PRINTED: 08/23/2024 FORM APPROVED OMB NO. 0938-0391

| - | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | LE CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
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| | | 240004 | | | | | R |
| | | 34G064 | B. WING | | | 08/ | 22/2024 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| TWINBRO | UKS | | | | 189 FAIRMONT DRIVE | | |
| IVIIII | ONO | | | | MOCKSVILLE, NC 27028 | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PRÉFIX | • | Y MUST BE PRECEDED BY FULL | PREFI | | (EACH CORRECTIVE ACTION SHOULD B | | COMPLETION DATE |
| TAG | REGULATORY OR L | LSC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | AIE. | DATE |
| | | | | | , , , , , , , , , , , , , , , , , , , | | |
| | | | | | | | |
| {E 039} | | | {E 0 |)39 | 9} | | |
| | CFR(s): 483.475(d)(2 | 2) | | | | | |
| | 0440 54(-1)(0) 0440 4 | 14.0(-1)(0) | | | | | |
| | | 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), | | | | | |
| | 9405.920(u)(2), 9491. | .12(d)(2), §494.62(d)(2). | | | | | |
| | *[For ASCs at 8/16 5/ | 4, CORFs at §485.68, REHs | | | | | |
| | at §485.542, OPO, "C | • | | | | | |
| | | §485.920, RHCs/FQHCs at | | | | | |
| | §491.12, and ESRD F | - | | | | | |
| | 3-01.12, and LOND 1 | uomites at 3+5+.02]. | | | | | |
| | (2) Testing. The Ifacili | ity] must conduct exercises | | | | | |
| | | plan annually. The [facility] | | | | | |
| | must do all of the follo | | | | | | |
| | | 3 | | | | | |
| | (i) Participate in a full- | -scale exercise that is | | | | | |
| | community-based eve | ery 2 years; or | | | | | |
| | | ity-based exercise is not | | | | | |
| | accessible, conduct a | ı facility-based functional | | | | | |
| | exercise every 2 year | | | | | | |
| | · | experiences an actual | | | | | |
| | | emergency that requires | | | | | |
| | | gency plan, the [facility] is | | | | | |
| | exempt from engaging | • | | | | | |
| | | individual, facility-based | | | | | |
| | | llowing the onset of the | | | | | |
| | actual event. | and eversion at least aver a | | | | | |
| | , , | onal exercise at least every 2 | | | | | |
| | years, opposite the ye | ear the full-scale or nder paragraph (d)(2)(i) of | | | | | |
| | | ted, that may include, but is | | | | | |
| | not limited to the follo | | | | | | |
| | (A) A second full-scale | • | | | | | |
| | | individual, facility-based | | | | | |
| | functional exercise; or | • | | | | | |
| | (B) A mock disaster d | | | | | | |
| | , , | se or workshop that is led by | | | | | |
| LABORATORY | , , | SUPPLIER REPRESENTATIVE'S SIGNATUR | <u> </u> | | TITI F | | (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.

