PRINTED: 08/30/2024 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G166	B. WING _		0	8/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 037	CFR(s): 483.475(d)(1) §403.748(d)(1), §41 §441.184(d)(1), §46 §483.73(d)(1), §483 §485.68(d)(1), §488 §485.727(d)(1), §488 §491.12(d)(1). *[For RNCHIs at §44 Hospitals at §482.19 at §484.102, REHs under §485.727, OF RHC/FQHCs at §49 (1) Training prograr the following: (i) Initial training in e policies and procede staff, individuals pro arrangement, and ve expected roles. (ii) Provide emerger least every 2 years. (iii) Maintain docum- preparedness trainir (iv) Demonstrate sta procedures. (v) If the emergency procedures are sign must conduct trainir procedures. *[For Hospices at §4 hospice must do all (i) Initial training in e policies and procede hospice employees, services under arrar expected roles.	6.54(d)(1), §418.113(d)(1), 0.84(d)(1), §482.15(d)(1), .475(d)(1), §484.102(d)(1), 5.542(d)(1), §485.625(d)(1), 5.920(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, 1.12:] m. The [facility] must do all of emergency preparedness ares to all new and existing viding services under colunteers, consistent with their ency preparedness training at entation of all emergency at entation of all emergency are preparedness policies and ificantly updated, the [facility] ag on the updated policies and at 18.113(d):] (1) Training. The	EO			(VG) DATE

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

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G166	B. WING	····	08/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	,
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
E 037	procedures. (iii) Provide emergel least every 2 years. (iv) Periodically revidemergency prepared employees (includin special emphasis play procedures necessations). (v) Maintain docume preparedness training (vi) If the emergency procedures are sign must conduct training procedures. *[For PRTFs at §44* program. The PRTF (i) Initial training in epolicies and procedustaff, individuals program. The procedures are sign must conduct training procedures and procedures. (ii) After initial training preparedness training (iii) Demonstrate state procedures. (iv) Maintain docume preparedness training (v) If the emergency procedures are sign must conduct training procedures. *[For PACE at §460 organization must definition of the state of the	ff knowledge of emergency fix concept preparedness training at the ew and rehearse its edness plan with hospice gonoemployee staff), with eaced on carrying out the early to protect patients and entation of all emergency eng. If preparedness policies and efficantly updated, the hospice gon the updated policies and entation of all of the following: Interpretation of all emergency preparedness cares to all new and existing eviding services under colunteers, consistent with their eng, provide emergency eng every 2 years. Iff knowledge of emergency entation of all emergency	E 03	37	

AND DUAN OF CORRECTION IDENTIFICATION NUMBER.		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G166	B. WING		08/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
E 037	staff, individuals pro arrangement, contra volunteers, consiste (ii) Provide emerger least every 2 years. (iii) Demonstrate sta procedures, includir what to do, where to case of an emergen (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 expolicies and procedustaff, individuals program arrangement, and vexpected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness trainin (iv) Demonstrate staprocedures. *[For CORFs at §48 CORF must do all of (i) Provide initial traingreparedness policiand existing staff, individuals programed existing e	ures to all new and existing viding on-site services under actors, participants, and int with their expected roles. Incy preparedness training at a ff knowledge of emergency ag informing participants of a go, and whom to contact in a go, and whom t	E 03		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 037	least every 2 years (iii) Maintain docum (iv) Demonstrate st procedures. All nev and assigned speci the CORF's emerge their first workday, include instruction i alarm systems and equipment. (v) If the emergen procedures are sign must conduct traini procedures. *[For CAHs at §488 The CAH must do a (i) Initial training in policies and proced reporting and exting and where necessa personnel, and gue cooperation with fir authorities, to all ne individuals providin and volunteers, cor roles. (ii) Provide emerge least every 2 years (iii) Maintain docum (iv) Demonstrate st procedures. (v) If the emergen procedures are sign	ney preparedness training at a mentation of the training. For aff knowledge of emergency of personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of the training program must in the location and use of signals and firefighting cy preparedness policies and inficantly updated, the CORF ing on the updated policies and side of the following: Emergency preparedness lures, including prompt guishing of fires, protection, and efighting and disaster ew and existing staff, go services under arrangement, insistent with their expected incy preparedness training at	EC			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED
