PRINTED: 07/25/2024 FORM APPROVED OMB NO. 0938-0391

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDIN | | NSTRUCTION | ' ' | E SURVEY PLETED |
|--------------------------|--|--|---------------------|-------|---|-----|----------------------------|
| | | 34G070 | B. WING _ | | | 07 | //24/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | 1 | 447 P | ET ADDRESS, CITY, STATE, ZIP CODE LEASANT ACRES DRIVE KSVILLE, NC 27028 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | §460.84(d)(2), §482 §483.475(d)(2), §485 §485.542(d)(2), §485 §485.542(d)(2), §485 §485.542(d)(2), §485 §485.542, OPO, §485.727, CMHCs as §491.12, and ESRE (2) Testing. The [facto test the emergen must do all of the formula of the following of the following of the following of the emergen community-based endowed exercise every 2 ye (B) If the [facility natural or man-made activation of the emexempt from engage community-based of functional exercise exercises exercise exercise exercises exercise exercises exercises exercise exerc | 3.113(d)(2), §441.184(d)(2), 9.15(d)(2), §483.73(d)(2), 9.15(d)(2), §485.68(d)(2), 9.15.625(d)(2), §494.62(d)(2). 9.11.12(d)(2), §494.62(d)(2), §494.62(d), §49 | EC | 39 | TITLE | | (X6) DATE |

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.

Facility ID: 922407

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|-----------------------------|---|-------------------------------|
| | | 34G070 | B. WING | | 07/24/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 447 PLEASANT ACRES 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | O BE COMPLETION |
| E 039 | a narrated, clinically scenario, and a set directed messages, designed to challeng (iii) Analyze the [facimaintain documental exercises, and emerifacility's] emergence *[For Hospices at 41 (2) Testing for hospices to test the annually. The hospicility home. The exercises to test the annually. The hospicility has ed every home and the emergency planengaging in its next community-based every has engaging in its next community-based every home to the emergency planengaging in its next community-based every home to the following: (A) A second full-socommunity-based over exercise; or (B) A mock disaster (C) A tabletop exercise. | aides a group discussion using relevant emergency of problem statements, or prepared questions ge an emergency plan. Ility's] response to and ation of all drills, tabletop gency events, and revise the gy plan, as needed. 8.113(d):] ices that provide care in the enospice must conduct emergency plan at least ice must do the following: ull-scale exercise that is very 2 years; or nity based exercise is not an individual facility based every 2 years; or periences a natural or recy that requires activation of an the hospital is exempt from required full scale exercise or individual scale exercise or individual enal exercise following the ncy event. It it is a facility based functional graph (d)(2)(i) of this section is an afacility based functional | E 039 | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 34G070 | B. WING | | | 07/: | 24/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | 4 | TREET ADDRESS, CITY, STATE, ZIP CODE 47 PLEASANT ACRES 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 | care directly. The hose exercises to test the exercises in an axis community-based; (A) When a community-based; (A) When a community-based function (B) If the hospice exportant manages are managed emergency plan, the emergency plan is next to exercise; or (B) A second full-scalar community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercise; aciditator that include narrated, clinically-reland a set of problem messages, or prepare challenge an emerger (iii) Analyze the hosp maintain documentation. | relevant emergency f problem statements, r prepared questions e an emergency plan. es that provide inpatient spice must conduct emergency plan twice per ust do the following: nnual full-scale exercise that or ty-based exercise is not an annual individual hal exercise; or eriences a natural or by 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 s a group discussion using a evant emergency scenario, statements, directed ed questions designed to ncy plan. ince's response to and on of all drills, tabletop lency events and revise the | E | 039 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 34G070 | B. WING | | | 07/24/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | , | | STREET ADDRESS, CITY, STATE, ZIP COL 447 PLEASANT ACRES DRIVE MOCKSVILLE, NC 27028 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY 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 E APPROPRIATE | (X5) COMPLETION DATE |