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | IPLE CONSTRUCTION NG | | (X3) DATE COMP | LETED |
|--------------------------|---|---|--------------------|--|--|-------------------|----------------------------|
| | | 34G064 | B. WING | | | | ⋜ 22/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, C 189 FAIRMONT DRI' MOCKSVILLE, NO | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH (| VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BI EFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {E 039} | a narrated, clinically-scenario, and a set or directed messages, or designed to challenge (iii) Analyze the [facility maintain documentate exercises, and emerge [facility's] emergency *[For Hospices at 418 (2) Testing for hospice patient's home. The exercises to test the exanually. The hospice (i) Participate in a full community based ever (A) When a community accessible, conduct a functional exercise expended emergency plan, engaging in its next recommunity-based exercise of the emergency plan, engaging in its next recommunity-based function onset of the emergency (ii) Conduct an addition opposite the year the exercise under parage is conducted, that may to the following: (A) A second full-scar community-based or exercise; or (B) A mock disaster (C) A tabletop exercise | des a group discussion using relevant emergency for problem statements, or prepared questions an emergency plan. Ity's] response to and iton of all drills, tabletop gency events, and revise the plan, as needed. 3.113(d):] The state provide care in the chospice must conduct emergency plan at least emergency plan at least emust do the following: I-scale exercise that is ery 2 years; or ty based exercise is not an individual facility based very 2 years; or eriences a natural or experiences a natural or experience and individual facility based exercise or individual facility based functional raph (d)(2)(i) of this section by include, but is not limited a facility based functional | {E 0 | 39} | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 34G064 | B. WING | | | l | R 22/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | 1 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/ | 22/2024 |
| TWINDDO | .o.vo | | | | 189 FAIRMONT DRIVE | | |
| TWINBRO | OKS | | | | MOCKSVILLE, NC 27028 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B 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 man-made emergency plan, the emergency plan is not considered to the emergency plan in the exercise; or (B) A mock disaster of (C) A tabletop exercise; and a set of problem is messages, or prepare challenge an emergency plan in the problem is messages, or prepare challenge an emergency plan in the problem is messages, or prepare challenge an emergency plan in the problem is messages, or prepare challenge an emergency plan in the problem is messages, or prepare challenge an emergency plan in the problem is messages, or prepare challenge an emergency plan in the problem is messages. | elevant emergency i problem statements, r prepared questions e an emergency plan. es that provide inpatient spice must conduct emergency plan twice per just do the following: nnual full-scale exercise that or ty-based exercise is not n annual individual al exercise; or eriences a natural or y that requires activation of the hospice is exempt from equired full-scale community d functional exercise the emergency event. onal annual exercise that of limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a se a group discussion using a evant emergency scenario, estatements, directed ed questions designed to ncy plan. ice's response to and on of all drills, tabletop ency events and revise the | {E C | 039 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | ' ' | OMPLETED |
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| | | 34G064 | B. WING_ | | | R 08/22/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | <u> </u> | 00/22/2024 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| {E 039} | §482.15(d), CAHs a (2) Testing. The [PR conduct exercises to twice per year. The do the following: (i) Participate in an is community-based (A) When a commun accessible, conduct facility-based function (B) If the [PRTF, Ho actual natural or ma requires activation of [facility] is exempt for required full-scale of facility-based function onset of the emerge (ii) Conduct an and that may include following: (A) A second full-so community-based of functional exercise; (B) A mock (C) A tabletop el led by a facilitator ar discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the maintain documenta | .184(d), Hospitals at t §485.625(d):] TF, Hospital, CAH] must to test the emergency plan [PRTF, Hospital, CAH] must annual full-scale exercise that is or nity-based exercise is not an annual individual, anal exercise; or spital, CAH] experiences an in-made emergency that if the emergency plan, the form engaging in its next formunity based or individual, anal exercise following the noty event. [additional] annual exercise or e, but is not limited to the ale exercise that is individual, a facility-based for disaster drill; or exercise or workshop that is not includes a group narrated, clinically-relevant in and a set of problem messages, or prepared to challenge an emergency [facility's] response to and tion of all drills, tabletop igency events and revise the interpretation of an ended. | {E 03 | 9} | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 1 | TIPLE CONSTRUCTION NG | | X3) DATE SURVEY COMPLETED |
