STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A revisit was conducted on 9/3/24 for all previous deficiencies cited on 6/4/24. The following deficiencies were corrected E006, E0018, E0023, E0030, W104, W148, W153, W159, W252, W255, W259, W289 and W454. Two new areas of non-compliance was at W323 and W347. The facility remained out of compliance in E0004, E0022, E0039, W210, W217, W262, W263 and W331.	E 000		
{E 004}	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal,	{E 004}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{E 004}	Continued From page 1 State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to review and update their emergency preparedness (EP) plan at least every 2 years. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 6/5/24 of the facility's EP plan revealed a completion date of 5/15/22. Further review revealed no evidence the plan had been updated in the past 2 years. Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was unable to provide any additional information that the EP had been updated. A follow-up visit was conducted on 9/3/24.	{E 004}		

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{E 004}	Continued From page 2 Record review on 9/3/24 of the EP plan revealed it was updated on 6/20/24. Review of their policies reveal there was no evidence of a pandemic policy in their EP plan. Interview on 9/3/24 with the QIDP revealed he did not have a pandemic policy for the EP plan.	{E 004}		
{E 022}	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:	{E 022}		

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{E 022}	Continued From page 3 (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop a shelter in place policy for their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 6/5/24 of the facility's EP plan dated 5/15/22 revealed there we no details to identify a shelter in place policy and procedures. Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was unable to provide any additional information regarding a shelter in place policy. A follow-up visit was conducted on 9/3/24. Record review on 9/3/24 of the EP plan revealed it was updated on 6/20/24 without a Shelter In Place policy. Interview on 9/3/24 with the QIDP revealed he contacted the office to inquire if there was a policy and did not receive a copy.	{E 022}		
{E 039}	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under	{E 039}		

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{E 039}	Continued From page 4 §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	{E 039}		

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{E 039}	Continued From page 5 *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:	{E 039}		

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	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{E 039}	Continued From page 6 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not	{E 039}		

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	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

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{E 039}	Continued From page 7	{E 039}		

accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

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	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

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{E 039}	Continued From page 8 (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.	{E 039}		

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	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

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{E 039}	Continued From page 9 (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based	{E 039}		

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	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

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{E 039}	Continued From page 10	{E 039}		

functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at
least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.
(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

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{E 039}	Continued From page 11	{E 039}		

exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.

(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

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THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 039}	Continued From page 12 OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct a full-scale exercise to test their emergency preparedness (EP) plan. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Review on 6/5/24 of the facility's EP plan dated 5/15/22 revealed the facility conducted tabletop and mock drill exercises for their EP plan. There was no evidence of a full-scale exercise. Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed he was not aware a full-scale exercise was required. A follow-up visit was conducted on 9/3/24. Record review on 9/3/24 of the EP plan dated 6/20/24 revealed there was no evidence a full-scale exercise was completed.	{E 039}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 039}	Continued From page 13 Interview on 9/3/24 with the QIDP revealed they did a full-scale exercise last Thursday and evacuated the home with the clients and staff, for a mock 7 days stay. The QIDP acknowledged, he did not record the staff who participated or other details of the exercise because he "did not have time yet with the holiday."	{E 039}		
{W 210}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure initial assessments were done for 1 of 3 audit clients (#3) that was newly admitted to the home. The finding is: Record review on 6/5/24 of client #3 was admitted to the facility on 8/23/23 and his individual program plan (IPP) dated 5/15/24 only had the qualified intellectual disabilities professional (QIDP) and guardian participating. The current IPP did not have assessments from nutrition, speech, auditory, physical or occupational therapy clinicians, despite a referral from the doctor in August 2023 to get them scheduled. Interview on 6/5/24 with the QIDP revealed he was using the IPP dated 7/20/23 from client #3's former group home. The QIDP revealed the physician examined client #3 and made recommendations to refer him to contract clinicians for his assessments. The QIDP	{W 210}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

