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

| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | The same of the sa | CONSTRUCTION | | ATE SURVEY OMPLETED | |
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| AND FLAN OF | CONNECTION | | A. BUILDING | and the second s | | |
| | | 34G064 | B. WING | | | 12/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | TREET ADDRESS, CITY, STATE, ZIP COD 89 FAIRMONT DRIVE | E | |
| TWINBRO | OKS | | | IOCKSVILLE, NC 27028 | | |
| | DIMBAADY CT | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CO | RRECTION | (X5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | COMPLETION |
| E 039 | EP Testing Requirem CFR(s): 483.475(d)(3 | | E 039 | E 039 | | 8/11/24 |
| | §460.84(d)(2), §482. §483.475(d)(2), §484. §485.542(d)(2), §485. §485.920(d)(2), §496. *[For ASCs at §416.6] at §485.727, CMHCs at §491.12, and ESRD. (2) Testing. The [fact to test the emergency must do all of the following of the facility natural or man-made activation of the emergency of the following of the following of the following of the following of the emergency of th | Ill-scale exercise that is very 2 years; or nity-based exercise is not a facility-based functional ars; or yl experiences an actual e emergency that requires ergency plan, the [facility] is ing in its next required r individual, facility-based following the onset of the tional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is lowing: ale exercise that is or individual, facility-based or | | The Regional Administra in-service the Qualified F on completing Table top drills for Emergency Pre The Qualified Profession complete a full scale drill home and document it a the future, all table top a will be monitored through safety meetings. | Professional's and Mock paredness. will with the ccordingly. In mock drills | |
| LABORATOR | 11. | ise or workshop that is led by R/SUPPLIER REPRESENTATIVE'S SIGNATU | RĘ | TITLE | n | (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: 952779

