PRINTED: 10/19/2023 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CO	DEFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100000000000000000000000000000000000000		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G247	B. WING			10	/47/2022
LINOAK GRO	OUP HOME			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1175 BANK ROAD INCOLNTON, NC 28092	1 10.	/17/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
S48 §48 §48 §48 §48 §48 §49 *[Fo Hos at § und RH0 (i) Ir polic staff arra expe (ii) F leas (iii) M prep (iv) I proc (v) If proc must proc *[For	individuals provide and voice and procedures, the emergency pedures.	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), .3.748, ASCs at §416.54, .6, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" Os at §486.360, 1.12:] a. The [facility] must do all of mergency preparedness res to all new and existing viding services under llunteers, consistent with their cy preparedness training at nutation of all emergency g. f knowledge of emergency preparedness and icantly updated, the [facility] on the updated policies and 8.113(d):] (1) Training. The	next for th	vill i are 12 e n	inservice staff on Emergency dness at every house meeting for months. QP will increase supervisext 60 days, by completing interanents 3 times per month. DHSR - Mental Heal	the sion ction	2/11/2023
(i) Ini polici hosp servi expe	tial training in emes and procedurice employees, aces under arrangeted roles.	nergency preparedness es to all new and existing and individuals providing ement, consistent with their			Lic. & Cert. Section		

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 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 program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G247	B. WING	i		10/17/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 3175 BANK ROAD LINCOLNTON, NC 28092	P CODE	10/17/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	(ii) Demonstrate star procedures. (iii) Provide emerger least every 2 years. (iv) Periodically revie emergency prepared employees (including special emphasis pla procedures necessare others. (v) Maintain docume preparedness training (vi) If the emergency procedures are signiful must conduct training procedures. *[For PRTFs at §441 program. The PRTF (i) Initial training in emplicies and procedures training in emplicies and procedures are signiful training in emplicies and procedures are signiful procedures. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain document preparedness training (v) If the emergency procedures are signiful must conduct training procedures. *[For PACE at §460.86 organization must do for the emergency procedures.	fr knowledge of emergency and preparedness training at the wand rehearse its diness plan with hospice gronemployee staff), with aced on carrying out the ry to protect patients and antation of all emergency group preparedness policies and ficantly updated, the hospice gron the updated policies and antation of all of the following: nergency preparedness res to all new and existing iding services under unteers, consistent with their grovide emergency greyery 2 years. It knowledge of emergency intation of all emergency intation of all emergency interpretations and cantly updated, the PRTF on the updated policies and 4(d):] (1) The PACE	EO	37		

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	A. BUILDING			COMPLETED	
		34G247	B. WING	i			0/47/0000	
	PROVIDER OR SUPPLIER		•	3	TREET ADDRESS, CITY, STATE, ZIP CODE 175 BANK ROAD INCOLNTON, NC 28092	1 10	0/17/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	21.00	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	policies and procedustaff, individuals pro arrangement, contravolunteers, consiste (ii) Provide emergent least every 2 years. (iii) Demonstrate staprocedures, includin what to do, where to case of an emergency of the emergency procedures are signimust conduct training procedures. *[For LTC Facilities and Program. The LTC fat following: (i) Initial training in erpolicies and procedustaff, individuals provarrangement, and vo expected role. (ii) Provide emergency least annually. (iii) Maintain document preparedness training (iv) Demonstrate staff procedures. *[For CORFs at §485 CORF must do all of its provide initial training preparedness policies and existing staff, individuals provides and existing staff, individuals procedures.	ures to all new and existing viding on-site services under actors, participants, and nt with their expected roles. The cy preparedness training at a superior of go, and whom to contact in cy. The contact of all training. The contact of go, and whom to contact in cy. The contact of all training. The contact of go, and whom to contact in cy. The contact of all training. The contact of go, and whom to contact in cy. The contact of all training. The contact of go, and whom to contact in cy. The contact of all training. The contact of go, and whom to contact in cy. The contact of all emergency go, and procedures to all new widuals providing services and procedures to all new viduals providing services and volunteers, consistent with their contact of all emergency go, and procedures to all new viduals providing services and volunteers, consistent	E	037				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G247	B. WING	i		1	0/47/2022