		34G166	B. WING		08/	28/2024
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
E 037	CMHC must provide preparedness policie and existing staff, incunder arrangement, a with their expected rodocumentation of the demonstrate staff kno procedures. Thereaf emergency prepared years. This STANDARD is Based on record revialled to provide and annual staff training or Preparedness Plan (In The finding is: Review of facility door revealed an EPP data of the 11/2023 EPP cannual staff in-service. Interview with the quaprofessional (QIDP) of evidence of the facility could not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview with the QII in-service training should not be located interview.	5.920(d):] (1) Training. The initial training in emergency is and procedures to all new dividuals providing services and volunteers, consistent oles, and maintain training. The CMHC must owledge of emergency iter, the CMHC must provide mess training at least every 2 mot met as evidenced by: iew and interview, the facility maintain documentation of on the Emergency EPP) for Yadkin III facility. Summentation on 8/28/24 and 11/4/23. Continued review did not reveal evidence of an extraining. Salified intellectual disabilities on 8/28/24 verified that the EPP ould be completed and and updates are completed tents	E 03			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
		34G166	B. WING		0:	3/28/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	,	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	*[For ASCs at §416. at §485.542, OPO, '§485.727, CMHCs at §491.12, and ESRD (2) Testing. The [fact to test the emergency must do all of the folion (i) Participate in a further community-based et (A) When a community-based et (A) When a community-based exercise every 2 year (B) If the [facility natural or man-made activation of the emergency from engagic community-based of functional exercise from the exempt from engagic community-based of functional exercise this section is conducted in the full (A) A second full-scatcommunity-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusion and a set directed messages,	1.12(d)(2), §494.62(d)(2). 54, CORFs at §485.68, REHs Organizations" under at §485.920, RHCs/FQHCs at Facilities at §494.62]: ility] must conduct exercises by plan annually. The [facility] llowing: Il-scale exercise that is every 2 years; or nity-based exercise is not a facility-based functional exercises an actual experiences an actual exercise plan, the [facility] is ng in its next required rindividual, facility-based ollowing the onset of the exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of acted, that may include, but is owing: ale exercise that is rindividual, facility-based or	E 03	39		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G166	B. WING			8/28/2024	
NAME OF P	ROVIDER OR SUPPLIER	,	•	STREET ADDRESS, CITY, STATE, ZIP COI 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020			
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E 039	exercises, and emergifacility's] emergency *[For Hospices at 418 (2) Testing for hospic patient's home. The exercises to test the annually. The hospic (i) Participate in a ful community based ev. (A) When a communi accessible, conduct a functional exercise ev. (B) If the hospice exp man-made emergency the emergency plan, engaging in its next r community-based ex facility-based function onset of the emerger (ii) Conduct an addit opposite the year the exercise under parag is conducted, that ma to the following: (A) A second full-sca community-based or exercise; or (B) A mock disaster (C) A tabletop exerci a facilitator and includ a narrated, clinically- scenario, and a set o directed messages, of	ity's] response to and ion of all drills, tabletop gency events, and revise the plan, as needed. 3.113(d):] ces that provide care in the hospice must conduct emergency plan at least ce must do the following: Ill-scale exercise that is ery 2 years; or ity based exercise is not an individual facility based every 2 years; or periences a natural or experiences a natural or experience or individual facility based exercise following the encise or individual facility based exercise following the ency event. In all exercise every 2 years, if full-scale or functional graph (d)(2)(i) of this section and include, but is not limited the exercise that is a facility based functional drill; or is en workshop that is led by it des a group discussion using	E 03	9			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020		
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E 039	care directly. The he exercises to test the year. The hospice in (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the hospice eximan-made emergenthe emergency plan, engaging in its next based or facility-based following the onset of (ii) Conduct an addit may include, but is in (A) A second full-secommunity-based or exercise; or (B) A mock disaster (C) A tabletop exercise facilitator that include narrated, clinically-reand a set of problem messages, or preparchallenge an emerge (iii) Analyze the hosmaintain documental exercises, and emerhospice's emergence *[For PRFTs at §441 §482.15(d), CAHs at (2) Testing. The [PR conduct exercises to	ces that provide inpatient ospice must conduct emergency plan twice per nust do the following: annual full-scale exercise that condity-based exercise is not an annual individual onal exercise; or periences a natural or cy that requires activation of the hospice is exempt from required full-scale community ed functional exercise of the emergency event. It is a facility based functional drill; or cise or workshop led by a sea a group discussion using a elevant emergency scenario, a statements, directed red questions designed to ency plan. Pice's response to and tion of all drills, tabletop gency events and revise the y plan, as needed.	E 03	9		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED
		34G166	B. WING		08/	28/2024
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	is community-based; (A) When a commun accessible, conduct a facility-based function (B) If the [PRTF, Hos actual natural or mar requires activation of [facility] is exempt from required full-scale confacility-based function onset of the emerger (ii) Conduct and and that may include following: (A) A second full-scale confunctional exercise; (B) A mock (C) A tabletop existed by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. (iii) Analyze the maintain documentate exercises, and emergency facility's] emergency *[For PACE at §460.8] (2) Testing. The PAC exercises to test the annually. The PACE following:	annual full-scale exercise that or lity-based exercise is not an annual individual, hal exercise; or spital, CAH] experiences an annual exercise; or spital, CAH] experiences an annual exercise following the mengaging in its next mmunity based or individual, hal exercise following the next event. [additional] annual exercise or but is not limited to the late exercise that is individual, a facility-based or disaster drill; or exercise or workshop that is dincludes a group arrated, clinically-relevant and a set of problem messages, or prepared or challenge an emergency [facility's] response to and ion of all drills, tabletop gency events and revise the plan, as needed.	E 03			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		34G166	B. WING		08/28/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	, 00.20.20	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
E 039	accessible, conduct a facility-based function (B) If the PACE experiment and a man-made emergency plan, engaging in its next in based or individual, if exercise following the event. (ii) Conduct an a years opposite the years opposite the years opposite the years conducted that matter following: (A) A second full-sca community-based or functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, clinister and inclusing a narrated as exercises, and emergency of the package of the	or ity-based exercise is not an annual individual, nal exercise; or riences an actual natural or cy that requires activation of the PACE is exempt from equired full-scale community acility-based functional e onset of the emergency additional exercise every 2 par the full-scale or functional graph (d)(2)(i) of this section y include, but is not limited to all exercise that is individual, a facility based or drill; or isse or workshop that is led by des a group discussion, ically-relevant emergency of problem statements, or prepared questions e an emergency plan. Se's response to and ion of all drills, tabletop gency events and revise the plan, as needed. It §483.73(d):] must conduct exercises to plan at least twice per year, ed staff drills using the es. The [LTC facility,	E 03	39		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G166	B. WING _			08/28/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	ODE		
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E 039	accessible, conduction facility-based functional catual natural or morequires activation LTC facility is exemined a full-scale individual, facility-be following the onset (ii) Conduct an admay include, but is (A) A second full-scommunity-based functional exercise (B) A mock disaste (C) A tabletop exemined a set of problemessages, or prepictually and a set of problemessages, or prepictually and maintain documentation of the community-based functional exercises, and emergiand maintain documentation of the community facility and maintain documentation of the community facility and maintain documentation of the community facility and the community-base (A) When a community-based functional facility-based functional	d; or unity-based exercise is not at an annual individual, ional exercise. Ity] facility experiences an an-made emergency that of the emergency plan, the apt from engaging its next ecommunity-based or ased functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based or are drill; or recise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. TC facility] facility's response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to the following: annual full-scale exercises that d; or unity-based exercise is not the an annual individual,	E	039			

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E 039	the emergency plan, engaging in its next rommunity-based or functional exercise for emergency event. (ii) Conduct an additional include, but is not (A) A second full-scat community-based or functional exercise; (B) A mock disaster of (C) A tabletop exercise a facilitator and including a narrated, clind scenario, and a set of directed messages, of designed to challeng (iii) Analyze the ICF/I maintain documentate exercises, and emergical ICF/IID's emergency (C) Testing. The Hoto test the emergency least annually. The Hoto test the emergency least annually accessible, conduct a facility-based function or. (B) If the HHA exercise or man-made emergency platengaging in its next recommunity in the community in the emergency platengaging in its next recommunity in the emergency platengaging in its n	cy that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based ollowing the onset of the onal annual exercise that of limited to the following: le exercise that is an individual, facility-based or drill; or se or workshop that is led by des a group discussion, ically-relevant emergency of problem statements, or prepared questions e an emergency plan. ID's response to and ion of all drills, tabletop gency events, and revise the plan, as needed. IO2] HA must conduct exercises y plan at IHA must do the following: lescale exercise that is munity-based exercise is not an annual individual, nal exercise every 2 years; experiences an actual natural ency that requires activation in, the HHA is exempt from	EOS	39	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G166	B. WING _			8/28/2024	
	NAME OF PROVIDER OR SUPPLIER YADKIN II & III			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 039	Continued From pag	ge 12	EC	139			
	functional exercise of emergency event. (ii) Conduct an addi opposite the year the exercise under para is conducted, the limited to the following (A) A second furctional exercise; (B) A mock disar (C) A tabletop of functional exercise; (B) A mock disar (C) A tabletop of functional exercise; (B) A mock disar (C) A tabletop of functional exercise; (B) A mock disar (C) A tabletop of functional exercise; (B) A mock disar (C) A tabletop of functional exercise; (B) A mock disar (C) A tabletop of functional exercise; (B) A mock disar (C) A tabletop of functional exercise; (B) A mock disar (C) A tabletop of functional exercise; (III) Analyze the HH/I documentation of all emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The Conduct a paperworkshop at least and led by a facilitator and discussion, using a emergency scenarior statements, directed questions designed plan. If the OPO expense of the emergency plan in the open exercise of the	tional 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 o, and a set of problem d messages, or prepared to challenge an emergency A's response to and maintain drills, tabletop exercises, and and revise the HHA's needed. 360] DPO must conduct exercises by plan. The OPO must do the ebased, tabletop exercise or innually. A tabletop exercise is					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	NAME OF PROVIDER OR SUPPLIER YADKIN II & III			STREET ADDRESS, CITY, STATE, ZIP CODE 1220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
E 039	(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 followir (i) Conduct a paper least annually. A tal discussion led by a clinically-relevant el of problem stateme prepared questions emergency plan. (ii) Analyze the RNI maintain document and emergency evergency plan, as This STANDARD is Based on record refacility failed to concemergency prepare which effects 12 of Yadkin III facilities (#9, #10, #11, and #Review of facility on 8/28/24 recontinued review or reveal evidence of a mock drill, or a table facility's EPP.	of the emergency event. D's response to and maintain Il tabletop exercises, and and revise the [RNHCl's and plan, as needed. 748]: RNHCl must conduct e emergency plan. The RNHCl ng: -based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, mergency scenario, and a set nts, directed messages, or designed to challenge an HCl's response to and ation of all tabletop exercises, ents, and revise the RNHCl's	E 039		
		evealed an EPP dated 11/4/23. y's EPP did not reveal			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G166	B. WING			08/	28/2024
NAME OF PROVIDER OR SUPPLIER YADKIN II & III		•	32:	REET ADDRESS, CITY, STATE, ZIP CODE 20 & 3224 US HWY 21 AMPTONVILLE, NC 27020			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	full-scale facility base facility's EPP. Interview with the quaprofessional (QIDP) of evidence of a full-scale exercises, tabletop of not available during the interview with the QII tabletop, mock drill, and Yadkin II and III were PROGRAM IMPLEM CFR(s): 483.440(d)(formulated a client's each client must receive treatment program conterventions and seriand frequency to support the support of th	drill, tabletop exercise or a ed exercise to test the alified intellectual disabilities on 8/28/24 revealed that ale community facility based or mock drill exercises were the survey. Continued DP verified that the facility and/or full-scale exercises for a not completed as required. ENTATION		2249			