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | NSTRUCTION | | ATE SURVEY MPLETED |
|---|--|---|---------------------|--|--------------------------------|----------------------------|
| | | 34G064 | B, WING | | | 06/12/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | 189 F | ETADDRESS, CITY, STATE, ZIP CO AIRMONT DRIVE CKSVILLE, NC 27028 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| E 039 | a facilitator and income a narrated, clinicall scenario, and a set directed messages designed to challer (iii) Analyze the [farmaintain document exercises, and emergencies, and emergencies to test the annually. The hospition of the hospition of the hospition of the hospition of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based opposite the year the exercise under parties conducted, that it to the following: (A) A second full-scommunity-based opposite the year the exercise; or (B) A mock disaste (C) A tabletop exercise | dudes a group discussion using y-relevant emergency of problem statements, or prepared questions age an emergency plan. Cility's] response to and lation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] pices that provide care in the ele hospice must conduct ele emergency plan at least pice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not at an individual facility based every 2 years; or experiences a natural or ency that requires activation of an the hospital is exempt from the required full scale exercise or individual in the ency event. Ititional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional | E 039 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A, BUILDI | TIPLE CONSTRUCTION | | ATE SURVEY OMPLETED |
|---|--|---|------------------------|--|------------------------------------|----------------------------|
| | | 34G064 | B. WING_ | | | 06/12/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN C X (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| E 039 | a narrated, clinicall scenario, and a set directed messages designed to challer (3) Testing for hosp care directly. The exercises to test th year. The hospice (i) Participate in an is community-based (A) When a community-based funct (B) If the hospice eman-made emergency pla engaging in its nex based or facility-based funct (II) Conduct an admay include, but is (A) A second full-scommunity-based exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercise; or (B) A mock disasted (C) A tabletop exercises, or prepending an emericial exercises, and emericial exercises. | y-relevant emergency is of problem statements, is, or prepared questions inge an emergency plan. Dices that provide inpatient thospice must conduct e emergency plan twice per must do the following: in annual full-scale exercise that dit; or unity-based exercise is not et an annual individual ional exercise; or experiences a natural or ency that requires activation of in, the hospice is exempt from et required full-scale community issed functional exercise of the emergency event. ditional annual exercise that in not limited to the following: scale exercise that is or a facility based functional er drill; or ercise or workshop led by a ides a group discussion using a relevant emergency scenario, em statements, directed hared questions designed to | E | 039 | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | NSTRUCTION | | TE SURVEY MPLETED | |
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| | | 34G064 | B. WING | | 0 | 6/12/2024 | |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFIC | Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION DATE | |
| E 039 | *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [I conduct exercises: twice per year. T do the following: (i) Participate in a is community-base (A) When a commaccessible, condu- facility-based fundations (B) If the [PRTF, actual natural or requires activatio [facility] is exemprequired full-scale facility-based fundationset of the emerical following: (A) A second full community-based functional exercise (B) A minute following: (C) A tableto led by a facilitate discussion, using emergency scene statements, direct questions design plan. (iii) Analyze maintain docume exercises, and exercises, and exercises. | A41.184(d), Hospitals at a sat §485.625(d):] PRTF, Hospital, CAH] must a to test the emergency plan the [PRTF, Hospital, CAH] must an annual full-scale exercise that a ted; or munity-based exercise is not act an annual individual, actional exercise; or thospital, CAH] experiences an annual emergency that an of the emergency plan, the attrone exercise following the argency event. In an [additional] annual exercise or unde, but is not limited to the exercise that is a dor individual, a facility-based se; or exercise or workshop that is a not includes a group a narrated, clinically-relevant ario, and a set of problem atted messages, or prepared the ded to challenge an emergency events and revise the ency plan, as needed. | E 039 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X: | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
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| AND PLAN O | FCORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED |
| | - | 34G064 | B. WING | | 06/12/2024 |
| NAME OF P | PROVIDER OR SUPPLIER | | 189 F | ET ADDRESS, CITY, STATE, ZIP CODE AIRMONT DRIVE CKSVILLE, NC 27028 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTING (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY) | D BE COMPLETION |
| E 039 | exercises to test the annually. The PACI following: (i) Participate in an is community-based (A) When a community-based function (B) If the PACE expressible, conduct facility-based functions are made emerged the emergency planengaging in its next based or individual exercise following the event. (ii) Conduct an years opposite the exercise under parties conducted that must be following: (A) A second full-scommunity-based of functional exercises: (B) A mock disasted: (C) A tabletop exercise a facilitator and including a narrated, conducted messages designed to challer (iii) Analyze the PAM maintain document exercises, and emergace: *[For LTC Facilities] | CE organization must conduct a emergency plan at least annual full-scale exercise that d; or mity-based exercise is not an annual individual, onal exercise; or veriences an actual natural or ney that requires activation of a required full-scale community facility-based functional the onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section lay include, but is not limited to cale exercise that is or individual, a facility based for ear drill; or reise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan. ACE's response to and lation of all drills, tabletop ergency events and revise the plan, as needed. | E 039 | | |

| | MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION LENGTH (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 34G064 | B. WING | 4 - 8 - 1000 (100 - | 06/12/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | 189 F | EET ADDRESS, CITY, STATE, ZIP CODE FAIRMONT DRIVE CKSVILLE, NC 27028 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION |
| E 039 | including unannounce emergency procedur ICF/IID] must do the (i) Participate in an a is community-based; (A) When a commun accessible, conduct a facility-based function (B) If the [LTC facility actual natural or mar requires activation of LTC facility is exemply required a full-scale individual, facility-based following the onset of (ii) Conduct an addit may include, but is in (A) A second full-scale community-based or functional exercise; (C) A tabletop exercise (C) A tabletop exe | plan at least twice per year, ed staff drills using the es. The [LTC facility, following: annual full-scale exercise that or ity-based exercise is not an annual individual, nal exercise. I facility experiences an an-made emergency that if the emergency plan, the trom engaging its next community-based or sed functional exercise if the emergency event. I ideal annual exercise that of limited to the following: ale exercise that is an individual, facility based or drill; or ise or workshop that is led by a group discussion, using a levant emergency scenario, statements, directed ed questions designed to ency plan. C facility] facility's response to entation of all drills, tabletop gency events, and revise the emergency plan, as needed. 3.475(d)]: IID must conduct exercises y plan at least twice per year. | E 039 | | |

