		AND HUMAN SERVICES			Ο		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G206	B. WING			08/2	28/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ANSONV	ILLE GROUP HOME				215 ANSONVILLE/ POLKTON ROAD NSONVILLE, NC 28007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	EP Training Progra CFR(s): 483.475(d) §403.748(d)(1), §44 §441.184(d)(1), §44 §483.73(d)(1), §48 §485.68(d)(1), §48 §485.727(d)(1), §48 §491.12(d)(1). *[For RNCHIs at §4 Hospitals at §482.1 at §484.102, REHs under §485.727, OI RHC/FQHCs at §49 (1) Training progra the following: (i) Initial training in o policies and proced staff, individuals pro arrangement, and v expected roles. (ii) Provide emerge least every 2 years. (iii) Maintain docum preparedness traini (iv) Demonstrate st procedures. (v) If the emergence procedures are sign must conduct traini procedures. *[For Hospices at § hospice must do all (i) Initial training in o policies and proced hospice employees	m (1) 16.54(d)(1), §418.113(d)(1), 50.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 5.542(d)(1), §485.625(d)(1), 35.920(d)(1), §486.360(d)(1), 03.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" POs at §486.360, 01.12:] m. The [facility] must do all of emergency preparedness lures to all new and existing oviding services under volunteers, consistent with their ncy preparedness training at mentation of all emergency ng. aff knowledge of emergency y preparedness policies and hificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The	E 0	037		RIATE	DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 08/29/2024

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.

TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		34G206	B. WING		08	/28/2024	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
ANSON	ILLE GROUP HOME			1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
E 037	procedures. (iii) Provide emerge least every 2 years. (iv) Periodically revi emergency prepare employees (includir special emphasis p procedures necess others. (v) Maintain docum preparedness traini (vi) If the emergence procedures are sign must conduct traini procedures are sign must conduct traini procedures. *[For PRTFs at §44 program. The PRTI (i) Initial training in o policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) After initial traini preparedness traini (iii) Demonstrate sta procedures. (iv) Maintain docum preparedness traini (v) If the emergence procedures are sign must conduct traini procedures. *[For PACE at §460 organization must of	aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice ng nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency ing. by preparedness policies and nificantly updated, the hospice ng on the updated policies and enter do all of the following: emergency preparedness lures to all new and existing by ing services under volunteers, consistent with their ing, provide emergency ing every 2 years. aff knowledge of emergency mentation of all emergency	E 03	37			

If continuation sheet Page 2 of 15

		AND HUMAN SERVICES				FORM	08/29/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G206	B. WING			08/;	28/2024
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ANSON	ILLE GROUP HOME				1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007		
(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 037	policies and proced staff, individuals pro arrangement, contr volunteers, consiste (ii) Provide emerger least every 2 years. (iii) Demonstrate sta procedures, includin what to do, where to case of an emerger (iv) Maintain docum (v) If the emergence procedures are sign must conduct training procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in e policies and proced staff, individuals pro arrangement, and v expected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate st procedures. *[For CORFs at §48 CORF must do all o (i) Provide initial tra preparedness polic and existing staff, in	Jures to all new and existing poiding on-site services under actors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergency ing informing participants of o go, and whom to contact in ncy. The tation of all training. By preparedness policies and hificantly updated, the PACE ing on the updated policies and at §483.73(d):] (1) Training facility must do all of the emergency preparedness lures to all new and existing poiding services under volunteers, consistent with their incy preparedness training at the tation of all emergency ing. aff knowledge of emergency as and procedures to all new individuals providing services , and volunteers, consistent	EC	)37			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/29/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G206	B. WING			08/2	28/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ANSONV	ILLE GROUP HOME				215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	<ul> <li>(ii) Provide emerger least every 2 years.</li> <li>(iii) Maintain docum (iv) Demonstrate staprocedures. All new and assigned speci the CORF's emerger their first workday.</li> <li>include instruction in alarm systems and equipment.</li> <li>(v) If the emergen procedures are sign must conduct training procedures.</li> <li>*[For CAHs at §485 The CAH must do at (i) Initial training in e policies and proced reporting and exting and where necessan personnel, and gue cooperation with fire authorities, to all ne individuals providing and volunteers, corr roles.</li> <li>(ii) Provide emerger least every 2 years.</li> <li>(iii) Maintain docum (iv) Demonstrate staprocedures.</li> <li>(v) If the emergen procedures.</li> </ul>	ncy preparedness training at nentation of the training. aff knowledge of emergency / personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must n the location and use of signals and firefighting cy preparedness policies and hificantly updated, the CORF ng on the updated policies and 6.625(d):] (1) Training program. all of the following: emergency preparedness ures, including prompt guishing of fires, protection, iry, evacuation of patients, sts, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, hisistent with their expected ncy preparedness training at	E	037			

