DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OI	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	`́сом	E SURVEY PLETED
		34G175	B. WING			R 08/12/2024	
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	Y 117 GROUP HOME			38	801 US 117 NORTH		
				G	OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	CFR(s): 483.475(d)	)(2)	{E 03	39}			
	§460.84(d)(2), §482 §483.475(d)(2), §48 §485.542(d)(2), §48	3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.68(d)(2), 35.625(d)(2), §485.727(d)(2), 91.12(d)(2), §494.62(d)(2).					
	at §485.542, OPO, §485.727, CMHCs	.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]:					
		cility] must conduct exercises icy plan annually. The [facility] bllowing:					
	community-based e (A) When a comm accessible, conduct exercise every 2 ye (B) If the [facilit	unity-based exercise is not t a facility-based functional					
	activation of the em exempt from engag community-based of functional exercise actual event.	ergency plan, the [facility] is jing in its next required or individual, facility-based following the onset of the itional exercise at least every 2					
	years, opposite the functional exercise this section is cond not limited to the fo	year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing:					
	functional exercise; (B) A mock disaster	or individual, facility-based or					
	. , .	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE

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

(X6) DATE

PRINTED: 08/12/2024

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		34G175	B. WING				R 12/2024
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				3801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (iii) Analyze the [fac maintain documenta exercises, and emer [facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based e (A) When a commu accessible, conduct functional exercise (B) If the hospice ex- man-made emergen the emergency plan engaging in its next community-based function onset of the emerged (ii) Conduct an add opposite the year the exercise under para is conducted, that n to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaster (C) A tabletop exer	udes a group discussion using <i>A</i> -relevant emergency of problem statements, or prepared questions ge an emergency plan. ility's] response to and ation of all drills, tabletop regency events, and revise the ey plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least ice must do the following: ull-scale exercise that is every 2 years; or unity based exercise is not an individual facility based every 2 years; or compare a natural or ncy that requires activation of a, the hospital is exempt from required full scale exercise or individual onal exercise following the ency event. litional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited cale exercise that is or a facility based functional	{E 03	39}			

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		AND HUMAN SERVICES				FORM	08/12/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		34G175	B. WING			R 08/12/2024	
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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}	a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The f exercises to test the year. The hospice (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functi (B) If the hospice ex- man-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an ador may include, but is (A) A second full-se community-based of exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the hos- maintain document	y-relevant emergency of problem statements, , or prepared questions age an emergency plan. bices that provide inpatient hospice must conduct e emergency plan twice per must do the following: a annual full-scale exercise that d; or unity-based exercise is not t an annual individual onal exercise; or xperiences a natural or ncy that requires activation of n, the hospice is exempt from t required full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or rcise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the	{E 0;	39}			

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		AND HUMAN SERVICES				FORM	08/12/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G175	B. WING			R 08/12/2024	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				3801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	*[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF conduct exercises to twice per year. The do the following: (i) Participate in an is community-based (A) When a community-based (A) When a community-based facility-based function (B) If the [PRTF, Hot actual natural or mare requires activation of [facility] is exempt for required full-scale of facility-based function onset of the emerge (ii) Conduct an and that may includ following: (A) A second full-scale of functional exercise; (B) A mock (C) A tabletop energe led by a facilitator at discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the maintain documents	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must a annual full-scale exercise that d; or unity-based exercise is not t an annual individual, ional exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, ional exercise following the ency event. [additional] annual exercise or de, but is not limited to the cale exercise that is or individual, a facility-based ; or disaster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared t to challenge an emergency e [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	{E 0:	39}			

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		AND HUMAN SERVICES				FORM	08/12/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G175	B. WING	·		R 08/12/2024	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				3801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	<ul> <li>(2) Testing. The PAR exercises to test the annually. The PACE following:</li> <li>(i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the PACE exp man-made emerged the emergency plane engaging in its next based or individual, exercise following the event.</li> <li>(ii) Conduct an years opposite the years is conducted that may the following:</li> <li>(A) A second full-sec community-based of functional exercise;</li> <li>(B) A mock disasted (C) A tabletop exer a facilitator and inclusing a narrated, cli scenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain documenta exercises, and eme PACE's emergency</li> </ul>	CE organization must conduct e emergency plan at least E organization must do the annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or periences an actual natural or ncy that requires activation of n, the PACE is exempt from required full-scale community facility-based functional he onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited to cale exercise that is or individual, a facility based or er drill; or rcise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, , or prepared questions ge an emergency plan. .CE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed.	{E 0	39}			