	Based on observation interviews, the facility continuous active tree of needed intervention identified in the person of 3 sampled clients. A. The facility failed to	not met as evidenced by: ons, record review and of failed to ensure that a atment program consisting ons were implemented as on-centered plan (PCP) for 2 (#1, #10). The findings are: o provide client #10 with a on ambulation. For example:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		34G166	B. WING)8/28/202 4	
NAME OF PROVIDER OR SUPPLIER YADKIN II & III				STREET ADDRESS, CITY, STATE, ZIP COE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 249	in various activities to personal care, and in Continued observations are also revealed clients. Review of the record revealed a PCP date osteopenia and arthreview of the record occupational therapy 1/23/24 which indicate equipment: high side protector, dycem may wheelchair for long of socks. Interview with the que professional (QIDP) client #10 wears a grambulation througher interview with the QIIII and the professional interview with the QIII and the pr	ealed client #10 to participate of include meal preparation, medication administration. One revealed client #10 to at the facility without a gait at 10:00AM in the day program #10 to not have on a gait belt. If for client #10 on 8/28/24 and 3/14/24 which indicated an ritis diagnosis. Continued for client #10 revealed and (OT) assessment dated ted the following adaptive ed divided dish, clothing at, bed alarm, gait belt, distances, and compression alified intellectual disabilities on 8/28/24 revealed that	W 24	9			
	current. Further interest that staff should ensignait belt during ambut B. The facility failed prescribed bilateral ashoes to help with all Observations in the 4:03 PM revealed clirecliner chair in the I and to not wear bilat orthotic shoes. Continued in the I and to shoes.	rview with the QIDP verified ure that client #10 has on a ulation as prescribed.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		34G166	B. WING _		08/28/2024
NAME OF PROVIDER OR SUPPLIER YADKIN II & III			,	STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
W 249	medication room usin living room. Continue client #1 to ambulate dining room to prepar time during the obser provide client #1 with and orthotic shoes. Review of records on dated 6/4/24 which stankle braces and orthambulation and the client. Continued revier revealed a podiatry of verified the client to blesion and at-risk dial. Interview with the quaprofessional (QIDP) of client #1's PCP and procontinued interview with ambulation. NURSING SERVICE: CFR(s): 483.460(c)(5) Nursing services must other members of the appropriate protective measures that include training clients and sthealth and hygiene mand the perform her trained to perform her trained to perform her trained to perform her training the observations to the perform her trained to perform her training training trained to perform her trained to perform her training	g walker and return to the d observations revealed with walker from living to the e for the dinner meal. At no vation was staff observed to his bilateral ankle braces 8/28/24 revealed a (PCP) ates client #1 has bilateral notic shoes to help with ient should always use ew of records for client #1 consult dated 7/2/24 which e followed due to left foot petic foot care. alified intellectual disabilities on 8/28/24 confirmed that hodiatry consult are current. with the QIDP confirmed that lient #1 with his prescribed and orthotic shoes to help Solition of the prescribed and preventive health explain an	W 2		

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	riple construction	(X3	(X3) DATE SURVEY COMPLETED	
		34G166	B. WING _			08/28/2024	
NAME OF PROVIDER OR SUPPLIER YADKIN II & III			,	STREET ADDRESS, CITY, STATE, ZIP COI 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	DE		
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W 340	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 3				
	the developmental lev (#10) in Yadkin III fac	ed in a form according to yel of 1 of 3 sampled clients illity. The finding is:					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		34G166	B. WING		0	8/28/2024
NAME OF PROVIDER OR SUPPLIER YADKIN II & III				STREET ADDRESS, CITY, STATE, ZIP COI 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 474	area to prepare for the breakfast meal consistency of client #10 with blending ground consistency of assistance. Further of revealed client #10 to its entirety. At no poistaff assist client #10 patties in a puree condeview of the record PCP dated 3/14/24 with diagnosis: Barrett's ecataracts, urinary free presbyopia, GERD, of compulsive disorder, menopausal disorder infection, hypermetro history of CVA. Conticulient #10 revealed a 1/23/24 which indicate change the client's distored to puree due to report dry mechanical foods. Interview with the quaprofessional (QIDP) of have been trained to based on the prescril Continued interview with further interview with goals a Further interview with	st client #10 to the kitchen the breakfast meal. The sted of cream of wheat, the sted of cream of the sted of the cream the sted of the cream of the	W 47	4		