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		AND HUMAN SERVICES				FORM	08/29/2024 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED			
		34G206	B. WING			08/2	28/2024			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
ANSON	ILLE GROUP HOME				215 ANSONVILLE/ POLKTON ROAD NSONVILLE, NC 28007					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
E 037	*[For CMHCs at §4. CMHC must provid preparedness polic and existing staff, ir under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on record re failed to ensure dire the facility's Emerge (EPP) at least bient Review of the facilit was updated on 11/ revealed no evident In-service training of Interview with the q professional on 8/2 biennial In-service to not been completed EP Testing Require CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §448 §485.542(d)(2), §448 §485.542(d)(2), §448 §485.542(d)(2), §448 §485.920(d)(2), §448	85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new ndividuals providing services , and volunteers, consistent roles, and maintain ne training. The CMHC must nowledge of emergency after, the CMHC must provide edness training at least every 2 s not met as evidenced by: eview and interview, the facility ect care staff were trained on ency Preparedness Plan nially. The finding is: ty's EPP on 8/28/24 revealed it /2/23. Continued review ce of initial or biennial staff on the EPP. ualified intellectual disabilities 8/24 confirmed that initial and training for current staff has d. ments	EO							

Facility ID: 921449

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		AND HUMAN SERVICES				FORM	08/29/2024 APPROVED 0938-0391			
STATEMENT	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED			
		34G206	B. WING	i		08/;	28/2024			
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
ANSONV	/ILLE GROUP HOME		1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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	<ul> <li>§491.12, and ESRE</li> <li>(2) Testing. The [fact to test the emergen must do all of the formula to all of the formula to all of the formula do a</li></ul>	D Facilities at §494.62]: cility] must conduct exercises ney plan annually. The [facility] ollowing: ull-scale exercise that is every 2 years; or unity-based exercise is not at a facility-based functional ears; or cy] experiences an actual de emergency that requires nergency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: cale exercise that is or individual, facility-based ; or r drill; or cise or workshop that is led by ludes a group discussion using y-relevant emergency of problem statements, , or prepared questions nge an emergency plan. cility's] response to and cation of all drills, tabletop ergency events, and revise the	EC	039						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/29/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G206	B. WING	i		08/2	28/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ANSONV	ILLE GROUP HOME				1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	*[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 et (A) When a commu- accessible, conduct functional exercise (B) If the hospice et man-made emerge the emergency plan engaging in its next community-based function onset of the emerge (ii) Conduct an add opposite the year the exercise under para is conducted, that no to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaster (C) A tabletop exer a facilitator and incl a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The h exercises to test the year. The hospice	18.113(d):] bices that provide care in the e hospice must conduct a emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or anity based exercise is not an individual facility based every 2 years; or experiences a natural or ncy that requires activation of a, the hospital is exempt from a required full scale exercise or individual onal exercise following the ency event. litional exercise every 2 years, be 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		)39			

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	08/29/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G206	B. WING	;			08/:	28/2024
NAME OF	PROVIDER OR SUPPLIER				STR	EET ADDRESS, CITY, STATE, ZIP CODE		
ANSON	ILLE GROUP HOME					5 ANSONVILLE/ POLKTON ROAD SONVILLE, NC 28007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	accessible, conduct facility-based functi (B) If the hospice ex- man-made emerge the emergency plar engaging in its next based or facility-base following the onset (ii) Conduct an add may include, but is (A) A second full-second community-based of exercise; or (B) A mock disaster (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the hose maintain document exercises, and emerge (iii) Analyze the hose maintain document exercises, and emerge (iii) Analyze the hose maintain document exercises, and emerge hospice's emergend *[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 commutive the top of the	d; or inity-based exercise is not t an annual individual onal exercise; or xperiences a natural or ncy that requires activation of a, the hospice is exempt from required full-scale community sed functional exercise of the emergency event. litional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or cise or workshop led by a des a group discussion using a elevant emergency scenario, n statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed. 1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must o test the emergency plan e [PRTF, Hospital, CAH] must annual full-scale exercise that	E	039	9			

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		AND HUMAN SERVICES				FORM	08/29/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		34G206	B. WING			08/2	28/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ANSONV	ILLE GROUP HOME				1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	facility-based functi (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-sc community-based of functional exercise; (B) A mock (C) A tabletop of led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the maintain documents exercises, and emergency [facility's] emergency (2) Testing. The PACE following: (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based function	onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is ind includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed. 0.84(d):] 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,	E	039			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/29/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G206	B. WING			08/2	28/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
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(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	man-made emerge the emergency plar engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the exercise under para is conducted that m the following: (A) A second full-sec community-based of functional exercise; (B) A mock disaster (C) A tabletop exer a facilitator and incl using a narrated, cl scenario, and a set directed messages; designed to challen (iii) Analyze the PA maintain documents exercises, and emergency *[For LTC Facilities (2) The [LTC facility test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu	ncy that requires activation of n, the PACE is exempt from required full-scale community facility-based functional ne onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section ay include, but is not limited to cale exercise that is or individual, a facility based or r drill; or cise 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 regency events and revise the plan, as needed. at §483.73(d):] ] must conduct exercises to plan at least twice per year, ced staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or inity-based exercise is not t an annual individual,	EC	)39			