| E 039 | conduct exercises to twice per year. The do the following: (i) Participate in an a is community-based; (A) When a commun accessible, conduct a facility-based function (B) If the [PRTF, Hosactual natural or mar requires activation of [facility] is exempt from the required full-scale confacility-based function onset of the emerger (ii) Conduct and and that may include following: (A) A second full-scale community-based or functional exercise; of (B) A mock (C) A tabletop exiled by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. (iii) Analyze the maintain documentated | \$485.625(d):] FF, Hospital, CAH] must test the emergency plan [PRTF, Hospital, CAH] must annual full-scale exercise that or ity-based exercise is not an annual individual, and exercise; or spital, CAH] experiences an annual emergency plan, the am engaging in its next mmunity based or individual, and exercise following the exercise following the exercise that is individual, a facility-based or disaster drill; or exercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency [facility's] response to and ion of all drills, tabletop gency events and revise the plan, as needed. | E 03 | 39 | | |

| AND BLAN OF CORRECTION IN INDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|--------------------|-------|--|-----|----------------------------|
| | | 34G070 | B. WING _ | | | 07/ | 24/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 447 P | ET ADDRESS, CITY, STATE, ZIP CODE LEASANT ACRES DRIVE KSVILLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| E 039 | exercises to test the annually. The PACE following: (i) Participate in an a is community-based; (A) When a commun accessible, conduct facility-based function (B) If the PACE experimental emergency plan, engaging in its next in based or individual, the exercise following the event. (ii) Conduct an a years opposite the years opposite the years opposite the years opposite that may the following: (A) A second full-scacommunity-based or functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, clir scenario, and a set of directed messages, designed to challeng (iii) Analyze the PAC maintain documental exercises, and emer PACE's emergency participate in the pace of the pa | E organization must conduct emergency plan at least organization must do the annual full-scale exercise that or ity-based exercise is not an annual individual, nal exercise; or references an actual natural or cy that requires activation of the PACE is exempt from required full-scale community facility-based functional e onset of the emergency additional exercise every 2 fear the full-scale or functional graph (d)(2)(i) of this section by include, but is not limited to all exercise that is individual, a facility based for drill; or ise or workshop that is led by des a group discussion, incally-relevant emergency of problem statements, for prepared questions e an emergency plan. CE's response to and tion of all drills, tabletop gency events and revise the plan, as needed. | E | 039 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 34G070 | B. WING _ | | | 07/ | 24/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 447 PL | T ADDRESS, CITY, STATE, ZIP CODE LEASANT ACRES DRIVE (SVILLE, NC 27028 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| E 039 | including unannounce emergency procedur ICF/IID] must do the (i) Participate in an is community-based (A) When a community-based function (B) If the [LTC facility actual natural or man requires activation of LTC facility is exemply required a full-scale individual, facility-bated following the onset of (ii) Conduct an addinary include, but is not (A) A second full-scale individual, facility-bated or functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator includes narrated, clinically-reand a set of problem messages, or preparchallenge an emerge (iii) Analyze the [LTC and maintain docum exercises, and emer [LTC facility] facility's [For ICF/IIDs at §48 (2) Testing. The ICF/IID must do The ICF/IID must do | colan at least twice per year, seed staff drills using the res. The [LTC facility, following: annual full-scale exercise that is or nity-based exercise is not an annual individual, anal exercise. If facility experiences an in-made emergency that if the emergency plan, the out from engaging its next community-based or seed functional exercise of the emergency event. It is an individual, facility based for drill; or cise or workshop that is led by a group discussion, using a elevant emergency scenario, a statements, directed red questions designed to ency plan. C facility] facility's response to entation of all drills, tabletop gency events, and revise the seemergency plan, as needed. 33.475(d)]: VIID must conduct exercises by plan at least twice per year. | E | 039 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 34G070 | B. WING | | | 07/ | 24/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER T ACRES | | | 4 | TREET ADDRESS, CITY, STATE, ZIP CODE 47 PLEASANT ACRES DRIVE MOCKSVILLE, NC 27028 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | EDED BY FULL PREFIX (EACH CO | | | RECTION (X5) HOULD BE COMPLETION PPROPRIATE DATE | |