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

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | INSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 34G064 | B. WING | | 06/12/2024 |
| NAME OF P | 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 YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETION |
| E 039 | is community-based; (A) When a commun accessible, conduct a facility-based function (B) If the ICF/IID exp man-made emergency the emergency plan, engaging in its next r community-based or functional exercise for emergency event. (ii) Conduct an additi may include, but is not an expensive to the emergency (C) A tabletop exercise a facilitator and inclu using a narrated, clin scenario, and a set of directed messages, of designed to challeng (iii) Analyze the ICF/I maintain documentate exercises, and emergical exercises, and emergical exercises, and emergical exercises. *[For HHAs at §484.* (d)(2) Testing. The H to test the emergency least annually. The H (i) Participate in a ful community-based; or (A) When a com- accessible, conduct | 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 equired full-scale individual, facility-based sollowing the onset of the onal annual exercise that of 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 tion of all drills, tabletop gency events, and revise the plan, as needed. 102] HA must conduct exercises y plan at IHA must do the following: l-scale exercise that is fununity-based exercise is not | E 039 | | |

Event ID; KJJJ11

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

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | | | TE SURVEY MPLETED |
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| | | 34G064 | B, WING | | | 6/12/2024 |
| NAME OF P | ROVIDER OR SUPPLIER DOKS | | 189 | EET ADDRESS, CITY, STATE, ZIP CO FAIRMONT DRIVE CKSVILLE, NC 27028 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| E 039 | (B) If the HHA or man-made emer of the emergency p engaging in its nex community-based of functional exercise emergency event. (ii) Conduct an add opposite the year to exercise under par is conducted, to limited to the follow (A) A second of community-based of functional exercise (B) A mock dis (C) A tabletop led by a facilitator of discussion, using a emergency scenar statements, directe questions designed plan. (iii) Analyze the HH documentation of a emergency events emergency plan, a *[For OPOs at §48 (d)(2) Testing. The to test the emergen following: (i) Conduct a pape workshop at least of discussion, using a emergency scenar | A experiences an actual natural regency that requires activation bian, the HHA is exempt from it required full-scale or individual, facility based following the onset of the litional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section that may include, but is not wing: full-scale exercise that is or an Individual, facility-based; or exercise or workshop that is and includes a group a narrated, clinically-relevant io, and a set of problem and messages, or prepared do to challenge an emergency that is the control of the control of the control of the control of the challenge and maintain all drills, tabletop exercises, and and revise the HHA's seneded. | E 039 | | | |