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| | | 34G064 | B. WING _ | | | R 08/22/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | jE | OO/LL/LOL4 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| {E 039} | (2) Testing. The PACI exercises to test the eannually. The PACE of following: (i) Participate in an a is community-based; (A) When a community accessible, conduct a facility-based function (B) If the PACE experiment and emergency plan, engaging in its next rebased or individual, factorise following the event. (ii) Conduct an any exercise under paraging is conducted that may the following: (A) A second full-scat community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and including a narrated, clinificated messages, of designed to challenge (iii) Analyze the PAC maintain documentating exercises, and emerging PACE's emergency participated in the pace of the pa | E organization must conduct emergency plan at least organization must do the innual full-scale exercise that or ty-based exercise is not in annual individual, all exercise; or iences an actual natural or y that requires activation of the PACE is exempt from equired full-scale community acility-based functional onset of the emergency diditional exercise every 2 are the full-scale or functional raph (d)(2)(i) of this section include, but is not limited to the exercise that is individual, a facility based of dirill; or see or workshop that is led by les a group discussion, cally-relevant emergency is problem statements, in prepared questions an emergency plan. E's response to and on of all drills, tabletop ency events and revise the fan, as needed. | {E 0 | 39} | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | DING (X3) DATE SURVE COMPLETED | | COMPLETED |
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| | | 34G064 | B. WING_ | | | R 08/22/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | | 00/22/2024 |
| (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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| {E 039} | including unannounce mergency procedu 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 ma requires activation of LTC facility is exempled individual, facility-based individual, facility-based following the onset of (ii) Conduct an addinay include, but is reported in the community-based of functional exercises; (B) A mock disaster (C) A tabletop exercise a facilitator includes narrated, clinically-reand a set of problem messages, or prepare challenge an emerg (iii) Analyze the [LT and maintain documexercises, and emerg [LTC facility] facility's and the incommunity facility facili | plan at least twice per year, bed staff drills using the res. The [LTC facility, following: annual full-scale exercise that ; or nity-based exercise is not an annual individual, anal exercise. by facility experiences an in-made emergency that for the emergency plan, the outfrom engaging its next community-based or sed functional exercise of the emergency event. It tional annual exercise that not limited to the following: ale exercise that is rean individual, facility based or drill; or cise or workshop that is led by a group discussion, using a elevant emergency scenario, in statements, directed red questions designed to ency plan. C facility] facility's response to be entation of all drills, tabletop regency events, and revise the seemergency plan, as needed. 33.475(d)]: VIID must conduct exercises by plan at least twice per year. | {E 03 | 39} | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | E CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | | 34G064 | B. WING | | | | ⋜ 22/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 89 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | <u> U6//</u> | 22/2024 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {E 039} | accessible, conduct a facility-based function (B) If the ICF/IID expense man-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 allowing the onset of the conal annual exercise that but limited to the following: e exercise that is an individual, facility-based or rill; or see or workshop that is led by des a group discussion, cally-relevant emergency of problem statements, or prepared questions e an emergency plan. ID's response to and on of all drills, tabletop plan, as needed. 102] 114A must conduct exercises of plan at the must do the following: e-scale exercise is not individual; and the plan, as more described in the plan at the must do the following: e-scale exercise is not individual. | {E C | 039} | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | FIPLE CONSTRUCTION NG | | DATE SURVEY COMPLETED |
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| | | 34G064 | B. WING_ | | | R 08/22/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | DDE | 00/22/2024 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| {E 039} | or man-made emergof the emergency plengaging in its next community-based of functional exercise 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 disaid (C) A tabletop of led by a facilitator and discussion, using an emergency scenarios 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 contest the emergency workshop at least and led by a facilitator and discussion, using an emergency scenarior discussion and discussion and discussion and discussion and discussion are discussion. | experiences an actual natural gency that requires activation an, the HHA is exempt from required full-scale r individual, facility based following the onset of the stional exercise every 2 years, e full-scale or functional graph (d)(2)(i) of this section at may include, but is not ng: Ill-scale exercise that is r an individual, facility-based or exercise or workshop that is not includes a group narrated, clinically-relevant or, and a set of problem it messages, or prepared to challenge an emergency A's response to and maintain it drills, tabletop exercises, and and revise the HHA's needed. 360] DPO must conduct exercises cy plan. The OPO must do the chased, tabletop exercise is | {E 0 | 39} | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | ' ' | ATE SURVEY OMPLETED |