| E 039 | accessible, conduct a facility-based function (B) If the ICF/IID expendent and an aman-made emergency the emergency plan, engaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an additionary include, but is not (A) A second full-scal community-based or functional exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and includusing a narrated, cliniscenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/II maintain documentati exercises, and emerg ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The HI to test the emergency least annually. The H (i) Participate in a full-community-based; or (A) When a community-based; or accessible, conduct as | ty-based exercise is not an annual individual, all exercise; or. eriences an actual natural or by that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based Illowing the onset of the onal annual exercise that of limited to the following: e exercise that is an individual, facility-based rurill; or see or workshop that is led by des a group discussion, cally-relevant emergency for problem statements, or prepared questions e an emergency plan. ID's response to and on of all drills, tabletop plan, as needed. O2] HA must conduct exercises of plan at HA must do the following: e-scale exercise that is munity-based exercise is not | E | 039 | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | | 34G070 | B. WING | | | 7/24/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 447 PLEASANT ACRES DRIVE MOCKSVILLE, NC 27028 | • | |
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| E 039 | or man-made emergory plengaging in its next community-based of functional exercise from emergency event. (ii) Conduct an addition 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 disain (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 Conduct a paperworkshop at least and led by a facilitator and discussion, using a emergency scenario 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, the full-scale or functional graph (d)(2)(i) of this section at may include, but is not at may include, but is not at may include, facility-based for exercise or workshop that is an individual, facility-based for exercise or workshop that is and includes a group for exercise or workshop that is and includes a group for exercise or workshop that is and includes a group for exercise or workshop that is and includes a group for exercise or workshop that is and includes a group for exercise or workshop that is and includes a group for exercise or workshop that is and includes a group for exercise or hold maintain and drills, tabletop exercises, and and revise the HHA's needed. 360] DPO must conduct exercises by plan. The OPO must do the obased, tabletop exercise is | E 03 | 39 | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 34G070 | B. WING | | 07/24/2024 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 447 PLEASANT ACRES DRIVE MOCKSVILLE, NC 27028 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE COMPLETION | |
| E 039 | plan. If the OPO exp man-made emergency plan, engaging in its next if 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 Revercises to test the must do the following (i) Conduct a paper-least annually. A table discussion led by a folinically-relevant emof problem statemen prepared questions of emergency plan. (iii) Analyze the RNH maintain documentation and emergency ever emergency plan, as This STANDARD is Based on record reversible to conduct bier Emergency Prepared finding is: Review of the facility no evidence of a full-facility-based exercise. | o challenge an emergency eriences an actual natural or cy that requires activation of the OPO is exempt from equired testing exercise of the emergency event. It is response to and maintain tabletop exercises, and and revise the [RNHCI's and alan, as needed. 48]: NHCI must conduct emergency plan. The RNHCI is passed, tabletop exercise at etop exercise is a group acilitator, using a narrated, rergency scenario, and a set its, directed messages, or designed to challenge an ion of all tabletop exercises, and revise the RNHCI's needed. not met as evidenced by: riew and interview, the facility inial testing of the facility's dness Plan (EPP). The | E 039 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION IG | , , | ATE SURVEY OMPLETED |
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| | | 34G070 | B. WING _ | | | 07/24/2024 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 447 PLEASANT ACRES DRIVE MOCKSVILLE, NC 27028 | | |
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| E 039 | Continued From pag | ge 9 | E 0 | 39 | | |
| W 474 | exercise or mock dri MEAL SERVICES CFR(s): 483.480(b)(| | W 4 | 74 | | |
| | developmental level This STANDARD is Based on observati interview, the facility consistent with the o prescribed diets of 4 #6). The findings are A. The facility failed | not met as evidenced by: ons, record review, and failed to serve food in a form levelopmental levels and of 6 clients (#1, #2, #4 and e: to ensure the prescribed diet | | | | |