	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 8175 BANK ROAD LINCOLNTON, NC 28092	1 1	0/17/2023
(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 APPROF DEFICIENCY)	DBF	(X5) COMPLETION DATE
	(ii) Provide emerger least every 2 years. (iii) Maintain docume (iv) Demonstrate star procedures. All new and assigned specifithe CORF's emerge their first workday. Tinclude instruction in alarm systems and sequipment. (v) If the emergence procedures are signimust conduct training procedures. *[For CAHs at §485.6] The CAH must do all (i) Initial training in erpolicies and procedure procedures and where necessary personnel, and guest cooperation with firef authorities, to all new individuals providing and volunteers, consiroles. (ii) Provide emergence least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. (v) If the emergency procedures are significations.	entation of the training. If knowledge of emergency personnel must be oriented in responsibilities regarding may plan within 2 weeks of the training program must the location and use of signals and firefighting and proper preparedness policies and ficantly updated, the CORF on the updated policies and of the following: If the following: If the following program must the location and use of signals and firefighting and the correction of the following: If the following program must the location program of the following: If the following program is the following prompt is the following prompt is fires, protection, and ighting and disaster and existing staff, services under arrangement, stent with their expected by preparedness training at	EO	037			

STATEME AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G247	B. WING			
	F PROVIDER OR SUPPLIER K GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 BANK ROAD LINCOLNTON, NC 28092	10/17/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RE COMPLETION	
E 037	*[For CMHCs at §48 CMHC must provide preparedness policie and existing staff, in under arrangement, with their expected r documentation of the demonstrate staff kn procedures. Therea emergency prepared years. This STANDARD is Based on record revialled to ensure direct the facility's emergen at least biennially. The Review on 10/17/23 on evidence of initial EPP.	85.920(d):] (1) Training. The initial training in emergency es and procedures to all new dividuals providing services and volunteers, consistent oles, and maintain estraining. The CMHC must owledge of emergency fter, the CMHC must provide liness training at least every 2 not met as evidenced by: riew and interview, the facility of care staff were trained on accypreparedness plan (EPP)	ΕO	37		
	confirmed that initial to for current staff were EP Testing Requirem CFR(s): 483.475(d)(2) §416.54(d)(2), §482.1 §460.84(d)(2), §482.1 §483.475(d)(2), §485.542(d)(2), §485.920(d)(2), §491. *[For ASCs at §416.54 at §485.542, OPO, "O §485.727, CMHCs at §485.727	raining and biennial training not completed. ents) 13(d)(2), §441.184(d)(2), 5(d)(2), §483.73(d)(2), 102(d)(2), §485.68(d)(2), 625(d)(2), §485.727(d)(2), 12(d)(2), §494.62(d)(2). 4, CORFs at §485.68, REHs rganizations" under §485.920, RHCs/FQHCs at	dr an	will conduct Emergancy Prepared ills monthly, at each house meeting densure that the emergency eparedness plan is updated annuall	11/30/2023	
	§491.12, and ESRD F	acilities at §494.62];				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G247	B. WING		1	0/17/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3175 BANK ROAD LINCOLNTON, NC 28092	ODE	0/1//2023
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	(2) Testing. The [facto to test the emergence must do all of the following to the following to the following the factor of the following the factor of the factor of the factor of the exercise every 2 years (B) If the [facility natural or man-made activation of the emergence of the following the factor of the	illity] must conduct exercises by plan annually. The [facility] llowing: Il-scale exercise that is very 2 years; or nity-based exercise is not a facility-based functional ars; or perpendiction of a facility-based functional ars; or experiences an actual exemergency that requires ergency plan, the [facility] is not into the individual, facility-based belowing the onset of the conal exercise at least every 2 ear the full-scale or not not paragraph (d)(2)(i) of beta, that may include, but is owing: It is exercise that is individual, facility-based or directly individual, facility-based or directly individual, facility-based or group discussion using relevant emergency for problem statements, or prepared questions an emergency plan. By its problem to and on of all drills, tabletop rency events, and revise the plan, as needed.	Nurse on p QP v	Shwill inservice staff on Fire & loger medicalist and implemental inservice on plan implemental	Evacuation of protocols entation.	

STATEMEN AND PLAN	AND FLAN OF CORRECTION I IDENTIFICATION NUMBER. I		1	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		34G247	B. WING		10	0/17/2023	
LINOAK	PROVIDER OR SUPPLIER GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 BANK ROAD LINCOLNTON, NC 28092		7772020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORREST TO THE APPOPULATION OF THE APP	ULD BE	(X5) COMPLETION DATE	
	patient's home. The exercises to test the annually. The hospi (i) Participate in a fuscommunity based ev (A) When a community based ev (A) When a community based ev (B) If the hospice ex man-made emergen the emergency plan, engaging in its next a community-based ex facility-based function onset of the emerger (ii) Conduct an addition opposite the year the exercise under paragis conducted, that may to the following: (A) A second full-sca community-based or exercise; or (B) A mock disaster (C) A tabletop exercial facilitator and include a narrated, clinically-rescenario, and a set of directed messages, of designed to challenge (3) Testing for hospical care directly. The hospice medical participate in an analysis community-based; in Participate in an analysis community-based; in community-based; in a com	hospice must conduct emergency plan at least ce must do the following: ull-scale exercise that is very 2 years; or nity based exercise is not an individual facility based every 2 years; or periences a natural or cy that requires activation of the hospital is exempt from required full scale tercise or individual nal exercise following the ncy event. ional exercise every 2 years, if full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited ale exercise that is a facility based functional drill; or se or workshop that is led by des a group discussion using relevant emergency f problem statements, or prepared questions e an emergency plan. es that provide inpatient espice must conduct emergency plan twice per ust do the following: noual full-scale exercise that	EO	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			34G247	B. WING			0/17/2023
1		PROVIDER OR SUPPLIER GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CO 3175 BANK ROAD LINCOLNTON, NC 28092	ODE	0/1//2023
PF	(4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
E		accessible, conduct facility-based function (B) If the hospice ex man-made emerger the emergency plant engaging in its next based or facility-based following the onset of (ii) Conduct an addit may include, but is not (A) A second full-soccommunity-based or exercise; or (B) A mock disaster (C) A tabletop exercise facilitator that include narrated, clinically-reand a set of problem messages, or preparate and a set of problem messages, or preparate (iii) Analyze the hospinal exercises, and emergination documentate exercises, and emergination documentate (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in an anis community-based; (A) When a community-based function facility-based function	an annual individual conal exercise; or reperiences a natural or recy 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 exercise that is a facility based functional drill; or ise or workshop led by a sea a group discussion using a levant emergency scenario, statements, directed ed questions designed to ency plan. Since's response to and it is response to an anitorial it is r	EO	039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G247	B. WING		10	1/17/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3175 BANK ROAD LINCOLNTON, NC 28092	E	0/17/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
	actual natural or ma requires activation of [facility] is exempt for required full-scale of facility-based functionset of the emerge (ii) Conduct an and that may include following: (A) A second full-scale of functional exercise; of (B) A mock of (C) A tabletop extended by a facilitator and discussion, using a memergency scenario, statements, directed questions designed to plan. (iii) Analyze the [imaintain documentate exercises, and emergency facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE of following: (i) Participate in an an is community-based; (A) When a community accessible, conduct a facility-based function (B) If the PACE experimen-made emergency	n-made emergency that If the emergency plan, the If the emergency plan its next If the exercise following the If the exercise following the If the exercise or If the exercise that is If the exercise or workshop that is If the exercise that is If the exercise or workshop that is If the exercise that is If the exercise or workshop that is If the exercise or works	EO	39		

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G247	B. WING	S	10	0/17/2023	
LINOAK	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 BANK ROAD LINCOLNTON, NC 28092		01112023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(=	UID BE	(X5) COMPLETION DATE	
E 039	- Fall page 0		E 0	039			
	engaging in its next based or individual, exercise following the event. (ii) Conduct an a years opposite the yexercise under parais conducted that mathe following: (A) A second full-sc community-based or functional exercise; (B) A mock disaster; (C) A tabletop exercise a facilitator and incluusing a narrated, clin scenario, and a set of directed messages, designed to challeng; (iii) Analyze the PAC maintain documentate exercises, and emerge PACE's emergency per per left of the facility of the participate in an an ais community-based;	required full-scale community facility-based functional are onset of the emergency additional exercise every 2 ear the full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited to all exercise that is individual, a facility based or drill; or ise or workshop that is led by des a group discussion, incally-relevant emergency of problem statements, or prepared questions e an emergency plan. E's response to and ion of all drills, tabletop gency events and revise the elan, as needed. It §483.73(d):] must conduct exercises to lan at least twice per year, ed staff drills using the es. The [LTC facility, following: nnual full-scale exercise that or ty-based exercise is not					
	facility-based function (B) If the [LTC facility] actual natural or man-	al exercise. facility experiences an made emergency that the emergency plan, the				-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		The State of the S	ULTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G247	B. WING	3	10	/17/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3175 BANK ROAD LINCOLNTON, NC 28092	CODE	11/1/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	LTC facility is exemprequired a full-scale individual, facility-bat following the onset of (ii) Conduct an addit may include, but is recommunity-based or functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator includes narrated, clinically-reand a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerge [LTC facility] facility's and maintain docume exercises, and emerge (2) Testing. The ICF/IID at §48. (2) Testing. The ICF/IID must do (i) Participate in an anis community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID expending in its next recommunity-based or if functional exercise followers and the emergency event.	ot from engaging its next community-based or sed functional exercise of the emergency event. Itional annual exercise that not limited to the following: ale exercise that is an individual, facility based or drill; or cise or workshop that is led by a group discussion, using a elevant emergency scenario, statements, directed red questions designed to ency plan. If facility facility's response to entation of all drills, tabletop gency events, and revise the emergency plan, as needed. 3.475(d)]: IID must conduct exercises of plan at least twice per year. The following: Intual full-scale exercise that or the following: Intual full-scale exercise is not annual individual, all exercise; or exiences an actual natural or the ICF/IID is exempt from the ICF/IID is exempt from	EC	039		

STATEMEN	IT OF DEFICIENCIES	(X1) DDOVIDED/GUDDUJED/GUD	T			NAID IAI	0. 0938-0391	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	6 Same	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G247	B. WING			1	0/17/2023	
	PROVIDER OR SUPPLIER			3175 E	ET ADDRESS, CITY, STATE, ZIP CODE BANK ROAD OLNTON, NC 28092	1 10	011112023	
(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 APPROPE DEFICIENCY)	RF	(X5) COMPLETION DATE	
i	may include, but is r (A) A second full-sca community-based or functional exercise; (B) A mock disaster (C) A tabletop exerci a facilitator and inclu using a narrated, clir scenario, and a set of directed messages, designed to challeng (iii) Analyze the ICF/I maintain documental exercises, and emen ICF/IID's emergency *[For HHAs at §484.* (d)(2) Testing. The H to test the emergency least annually. The H (i) Participate in a full community-based; or (A) When a community-based function or. (B) If the HHA exe or man-made emerge of the emergency plan engaging in its next re community-based or if functional exercise for emergency event. (ii) Conduct an addition exercise under paragi	not limited to the following: ale exercise that is an individual, facility-based or drill; or ise or workshop that is led by ides a group discussion, nically-relevant emergency of problem statements, or prepared questions ie an emergency plan. IID's response to and tion 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: -scale exercise that is -munity-based exercise is not an annual individual, hal exercise every 2 years; experiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based flowing the onset of the smal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section may include, but is not	EC	39				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G247	B. WING	;	44	1/47/2022	
NAME OF PROVIDER OR SUPPLIER LINOAK GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP (3175 BANK ROAD LINCOLNTON, NC 28092	CODE	0/17/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
	(A) A second full community-based of functional exercise; (B) A mock disa (C) A tabletop existed by a facilitator and discussion, using a memergency scenarior statements, directed questions designed in plan. (iii) Analyze the HHA documentation of all emergency events, a emergency plan, as in the emergency plan, as in the emergency expension of the emergency scenarior, statements, directed questions designed to plan. If the OPO expension, and the emergency plan, in the emergency plan in	Il-scale exercise that is an individual, facility-based or ster drill; or exercise or workshop that is ad includes a group narrated, clinically-relevant and a set of problem messages, or prepared to challenge an emergency and revise the HHA's needed. 360] PO must conduct exercises and and revise the HHA's needed. 360] PO must conduct exercises or nually. A tabletop exercise or nually. A tabletop exercise is dincludes a group arrated, clinically relevant and a set of problem messages, or prepared or challenge an emergency eriences an actual natural or by that requires activation of the OPO is exempt from equired testing exercise the emergency event. It is response to and maintain abletop exercises, and and revise the [RNHCI's and an, as needed.	EO)39			

AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G247	B. WING	f		0/47/0000	
NAME OF PROVIDER OR SUPPLIER LINOAK GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 3175 BANK ROAD LINCOLNTON, NC 28092	_ 10	0/17/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE	
E 039	(d)(2) Testing. The Fexercises to test the must do the following (i) Conduct a paperleast annually. A tab discussion led by a folinically-relevant emof problem statement prepared questions of emergency plan. (ii) Analyze the RNH maintain documentation and emergency ever emergency plan, as in This STANDARD is Based on record revisible failed to conduct bier emergency prepared finding is:	RNHCI must conduct emergency plan. The RNHCI g: based, tabletop exercise at letop exercise is a group acilitator, using a narrated, hergency scenario, and a set its, directed messages, or designed to challenge an CI's response to and tion of all tabletop exercises, its, and revise the RNHCI's heeded. not met as evidenced by: iew and interview, the facility inial testing of the facility's heess plan (EPP). The	EO	39			
W 249	no evidence of a full- facility-based training scale-community or fa mock drill, or a tableto Interview on 10/17/23 confirmed the facility full-scale community of second full scale-com training or mock drill, PROGRAM IMPLEME CFR(s): 483.440(d)(1) As soon as the interdifermulated a client's in	, a second full acility-based training or op exercise. with the program manager has not conducted a per facility-based training, a munity or facility-based or a tabletop exercise. ENTATION sciplinary team has adividual program plan, we a continuous active	objectiv QP will months,	will inservice on current program es with staff to ensure all needs a increase supervision for the next 2 by completing 4 assessments pere program implementation.	re met.	11/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2007 0000000000000000000000000000000000	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		34G247	B. WING	3			
NAME OF PROVIDER OR SUPPLIER LINOAK GROUP HOME			STREET ADDRESS, CITY, STATE, 2 3175 BANK ROAD LINCOLNTON, NC 28092	ZIP CODE	0/17/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	, , , , , , , , , , , , , , , , , , , ,	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 249	and frequency to su	ge 14 ervices in sufficient number pport the achievement of the in the individual program	W 2	249			
	Based on observati- interviews, the facilit clients (#1, #3, #4 ar active treatment pro- equipment. The findi	to provide client #1 with a					
	during the 10/16-17//to be provided with a weighted spoon, and mealtime. Continued #1 to participate inde Review of client #1's a person-centered playsician orders date documentation reveal high-sided divided dis	observation revealed client pendently during mealtime. record on 10/17/23 revealed an dated 5/13/23 and ed 10/5/23. Review of the led client #1 is prescribed a sh, weighted spoon, and					
	weighted cup during a eating/drinking habits Interview with the pro confirmed client #1's adaptive equipment a interview confirmed the with all adaptive equipment and with all adaptive equipment	gram manager on 10/17/23 orders for mealtime ure current. Continued ne client should be provided					

STATEMEN	T OF DEFICIENCIES	(V4) SPOURSE GUILLIANS				MR M	<u>0. 0938-0391</u>
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G247	B. WING	i		1	0/17/2023
	GROUP HOME			3	TREET ADDRESS, CITY, STATE, ZIP CODE 175 BANK ROAD INCOLNTON, NC 28092	1 1	0/11/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	during the 10/16-17/ to be provided with a include a cup with a Continued observati to place a non-skid r placemat for the bre observation revealed independently during Review of client #3's a person-centered pl occupational therapy Review of the docum prescribed a non-skid drinks during mealtin eating/drinking habits Interview with the pro confirmed client #3's adaptive equipment a interview confirmed ti with all adaptive equip C. The facility failed to eyeglasses. For exan Observations through revealed client #4 to p activities to include ric television, hygiene, ch administration. Contin throughout the survey without eyeglasses wi regarding his eyeglass 10/17/23, confirmed b	dinner and breakfast meal /23 survey revealed client #3 a regular place setting to straw during mealtime. on on 10/17/23 revealed staff mat underneath client #1's akfast meal. Further d client #3 to participate g mealtime. record on 10/17/23 revealed lan dated 7/25/23 and an revaluation dated 7/28/22. hentation revealed client #3 is d mat and a straw with all he to support his s. ogram manager on 10/17/23 orders for mealtime are current. Continued he client should be provided pment as prescribed. o provide client #4 with hople: hout the 10/16-17/23 survey participate in various ding his bike, watching hores, and medication	W 2	249			

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		34G247	B. WING	-		1	0/17/2023		
	NAME OF PROVIDER OR SUPPLIER LINOAK GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 3175 BANK ROAD LINCOLNTON, NC 28092	'	0/1//2020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	BF	(X5) COMPLETION DATE		
	the medication room Review of client #4's a person-centered produced indicated he wears of the person of the perso	s record on 10/17/23 revealed lan dated 5/10/23 which eyeglasses daily. Ogram manager on 10/17/23 or orders for eyeglasses are it they were unaware the oken. Continued interview cilities responsibility to equipment is kept in good rovided as prescribed. To ensure client #6 utilized his riately: For example: The facility survey that client #6 participated in fast meal with the following small spoon, high sided that client #6 to be served cup for both meals. Further dithat client #6 removed the to drink his water for both ring observations was staff lient #6 to replace the lid to then allow the client to drink 10/17/23 for client #6 ntered plan (PCP) dated oview of the PCP revealed py evaluation dated 7/28/22 metered cup but will the lid and staff will provide ent to replace the lid and	W 2	249					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY	
		DENTIFICATION NUMBER:	A. BUILI	DING _	COMPLETED			
NAME 05		34G247	B. WING	·		10	/17/2023	
	NAME OF PROVIDER OR SUPPLIER LINOAK GROUP HOME			31	TREET ADDRESS, CITY, STATE, ZIP CODE 175 BANK ROAD INCOLNTON, NC 28092		71112020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BF	(X5) COMPLETION DATE	
W 249	Continued From page	ge 17	W 2	249				
	Interview with the priverified the PCP for Continuing interview confirmed that staff #6 to replace the lid drinking water. DRUG ADMINISTRACFR(s): 483.460(k)(The system for drug that all drugs are adrithe physician's order This STANDARD is Based on observation interview, the system failed to assure all drugs are all drugs are adritherview, the system failed to assure all drugs (#3) in the group hormodication administration for clies medication room for recontinued observation administration for clies anitize his hands and	ogram manager on 10/17/23 client #6 to be current. with the program manager should have prompted client on the metered cup prior to ATION 1) administration must assure ministered in compliance with s. not met as evidenced by: on, record review and for drug administration ugs were administered in sician orders for 1 of 6 clients he observed during ation. The finding is: oup home on 10/17/23 at ent #3 to walk into the morning medications. n of the medication of the medication of the medication of the pill packet	W 3 Nur on p QP	68 sing prop will	g will complete an inservice training per medication administration prot inservice on plan implementation of during house meetings.	ng nocols	2/11/2023	
i i i i	revealed staff assistin medications into the nobservation revealed medications whole with medication observation or covide client #3's me	th a cup of water. During the on staff was not observed to dications in apple sauce. rders for client #3 on prescribed order dated						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G247	B. WING		10	/47/2022	
100 100 100 100 100 100 100 100 100 100	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3175 BANK ROAD LINCOLNTON, NC 28092	1 10	/17/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTICIENCY)	DBF	(X5) COMPLETION DATE	
W 368	Continued From page	ge 18	W 36	68			
W 440	confirmed that client medications in apple with the facility nursureceives medication edentulous. EVACUATION DRIL CFR(s): 483.470(i)(1) at least quarterly for This STANDARD is Based on review of facility failed to show were conducted with relative to first, second		W 44 QP w drills	vill inservice staff on Fire & Evacua at each house meeting every mon	tion th. 1:	2/11/2023	
	through 9/23 reveale 12/22, 1/23, and 4/23 fire drill reports reveal in the first quarter, fire second quarter, third quarter, and a second missing in the fourth the fire drill reports responsively of 10 minutes; additional documental an action plan for the 3 minutes. There was documentation availad drills.	fire drill reports from 10/22 d missing fire drills for 10/22, 3. Continued review of the aled a first shift drill missing in the shift drill missing in the shift drill missing in the third d shift and third shift drill quarter. Further review of evealed that drills completed and 8/23 had evacuation however, the facility had no tion providing evidence of evacuation time exceeding in additional ble for the missing quarterly gram manager on 10/17/23 hould have been conducted it. Continued interview with					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPI IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DA	(X3) DATE SURVEY COMPLETED	
		34G247	B. WING		40	147/0000	
LINOAK GROUP HOME				3175 BANK ROAD	10	/17/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	UIDBE	(X5) COMPLETION DATE	
W 440	the program manage	er confirmed there was no ation to reflect the missing	W 44				
	(X4) ID PREFIX TAG	(X4) ID SUMMARY STATE (EACH DEFICIENCY REGULATORY OR LS W 440 Continued From page the program manage additional document	NAME OF PROVIDER OR SUPPLIER LINOAK GROUP HOME (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	NAME OF PROVIDER OR SUPPLIER LINOAK GROUP HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 440 Continued From page 19 the program manager confirmed there was no additional documentation to reflect the missing	NAME OF PROVIDER OR SUPPLIER LINOAK GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE 3175 BANK ROAD LINCOLNTON, NC 28092 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 440 Continued From page 19 the program manager confirmed there was no additional documentation to reflect the missing	NAME OF PROVIDER OR SUPPLIER LINOAK GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE 3175 BANK ROAD LINCOLNTON, NC 28092 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 440 Continued From page 19 the program manager confirmed there was no additional documentation to reflect the missing	