Event ID: KJJJ11

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCT A, BUILDING | | | | ATE SURVEY DMPLETED | | |
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| | | 34G064 | B. WING | | | 06/12/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 189 FAIRMONT DRIVE MOCKSVILLE, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION DATE |
| E 039 | questions designed plan. If the OPO exp man-made emerger the emergency plan engaging in its next following the onset of (ii) Analyze the OPO documentation of al emergency events, OPO's] emergency events, OPO's] emergency events (i) Conduct a paperleast annually. A tab discussion led by a clinically-relevant er of problem statemer prepared questions emergency plan. (ii) Analyze the RNI-maintain documenta and emergency eve emergency plan, as This STANDARD is Based on record refacility failed to concemergency prepared which effects all clie #4, #5 and #6). The Review of facility do revealed an EPP da review of the facility evidence of a full-so | to challenge an emergency periences an actual natural or ney that requires activation of , the OPO is exempt from required testing exercise of the emergency event. D's response to and maintain I tabletop exercises, and and revise the [RNHCl's and plan, as needed. 748]: RNHCl must conduct emergency plan. The RNHCl g: based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set nots, directed messages, or designed to challenge an HCl's response to and attion of all tabletop exercises, nots, and revise the RNHCl's needed. Into the tabletop exercises, not met as evidenced by: view and interviews, the duct exercises to test the dness plan (EPP) annually ints in the facility (#1, #2, #3, | E 038 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A, BUILDING _ | CONSTRUCTION | (X3) DATE SURV COMPLETE | |
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| | | 34G064 | B. WING | | 06/12/2 | 2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | 1: | TREET ADDRESS, CITY, STATE, ZIP CODE 89 FAIRMONT DRIVE IOCKSVILLE, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) MPLETION DATE |
| E 039 W 249 | Interview with the questional (QIDP) tabletop exercise was however, evidence of acility-based exercinot completed. Intermanager (PM) and a copy of the facility | ualified intellectual disabilities on 6/12/24 revealed a as completed on 3/5/24; of a full-scale community, se, or tabletop exercise was view with the program QIDP on 6/12/24 verified that tabletop, mock drill, and/or hould be stored in the ins plan manual. | E 039 | W 249 | 8/ | 11/24 |
| | formulated a client's each client must rec treatment program of interventions and se and frequency to su | disciplinary team has individual program plan, serve a continuous active consisting of needed ervices in sufficient number pport the achievement of the in the individual program | | The Qualified Professional will Inservice all staff on Client #1's programs. The clinical team will monitor through interaction assessments 2x a week for a pe of one month and then on a rout basis. In the future, the Qualified Professional will ensure all staff trained on the programs and need of People Supported. | ine I are | |
| | Based on observati interviews, the facility continuous active tree of needed interventification in the personal continuous active tree of needed in the personal continuous active tree in the personal continuous ac | not met as evidenced by: ons, record review and ty failed to ensure that a eatment program consisting ons were implemented as son-centered plan (PCP) for 1 (#1). The finding is: | | | | |
| | staff to prompt client prepare for dinner. Or revealed client #1 to and serve his plate: | 11/24 at 5:15 PM revealed t #1 to wash his hands and Continued observations o sit at the dining room table and participate in the dinner uring the observation did staff | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | LE CONSTRUCTION | | TE SURVEY MPLETED |
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| | | 34G064 | B, WING | | 1 0 | 6/12/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| W 249 | allow client #1 to p dinner meal. Review of the recodated 4/6/23 which the following programmed interview with the professional (QIDF of client #1's goals interview with the (PM) revealed that follow client #1's p level of independe PM and QIDP revelient #1's dinner (PROGRAM MONI CFR(s): 483.440(f) The committee should be committee of the protection at the opinion of the client protection at This STANDARD Based on observations the fact restrictive techniques reviewed annually (HRC) for 6 of 6 client protections through the period from 6/11/2 surrounding the gillowed annually the guide from 6/11/2 surrounding the gillowed and the guide from 6/11/2 surrounding the gillowed and the guide from 6/11/2 surrounding the gillowed annually the guide from 6/11/2 surrounding the guide fr | ord for client #1 revealed a PCP in indicated that the client has ram goals: exercise, wash his assigned task and prepare a err. qualified intellectual disabilities P) on 6/12/24 revealed that all is were current. Continued QIDP and program manager it staff have been trained to program goals to increase his ence, Further interview with the ealed staff should implement goal as prescribed. TORING & CHANGE (3)(i) ould review, approve, and programs designed to manage avior and other programs that, we committee, involve risks to and rights. is not met as evidenced by: ations, record review and illity failed to ensure that were monitored and by the human rights committee lients (#1, #2, #3, #4 #5 and | W 24 | | nts for all 6 Aualified I through I and Is top ensure I for In the I fessional will I ained from | 8/11/24 |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | Mary Mary and State of State o | CONSTRUCTION | | ATE SURVEY MPLETED |
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| | | 34G064 | B. WING | The second secon | | 06/12/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | 18 | REET ADDRESS, CITY, STATE, ZIP COD 19 FAIRMONT DRIVE OCKSVILLE, NC 27028 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | (X5) COMPLETION DATE |
| W 262 | revealed exterior of clients and surveyor group home. A. Review of client revealed a signed legal guardian for the door alarms. Continuous consents were reviewed a signed legal guardian for the door alarms. Continuous reviewed or approved. C. Review of client reveal a consent situation to the fence, carabine Continued reviewed or approved. Review of client revealed a signed legal guardian for the door alarms. Continuous consents were reviewed or alarms. Continuous as signed legal guardian for the door alarms. Continuous consents were reviewed a signed legal guardian for the door alarms. Continuous as signed legal guardian for the door alarms. Continuous as signed legal guardian for the door alarms. Continuous as signed legal guardian for the door alarms. Continuous as signed legal guardian for the door alarms. Continuous c | to 1's records on 6/12/24 consent dated 2/16/24 by the the fence, carabineer and exit nued review did not reveal iewed or approved by the HRC. 2's records on 6/12/24 consent dated 6/28/22 by the the fence, carabineer and exit nued review did not reveal iewed or approved by the HRC. | W 262 | | | |