| | 5:20 PM revealed the portions, 3-ounce Pocup cole slaw, ½ greepudding, 8-ounce musupplement drink. Or revealed staff to service four halves to client one hundred percent observation revealed the posterior of the posterior in the posterior of th | group home on 7/23/24 at e dinner meal to be double ork BBQ sandwich on bun, ½ een beans, ½ cup banana ilk, 16-ounces of water, | | | | |
| | client #1. Continued following diet order f weight gain, ½-1-inc portions, Boost High meals, mix all meds | n 7/24/24 revealed a ent (NA) dated 11/27/23 for d review NA revealed the for client #1: low sodium, h consistency, double protein q hs, milk at all in applesauce, yogurt or c beverage such as juice with | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| NAME OF PR | ROVIDER OR SUPPLIER | | • | 4 | STREET ADDRESS, CITY, STATE, ZIP CODE 47 PLEASANT ACRES DRIVE MOCKSVILLE, NC 27028 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY 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 |
| W 474 | Observations of the saddition of 75ml of fr serve client #3 a who Continued observation on client #3's meal to the medically prescribed. Observation in the gray of fruit butter, 8-ound orange juice. Continuelient #3 to serve him turkey bacon. Further #3 consumes one hubreakfast meal. Subrevealed staff failed to 1/2-1-inch consistency. Record review on 7/2 Assessment (NA) da Continued review of the following: heart is calories) diet, 1/2 -1-ir 75ml BID with meals. C. The facility failed to for client #4. For example of the following is the fo | o ensure the prescribed diet mple: same dinner meal with the uit butter revealed staff to ble pork BBQ sandwich. On revealed client #3 to be depercent of his dinner meal. Prevealed staff failed to cut be 1/2-1-inch consistency as a coup home on 7/23/24 at 7:20 be akfast meal to be 3/4 cups of procession of milk and 8-ounces of prevealed observations revealed diself two slices of uncut be represented observation revealed client andred percent of his sequent observation or cut client #3's bacon to the represented a Nutritional the 10/04/21 for client #3. The NA for client #3 revealed the althy, weight loss (1800 and consistency, fruit butter (breakfast, supper). | W | 474 | | | |
| | AM revealed the brea | roup home on 7/24/24 at 7:20 akfast meal to be ¾ cups of pacon, ½ cup peaches, 75ml | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| W 474 | orange juice and Bod Continued observation reating bacon when s Subsequent observa client #4 to cut his backed review on 7/2 Assessment (NA) da Continue review of the following: weight pureed diet, may have bedtime snack. D. The facility failed the for client #6. For exacced Pork BBQ sandwich green beans, ½ cup milk, 16-ounces of w. Continued observations erve himself one whinto quarters and clie hundred percent of horevealed staff not to a meal to the ¼ inch processor orange juice. Continued observe orange juice. Continued observed the cups of cheese grits, peaches, 8-ounces or orange juice. Continued observed in the green beans, 1/2 cup milk, 16-ounces of w. Continued observation of the whinto quarters and clie hundred percent of horevealed staff not to a meal to the ½ inch processor orange juice. Continued observed in the green beans, 8-ounces or orange juice. Continued observed in the green beans, 8-ounces or orange juice. Continued observed in the green beans, 8-ounces or orange juice. Continued the green beans, 9-ounces or orange juice. | es of milk, 8-ounces of post Ensure supplement. One revealed client #4 to pose of uncut turkey bacon. Revealed client #4 began taff redirected him to stop. Revealed staff to assist acon that should be pureed. 124/24 revealed a Nutritional ted 09/27/22 for client #4. Revealed a gain (2000 + calories) re applesauce or yogurt with represented to be 3-ounce on bun, ½ cup cole slaw, ½ banana pudding, 8-ounce after and 4-ounce diet coke. One revealed client #6 to cole bun with pork BBQ cut not #6 to consume one is meal. Further observation assist client #6 in cutting his rescribed consistency. Toup home on 7/23/24 at the breakfast meal to be 3/4 turkey bacon, ½ cup finilk and 8-ounces of used observations revealed client revealed revealed client revealed revealed revealed client revealed revealed revealed revealed revealed revealed revealed revealed reve | W 47 | 4 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|---|---|-------------------------------|----------------------------|
| 34G070 | | | B. WING _ | | | 07/24/2024 | |
| NAME OF PROVIDER OR SUPPLIER PLEASANT ACRES | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 447 PLEASANT ACRES 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 | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| W 474 | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | W | PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI | | | |