24 of the facility's EPP of a full-scale facility-based functional valuate the emergency plan. 	E 039				

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						<u>O. 0938-03</u>	
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		(X3) DATE SURVEY COMPLETED		
		34G168	B. WING		07	7/16/2024	
NAME OF PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE				
NORTHBAY GROUP HOME				1907 NORTHBAY DRIVE BROWN SUMMIT, NC 27214			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
E 039	Continued From page	9	E 039				
	,	confirmed the facility has not e community or facility-based					
W 369	-		W 369				
	that all drugs, includir self-administered, are This STANDARD is r Based on observatio interview, the facility f were administered wi	administered without error. not met as evidenced by:					
	AM revealed staff to p cup from the kitchen a medication room. Con staff to prompt client a and identify their med observation revealed place all morning med cup and the client wa	ntinued observation revealed #5 to pour water into a cup lication basket. Further staff to educate client #5, dications into a medicine					
	of the 7/1/24 physicia medications to admin Gavilax Powder, Furc 15 MG, Vitamin D3 25 100 MG, Metoprolol S	ders dated 7/1/24. Review n orders revealed ister at 8:00 AM to be osemide 20 MG, Meloxicam 5 MCG (1,000), Minocycline SUCC ER 50 MG, 500 MG, Divalproex 125					

Event ID: WGT811

Facility ID: 922774

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/17/2024 MAPPROVED). 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION		(X3) DATE SU COMPLE		
34G168			B. WING			_	07/	16/2024	
NAME OF PF	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STA	ATE, ZIP CODE			
NORTHBAY GROUP HOME					007 NORTHBAY DRIVE ROWN SUMMIT, NC 27	7214			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 369	Staff administered clie MCG at 7:03 AM which the morning on an em- minutes before eating Levothyroxine 200 MG 6:30 AM was adminis medications after the Interview with the faci- confirmed the 7/1/24 p #5 to be current. Conti- facility nurse revealed medications as prescri EVACUATION DRILL CFR(s): 483.470(i)(1) at least quarterly for en- this STANDARD is in Based on review of re- facility failed to show drills were conducted relative to third shift. T Review of the facility for through 6/24 revealed Continued review of the shift drill to be conduct additional documenta a third shift drill in the and 4th quarter of the Interview on 7/16/24 w (PM) and qualified interview should have been cor- shift. Continued interview	ent #5's Levothyroxine 200 ch is to be taken first thing in apply stomach with water 30 g or drinking. Client #5's CG to be administered at itered with all morning breakfast meal. ility nurse on 7/16/24 physician orders for client tinued interview with the d that staff should administer ribed. S each shift of personnel. not met as evidenced by: ecord and interview, the evidence that quarterly fire with each shift of personnel The finding is: fire drill reports from 7/23 d a missing fire drill for 3/24. he fire drills revealed a third cted on 7/23. There was no tion provided for conducting 1 st quarter, 2nd quarter, e review year. with the program manager ellectual disabilities confirmed facility fire drills nducted quarterly for each view with PM and QIDP no additional documentation	W 3						

Facility ID: 922774

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ____ 34G168 B. WING 07/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1907 NORTHBAY DRIVE** NORTHBAY GROUP HOME **BROWN SUMMIT, NC 27214** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 440 Continued From page 11 W 440 conducted during the review year. W 455 INFECTION CONTROL W 455 CFR(s): 483.470(I)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure an active program for the prevention and control of infection and communicable diseases was present in the group home specific to ensuring toilets are free of feces and soap in the bathroom for 5 of 5 clients (#1, #2, #3, #4, and #5). The finding is: Observation in the group home during recertification survey 7/15/24-7/16/24 revealed two bathrooms utilized by clients #1, #2, #3, #4, and #5. Observations of both bathrooms throughout the survey revealed toilets in both bathrooms contained a substantantial amount of feces around the toilet seats and rim of toilets. Continued observations revealed clients entering and exiting both bathrooms to perform hygiene needs which included toileting and hand washing. Further observations duing the survey revealed client #5 to use the hallway bathroom near the side door to wash his hands several times with no soap being provided. Interview with the program manager (PM) verified that staff should ensure bathrooms are clean including toilets. Continued interview with the PM verified that soap should be provided in the bathrooms for all clients.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: WGT811

Facility ID: 922774

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PRINTED: 07/17/2024