| 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 | 1/12/2024 |
| NAME OF PROVIDER OR SUPPLIER TWINBROOKS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | | |
| (X4) ID PREFIX TAG | (EACH 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 APPROVIDERICIENCY) | D BE | (X5) COMPLETION DATE |
| W 262 | Continued From page | ge 12 | W 2 | 62 | | |
| W 263 | confirmed that update were not reviewed of Continued interview consent forms for a signed by the HRC PROGRAM MONIT CFR(s): 483.440(f)(The committee should are conducted only consent of the client minor) or legal guar This STANDARD is Based on observating interviews, the facility restrictive technique reviewed annually be clients (#3). The fine Cobservations througheriod from 6/11/24 surrounding the grosside gate entrance, revealed exterior declients and surveyor group home. Review of client 3's reveal a consent signed. | essional (QIDP) on 6/12/24 ated signed consent forms or signed by the HRC. A revealed HRC limitation Il clients will be updated and annually. ORING & CHANGE 3)(ii) uld insure that these programs with the written informed to parents (if the client is a dian. In our met as evidenced by: ions, record review and ty failed to ensure that as were monitored and by the legal guardian for 1 of 6 ding is: In our met as evidenced by: In our met as evidenced and by the legal guardian for 1 of 6 ding is: In our met as evidenced a fence up with a carabineer at the Continued observations for alarms to chime as staff, are entered and exited the In our met as evidenced the In our met as evidenced and It is a considered the conside | W 2 | W 263 Cross Reference W 263 | | 8/11/24 |
| | developmental profice confirmed that update | essional (QIDP) on 6/12/24 ated signed consent form for be located during the survey. | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| CENTER | S FUR MEDICARE | & MEDICAID SERVICES | | | OMB NO. 0938-0391 | |
|---|--|---|--|---|-------------------------------|--|
| 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 P | ROVIDER OR SUPPLIER | | S. | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| TWINBRO | OOKS | | | 89 FAIRMONT DRIVE IOCKSVILLE, NC 27028 | | |
| (V4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | over . | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| W 263 | Continued From page 13 | | W 263 | | | |
| W 474 | Continued interview forms for all clients the legal guardian | w revealed limitation consent will be updated and signed by | W 474 | | | |
| VV 4/4 | CFR(s): 483.480(b)(2)(iii) | | VV 4/4 | W474 | 8/11/24 | |
| | Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure food consistency was served in a form according to the developmental level of 1 of 6 clients (#4). The finding is: Observations on 6/12/24 at 7:20 AM revealed client #4 to wash his hands and transition to the table to prepare for the breakfast meal. The breakfast meal consisted of a toasted bagel cut in half, cream cheese, orange juice, milk, blueberries and strawberries. Continued observations revealed staff to place two half pieces of bagel onto client #4's plate. Further observations revealed client #4 to consume the | | | The Qualified Professional will in-service all staff on Client #4's corder and consistency. The clinic team will monitor through meal assessments 2x a week for a per of one month and then on a routi basis. In the future, the Qualified Professional will ensure all staff a trained on diet orders and consistencies. | iod ne | |
| | observation did sta 1" pieces as presci Review of the reco revealed a PCP da that the client musi due to a history of the record for clien order dated 6/3/24 must have a regula | At no point during the aff cut client #4's bagel into ½" - ribed. and for client #4 on 6/12/24 ated 12/21/23 which indicated thave ½" - 1" diet consistency seizures. Continued review of at #4 revealed a physician's which indicated that the client ar diet, with ½" - 1" consistency. qualified intellectual disabilities P) and program manager (PM) | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--|--|-------------------|--|
| | | A. BUILDING | A CONTRACTOR OF THE CONTRACTOR | | | |
| | | 34G064 | B. WING | | 06/12/2024 | |
| NAME OF P | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE COMPLETION | |
| W 474 | on 6/12/24 revealed to follow client #4's Continued interview verified that client # Further interview wi | ge 14 I that staff have been trained diet consistency as ordered. I with the PM and QIDP I's prescribed diet is current, the the PM revealed that all clients' diet consistency as | W 474 | | | |