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| | | 34G064 | B. WING _ | | | R 08/22/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | | 00/22/2024 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| {E 039} | plan. If the OPO expman-made emerger the emergency plan engaging in its next following the onset of (ii) Analyze the OPO documentation of all emergency events, OPO's] emergency exercises to test the must do the followin (i) Conduct a paperleast annually. A tab discussion led by a clinically-relevant er of problem statemer prepared questions emergency plan. (ii) Analyze the RNH 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 act that requires activation of the OPO is exempt from required testing exercise of the emergency event. O's response to and maintain tabletop exercises, and and revise the [RNHCI's and tolan, as needed. 248]: RNHCI must conduct emergency plan. The RNHCI g: based, tabletop exercise at alletop exercise is a group facilitator, using a narrated, pergency scenario, and a set at alletop exercise is a group facilitator of all tabletop exercises, and and revise the RNHCI's needed. 161's response to and a tion of all tabletop exercises, and revise the RNHCI's needed. 178 not met as evidenced by: 179 view and interviews, the auct exercises to test the diness plan (EPP) annually ants in the facility (#1, #2, #3, | {E 03 | | | |

PRINTED: 08/23/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | IPLE CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
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| | | 34G064 | B. WING _ | | | | R 22/2024 |
| NAME OF PE | ROVIDER OR SUPPLIER | | 1 | STREET ADDRESS, CITY, STATE, 2 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | ZIP CODE | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD I | | | (X5) COMPLETION DATE |
| (E 039) W 000 | professional (QIDP) of tabletop exercise was however, evidence of facility-based exercise not completed. Interv manager (PM) and Q a copy of the facility to full-scale exercise she emergency operation. A revisit survey was of 2024 for deficiencies. The deficiencies were documentation was not terms of the plan of complete | alified intellectual disabilities on 6/12/24 revealed a scompleted on 3/5/24; fa full-scale community, e, or tabletop exercise was iew with the program IDP on 6/12/24 verified that abletop, mock drill, and/or ould be stored in the splan manual. completed on August 22, cited on June 12, 2024. e not corrected and ot provided according to the orrection (POC) submitted. e re-cited. ted on August 22, 2024 for ies cited on June 12, 2024. e not corrected and ot available according to the ction (POC) that was encies will be re-cited. ENTATION) isciplinary team has ndividual program plan, ive a continuous active | {W 2 | 000 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | TIPLE CONSTRUCTION | | OATE SURVEY OMPLETED |
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| | | 34G064 | B. WING _ | | | R 08/22/2024 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | • | 00/22/2024 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| {W 249} | Continued From page | ge 10 | {W 2 | 49} | | |
| | Based on observatinterviews, the facilicontinuous active trof needed interventidentified in the persof 3 sampled clients. Observations on 6/2 staff to prompt client prepare for dinner. The revealed client #1 to and serve his plate meal. At no point duallow client #1 to predinner meal. Review of the recordated 4/6/23 which the following program. | s not met as evidenced by: ions, record review and ty failed to ensure that a eatment program consisting ions were implemented as son-centered plan (PCP) for 1 s (#1). The finding is: 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 epare a beverage for the d for client #1 revealed a PCP indicated that the client has m goals: exercise, wash his esigned task and prepare a | | | | |
| | professional (QIDP) of client #1's goals of client #1's goals of interview with the Q (PM) revealed that is follow client #1's professed of independen PM and QIDP reveation #1's dinner goal A revisit was conducted previous deficiencied deficiency was not of was not provided as | ualified intellectual disabilities on 6/12/24 revealed that all were current. Continued IDP and program manager staff have been trained to ogram goals to increase his ce. Further interview with the aled staff should implement oal as prescribed. cted on August 22, 2024 for all as cited on June 12, 2024. The corrected and documentation is referenced in the facility's POC). The deficiency will be | | | | |

| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | | (X3) DATE S | ETED . |
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| | 34G064 | B. WING | | | 22/2024 |
| | | | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | 1 00.2 | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SH | OULD BE | (X5) COMPLETION DATE |
| | e 11 | {W 24 | 9} | | |