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		AND HUMAN SERVICES				FORM	08/12/2024 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		34G175	B. WING	i			२ 12/2024	
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
HIGHWA	Y 117 GROUP HOME				3801 US 117 NORTH GOLDSBORO, NC 27530			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
{E 039}	test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the [LTC facility actual natural or marequires activation of LTC facility is exem- requires activation of LTC facility is exem- required a full-scale individual, facility-ba- following the onset of (ii) Conduct an add may include, but is an (A) A second full-scale individual, facility-ba- following the onset of (iii) Conduct an add may include, but is an (A) A second full-scale community-based of functional exercise; (B) A mock disaste (C) A tabletop exer- a facilitator includes narrated, clinically-r- and a set of problem messages, or prepar- challenge an emerg (iii) Analyze the [LT and maintain docum exercises, and eme [LTC facility] facility' *[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergen The ICF/IID must do	<ul> <li>plan at least twice per year, need staff drills using the ures. The [LTC facility, e following:</li> <li>annual full-scale exercise that d; or</li> <li>unity-based exercise is not t an annual individual, onal exercise.</li> <li>ty] facility experiences an an-made emergency that of the emergency plan, the of the emergency plan, the of the emergency event.</li> <li>ditional annual exercise that not limited to the following:</li> <li>cale exercise that is or an individual, facility based for er drill; or</li> <li>rcise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan.</li> <li>C facility] facility's response to nentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed.</li> <li>83.475(d)]:</li> <li>F/IID must conduct exercises of year.</li> </ul>	{E 0	39}	<pre>}</pre>			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G175	B. WING			R 08/12/2024	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				3801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	is community-based (A) When a community- accessible, conduct facility-based function (B) If the ICF/IID ex- man-made emerged the emergency plane engaging in its next community-based of functional exercises emergency event. (ii) Conduct an addi may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exerce a facilitator and inclusing a narrated, clis scenario, and a set directed messages, designed to challen (iii) Analyze the ICF maintain documenta exercises, and emer ICF/IID's emergence *[For HHAs at §484 (d)(2) Testing. The to test the emergen least annually. The (i) Participate in a fu community-based; of (A) When a cor accessible, conduct	d; or nity-based exercise is not an annual individual, onal exercise; or. periences an actual natural or ncy that requires activation of a, the ICF/IID is exempt from required full-scale r individual, facility-based following the onset of the tional annual exercise that not limited to the following: ale exercise that is r an individual, facility-based or t drill; or cise or workshop that is led by udes a group discussion, nically-relevant emergency of problem statements, or prepared questions ge an emergency plan. /IID's response to and ation of all drills, tabletop rgency events, and revise the y plan, as needed. .102] HHA must conduct exercises cy plan at HHA must do the following: Ill-scale exercise that is	{E 03	39}			

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		AND HUMAN SERVICES				FORM	08/12/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		34G175	B. WING				≺ 12/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	<ul> <li>(B) If the HHA or man-made emery of the emergency pengaging in its next community-based of functional exercise emergency event.</li> <li>(ii) Conduct an addi opposite the year the exercise under para is conducted, that limited to the followin (A) A second functional exercise;</li> <li>(B) A mock disa (C) A tabletop eled by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan.</li> <li>(iii) Analyze the HHA documentation of a emergency plan, as</li> <li>*[For OPOs at §486 (d)(2) Testing. The following:</li> <li>(i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenario following:</li> </ul>	experiences an actual natural gency that requires activation lan, the HHA is exempt from required full-scale or individual, facility based following the onset of the itional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section it may include, but is not ing: Ill-scale exercise that is or an individual, facility-based or aster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared t o challenge an emergency A's response to and maintain II drills, tabletop exercises, and and revise the HHA's s needed.	{E 0	39}			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/12/2024 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		34G175	B. WING				< 12/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHWA	Y 117 GROUP HOME				801 US 117 NORTH GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 039}	questions designed plan. If the OPO ex man-made emerge the emergency plan engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[ RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followin (i) Conduct a paper least annually. A tak discussion led by a clinically-relevant en of problem stateme prepared questions emergency plan. (ii) Analyze the RNI maintain document and emergency even	to challenge an emergency periences an actual natural or ncy that requires activation of n, the OPO is exempt from a required testing exercise of the emergency event. D's response to and maintain Il tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: -based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set onts, directed messages, or designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's	{E 0:	39}			
W 000	INITIAL COMMENT	ſS	W 0	00			
{W 159}	level deficiencies pr 6/25/24. The condit been corrected. A s conducted for stand during the recertific	-	{W 1	59}			

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		AND HUMAN SERVICES					FORM	08/12/2024 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	TIPLE CON	STRUCTION		(X3) DATE SURVEY COMPLETED		
		34G175	B. WING			_	R 08/12/2024		
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STA	TE, ZIP CODE			
HIGHWA	Y 117 GROUP HOME				5 117 NORTH BORO, NC 2753	0			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVI CROSS-REFERENCED		BE	(X5) COMPLETION DATE	
{W 159}	Continued From pa	ge 9	{W 1	59}					
	integrated, coordina qualified intellectua	treatment program must be ated and monitored by a I disability professional who- s not met as evidenced by:							
{W 288}	MGMT OF INAPPF BEHAVIOR CFR(s): 483.450(b)		{W 28	38}					
	behavior must neve an active treatment	age inappropriate client er be used as a substitute for program. s not met as evidenced by:							
{W 436}	SPACE AND EQUI CFR(s): 483.470(g)		{W 4:	36}					
	and teach clients to choices about the u hearing and other of and other devices in interdisciplinary tea	rnish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces, dentified by the m as needed by the client. s not met as evidenced by:							
{W 460}	FOOD AND NUTR CFR(s): 483.480(a)		{W 40	60}					
	Each client must re well-balanced diet i specially-prescribed	ncluding modified and							
	This STANDARD i	s not met as evidenced by:							

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