Facility ID: 921449

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/29/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G206	B. WING	i		08/	28/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ANSONV	ILLE GROUP HOME				1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	actual natural or ma requires activation of LTC facility is exem required a full-scale individual, facility-ba following the onset (ii) Conduct an add may include, but is f (A) A second full-sc community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically-r and a set of probler messages, or prepa 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 (i) Participate in an is community-based function (B) If the ICF/IID exer man-made emergen the emergency plan engaging in its next community-based of	an-made emergency that of the emergency plan, the pt from engaging its next e community-based or ased functional exercise of the emergency event. litional annual exercise that not limited to the following: cale exercise that is or an individual, facility based or er drill; or cise or workshop that is led by a group discussion, using a elevant emergency scenario, n statements, directed ared questions designed to gency plan. C facility] facility's response to nentation of all drills, tabletop ergency events, and revise the s emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises cy plan at least twice per year. o the following: 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 a, the ICF/IID is exempt from	E	039			

		AND HUMAN SERVICES				FORM	08/29/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G206	B. WING	i		08/2	28/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ANSONV	ILLE GROUP HOME				1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007		
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	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 incl using a narrated, cl scenario, and a set directed messages, designed to challen (iii) Analyze the ICF maintain documents exercises, and eme ICF/IID's emergence *[For HHAs at §484 (d)(2) Testing. The to test the emergence least annually. The (i) Participate in a fu community-based; (A) When a cor accessible, conduct facility-based function. (B) If the HHA or man-made emer of the emergency p engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi opposite the year the	itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based or r drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, , or prepared questions ge an emergency plan. //IID's response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. //IO2] HHA must conduct exercises to plan at HHA must do the following: ull-scale exercise that is or mmunity-based exercise is not t an annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation lan, the HHA is exempt from	E	039			

Facility ID: 921449

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/29/2024 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G206	B. WING			08/:	28/2024	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ANSONV	ILLE GROUP HOME		1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
E 039	is conducted, tha limited to the follow (A) A second fur community-based of functional exercise; (B) A mock disa (C) A tabletop of led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HHL documentation of a emergency events, emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The to test the emergen following: (i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. If the OPO ex man-made emerge the emergency plar engaging in its next following the onset (ii) Analyze the OPO documentation of a	t 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 to challenge an emergency A's response to and maintain Il drills, tabletop exercises, and and revise the HHA's a needed. 3.360] OPO must conduct exercises icy plan. The OPO must do the -based, tabletop exercise or nnually. A tabletop exercise is nd includes a group narrated, clinically relevant o, and a set of problem d messages, or prepared 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	E	039				

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DEPART CENTER	RINTED: 08/29/2024 FORM APPROVED MB NO. 0938-0391							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
34G206			B. WING	·		08/28/2024		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ANSONV	ILLE GROUP HOME		1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX (EACH CORRECTIVE ACTION SHOU		BE	(X5) COMPLETION DATE	
E 039	Continued From page 13		E (	039				
	exercises to test the must do the followir (i) Conduct a paper least annually. A tal discussion led by a clinically-relevant en of problem stateme prepared questions emergency plan. (ii) Analyze the RNH maintain document and emergency eve emergency plan, as This STANDARD is Based on record re failed to conduct bio	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 ents, directed messages, or designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's						
	tabletop exercise da review revealed no	ty's EPP on 8/28/24 revealed a ated 8/21/24. Continued evidence of an additional ty/facility-based exercise or						
W 463	professional on 8/2 not conducted an a community/facility-b exercise.	based exercise or mock drill	W 4	463				
		ciplinary team, including a nd physician must prescribe all						

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DEPAR <sup>-</sup> CENTE	RINTED: 08/29/2024 FORM APPROVED MB NO. 0938-0391							
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	34G206		B. WING	i		08/28/2024		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
ANSON	/ILLE GROUP HOME		1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 463	modified and specia This STANDARD is Based on observat interview, the facility sampled clients (#1 prescribed diet as of team. The finding is Observation in the g revealed the dinner squash, sweet pota observation revealed non-diet ginger ale meal. Further obser participate independ the dinner meal. Review of client #1' a nutritional evaluat indicated their curre sugary beverages, offer fruits, diet Jelle except non-starchy Interview with the q professional (QIDP diet order to be curre	al diets. s not met as evidenced by: tions, record review and y failed to ensure 1 of 2 1) received their specially ordered by the interdisciplinary s: group home on 8/27/24 meal to include baked Spam, atoes, and Jello. Continued ed client #1 to be served and water with their dinner rvations revealed client #1 to dently and consume 100% of 's record on 8/28/24 revealed tion dated 4/29/24 which ent diet order as regular, no limit desserts to twice a week, o for desserts, no seconds 'vegetables. ualified intellectual disabilities ) on 8/28/24 verified client #1's rent. Continued interview with d the client's diet order should	W 2	463				

Facility ID: 921449

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