| PROGRAM MONITO | | {W 262 | 2} | | |
| monitor individual pro- inappropriate behavior in the opinion of the o- client protection and This STANDARD is a Based on observation interviews, the facility restrictive techniques reviewed annually by (HRC) for 6 of 6 client | ograms designed to manage or and other programs that, committee, involve risks to rights. not met as evidenced by: ons, record review and railed to ensure that is were monitored and the human rights committee ats (#1, #2, #3, #4 #5 and | | | | |
| period from 6/11/24 - surrounding the grou side gate entrance. C revealed exterior doo | 6/12/24 revealed a fence p with a carabineer at the Continued observations or alarms to chime as staff, | | | | |
| revealed a signed co legal guardian for the door alarms. Continu | nsent dated 2/16/24 by the fence, carabineer and exit ed review did not reveal | | | | |
| revealed a signed co legal guardian for the door alarms. Continu consents were review | nsent dated 6/28/22 by the fence, carabineer and exit ed review did not reveal ved or approved by the HRC. | | | | |
| | Continued From page re-cited. PROGRAM MONITO CFR(s): 483.440(f)(3) The committee should monitor individual profinappropriate behavior in the opinion of the colient protection and This STANDARD is Based on observation interviews, the facility restrictive techniques reviewed annually by (HRC) for 6 of 6 client #6). The findings are Observations through period from 6/11/24 - surrounding the grous side gate entrance. Or revealed exterior doc clients and surveyors group home. A. Review of client 1 revealed a signed collegal guardian for the door alarms. Continuations were review B. Review of client 2 revealed a signed collegal guardian for the door alarms. Continuations were review consents were review to the door alarms. Continuations were review to the door alarms were review to the door alarms. Continuations were review to the door alarms were review to the door alarms. Continuations were review to the door alarms were review to the door alarms. | AGORECTION 34G064 ROVIDER OR SUPPLIER OKS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 re-cited. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of 6 clients (#1, #2, #3, #4 #5 and #6). The findings are: Observations throughout the recertification survey period from 6/11/24 - 6/12/24 revealed a fence surrounding the group with a carabineer at the side gate entrance. Continued observations revealed exterior door alarms to chime as staff, clients and surveyors entered and exited the | ROVIDER OR SUPPLIER OKS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 re-cited. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of 6 clients (#1, #2, #3, #4 #5 and #6). 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PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(f) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of 6 clients (#1, #2, #3, #4 #5 and #6). The findings are: Observations throughout the recertification survey period from 6/11/24 - 6/12/24 revealed a fence surrounding the group with a carabineer at the side gate entrance. Continued observations revealed exterior door alarms to chime as staff, clients and surveyors entered and exited the group home. A. 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Continued review did not reveal consents were reviewed or approved by the HRC. |

| | | | | | (X3) DATE SURVEY COMPLETED | |
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| | 34G064 | B WING | | | R | |
| NAME OF PROVIDER OR SUPPLIER TWINBROOKS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | | 08/22/2024 | |
| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI) TAG | X (EACH CORRECTIVE ACTION S | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| reveal a consent sign the fence, carabineer Continued review did reviewed or approved. D. Review of client 4's revealed a signed cor legal guardian for the door alarms. Continue consents were review. E. Review of client 5's revealed a signed cor legal guardian for the door alarms. Continue consents were review. F. Review of client 6's revealed a signed cor legal guardian for the door alarms. Continue consents were review. Interview with the quadevelopmental profess confirmed that update were not reviewed or Continued interview reconsent forms for all consents was conducted as a revisit was conducted previous deficiencies deficiency was not cowas not provided as replan of correction (PC) re-cited. | ed by the legal guardian for and exit door alarms. not reveal consents were by HRC. Is records on 6/12/24 Insent dated 10/6/23 by the fence, carabineer and exit ed review did not reveal red or approved by the HRC. Is records on 6/12/24 Insent dated 5/3/24 by the fence, carabineer and exit ed review did not reveal red or approved by the HRC. Is records on 6/12/24 Insent dated 5/3/24 by the fence, carabineer and exit ed review did not reveal red or approved by the HRC. Is records on 6/12/24 Insent dated 11/23/23 by the fence, carabineer and exit ed review did not reveal red or approved by the HRC. Idified intellectual sional (QIDP) on 6/12/24 Indicated on June 12/24 Indicated HRC limitation clients will be updated and invally. Indicated on June 12, 2024 for all cited on June 12, 2024. The receted and documentation eferenced in the facility's occorrect of the process of the facility's occorrect of the facility's occorrect of the facility's occorrect of the facility is occorrect on the facility's occorrect of the facility is occorrect on the | | | | | |
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| | CONTINUED CONTINUED CONSENSE SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTORY OR LETTO | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 reveal a consent signed by the legal guardian for the fence, carabineer and exit door alarms. Continued review did not reveal consents were reviewed or approved by HRC. D. Review of client 4's records on 6/12/24 revealed a signed consent dated 10/6/23 by the legal guardian for the fence, carabineer and exit door alarms. Continued reviewed or approved by the HRC. E. Review of client 5's records on 6/12/24 revealed a signed consent dated 5/3/24 by the legal guardian for the fence, carabineer and exit door alarms. Continued review did not reveal consents were reviewed or approved by the HRC. E. Review of client 5's records on 6/12/24 revealed a signed consent dated 5/3/24 by the legal guardian for the fence, carabineer and exit door alarms. 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WING ROVIDER OR SUPPLIER OKS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 reveal a consent signed by the legal guardian for the fence, carabineer and exit door alarms. Continued review did not reveal consents were reviewed or approved by HRC. D. Review of client 4's records on 6/12/24 revealed a signed consent dated 10/6/23 by the legal guardian for the fence, carabineer and exit door alarms. Continued review did not reveal consents were reviewed or approved by the HRC. E. Review of client 5's records on 6/12/24 revealed a signed consent dated 5/3/24 by the legal guardian for the fence, carabineer and exit door alarms. Continued review did not reveal consents were reviewed or approved by the HRC. F. Review of client 6's records on 6/12/24 revealed a signed consent dated 11/23/23 by the legal guardian for the fence, carabineer and exit door alarms. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 19 FARMONT DRIVE MOCKSVILLE, NC 27028 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFINITY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY MOR INFORMATION) Continued From page 12 reveal a consent signed by the legal guardian for the fence, carabineer and exit door alarms. Continued review did not reveal consents were reviewed or approved by HRC. D. Review of client 4's records on 6/12/24 revealed a signed consent dated 10/6/23 by the legal guardian for the fence, carabineer and exit door alarms. Continued review did not reveal consents were reviewed or approved by the HRC. E. Review of client 5's records on 6/12/24 revealed a signed consent dated 5/3/24 by the legal guardian for the fence, carabineer and exit door alarms. Continued review did not reveal consents were reviewed or approved by the HRC. F. 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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---|---|-----------------------------------|-------------------------------|--|
| | | 34G064 | B. WING _ | | | R 08/22/2024 | |
| NAME OF PROVIDER OR SUPPLIER TWINBROOKS | | | | STREET ADDRESS, CITY, STATE, ZIP O 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | • | 08/22/2024 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| {W 263} | REGULATORY OR LSC IDENTIFYING INFORMATION) | | {W 2 | 63} | | | |
| | was not provided as | corrected and documentation s referenced in the facility's POC). The deficiency will be | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | | |
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| | | 34G064 | B. WING _ | | | R 08/22/2024 | |
| NAME OF PROVIDER OR SUPPLIER TWINBROOKS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | | • | 08/22/2024 | |
| (X4) ID PREFIX TAG | EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE EAPPROPRIATE | (X5) COMPLETION DATE | |
| {W 474} | Food must be served developmental lever This STANDARD is Based on observatinterview, the facilit consistency was set the developmental The finding is: Observations on 6/client #4 to wash hit table to prepare for breakfast meal conhalf, cream cheese blueberries and straobservations revea pieces of bagel onto observations revea bagel in its entirety observation did start "pieces as prescribered a PCP darthat the client must due to a history of sthe record for client order dated 6/3/24 must have a regular Interview with the querofessional (QIDP on 6/12/24 revealed to follow client #4's Continued interview verified that client # | ed in a form consistent with the el of the client. Is not met as evidenced by: Ition, record review and y failed to assure food Inved in a form according to level of 1 of 6 clients (#4). 12/24 at 7:20 AM revealed is hands and transition to the level of a toasted bagel cut in the breakfast meal. The sisted of a toasted bagel cut in the led staff to place two half of client #4's plate. Further led client #4 to consume the led staff to point during the ff cut client #4's bagel into ½" - | {W 4 | 74} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|---|---|---|-------------------------------|--|
| | | 34G064 | B. WING | | | R | |
| NAME OF PROVIDER OR SUPPLIER TWINBROOKS | | | B. WING | STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFII TAG | X (EACH CORRECTIVE A CROSS-REFERENCED TO | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| {W 474} | staff must follow the or prescribed. A revisit was conduct previous deficiencies deficiency was not cowas not provided as it | clients' diet consistency as red on August 22, 2024 for all cited on June 12, 2024. The prected and documentation referenced in the facility's DC). The deficiency will be | {W 4 | 74} | | | |