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{W 210}	Continued From page 14 acknowledged it was his responsibility to schedule these appointments and it was not done. A follow-up visit was conducted on 9/3/24. Record review on 9/3/24 of client #3's IPP dated 5/15/24 revealed the client had still not received assessments from nutrition and auditory. Record review also revealed client #3 had still not received a physical exam. Interview on 9/3/24 with the QIDP confirmed client #3 had not had an auditory or nutritional evaluation. The QIDP also confirmed client #3 had not had an annual physical.	{W 210}		
{W 217}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 3 audit clients (#1, #2 and #3) received annual nutritional evaluations. The findings are: A. Record review on 6/4/24 of client #1's nutritional review revealed the last assessment was done on 4/19/23. B. Record review on 6/4/24 of client #2's nutritional review revealed the last assessment was done on 4/19/23. C. Record review on 6/5/24 of client #3's nutritional review revealed an absence of a nutritional assessment since his admission to the	{W 217}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 217}	Continued From page 15 home on 8/21/23. Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed they have not had a registered dietician since a year ago. The QIDP revealed they were using the dietary orders that client #3 was on from his last group home. A follow-up survey was conducted on 9/3/24. A. Record review on 9/3/24 of client #1's nutritional review revealed the last assessment was done on 4/19/23. B. Record review on 9/3/24 of client #2's nutritional review revealed the last assessment was done on 4/19/23. C. Record review on 9/3/24 of client #3's nutritional review revealed an absence of a nutritional assessment since his admission to the home on 8/21/23. Interview on 9/3/24 with the QIDP confirmed no nutritional evaluations had been completed for client #1, #2 or #3. The QIDP revealed the facility still had no obtained a registered dietician.	{W 217}		
{W 262}	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	{W 262}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 262}	Continued From page 16	{W 262}		

failed to ensure techniques used to manage behaviors were reviewed and monitored by the Human Rights Committee (HRC) for 3 of 3 audit clients (#1, #2 and #3) on behavior support plans (BSP). The findings are:

A. Record review on 6/4/24 of client #1's BSP from 5/5/23 revealed a goal to decrease episodes of inappropriate behaviors to 15 per month for during the review period. Inappropriate targeted behaviors were defined as non-compliance, aggression, self-injurious behaviors, public masturbation and taking food that does not belong to him. Medications used to treat his behaviors were Fluvoxamine Mal and Quetiapine Fumarate. There was no record that client #1's BSP had been reviewed and approved by the facility's HRC.

B. Record review on 6/4/24 of client #2's BSP from 6/1/23 revealed a goal to decrease episodes of inappropriate behavior to 15 or fewer per month. Inappropriate behaviors were defined as hitting, kicking, attacking staff when redirected, self-wetting, PICA, sexually inappropriate behaviors, loud vocalizations, taking food that did not belong to her and public masturbation. Medications to treat her behaviors included Citalopram, Clonidine, Fanapt, Topiramate, Hydroxyzine, Trazadone, Celexa, Zyprexa and Diazepam prn. There was no record that client #2's BSP had been reviewed and approved by the facility's HRC.

C. Record review on 6/5/24 of client #3's BSP revealed the facility had incorporated behavioral guidelines from his previous placement. Client #3's target behaviors were defined as threatening self-harm, verbal aggression, self-injurious

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 262}	Continued From page 17	{W 262}		

behaviors, property destruction, noncompliance, physical aggression, attempted AWOL and making untrue statements. Medications used to treat his behaviors were Risperidone ER bi-monthly injections, Clonazepam, Lithium Carb and Gabapentin. There was no record that client #3's BSP had been reviewed and approved by the facility's HRC.

Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed the facility did not have a Human Rights Committee.

A follow-up survey was completed on 9/3/24.

A. Record review on 9/3/24 of client #1's BSP from 5/5/23 revealed a goal to decrease episodes of inappropriate behaviors to 15 per month for during the review period. Inappropriate targeted behaviors were defined as non-compliance, aggression, self-injurious behaviors, public masturbation and taking food that does not belong to him. Medications used to treat his behaviors were Fluvoxamine Mal and Quetiapine Fumarate. There was no record that client #1's BSP had been reviewed and approved by the facility's HRC.

B. Record review on 9/3/24 of client #2's BSP from 6/1/23 revealed a goal to decrease episodes of inappropriate behavior to 15 or fewer per month. Inappropriate behaviors were defined as hitting, kicking, attacking staff when redirected, self-wetting, PICA, sexually inappropriate behaviors, loud vocalizations, taking food that did not belong to her and public masturbation. Medications to treat her behaviors included Citalopram, Clonidine, Fanapt, Topiramate, Hydroxyzine, Trazadone, Celexa, Zyprexa and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 262}	Continued From page 18 Diazepam prn. There was no record that client #2's BSP had been reviewed and approved by the facility's HRC. C. Record review on 9/3/24 of client #3's BSP revealed the facility had incorporated behavioral guidelines from his previous placement. Client #3's target behaviors were defined as threatening self-harm, verbal aggression, self-injurious behaviors, property destruction, noncompliance, physical aggression, attempted AWOL and making untrue statements. Medications used to treat his behaviors were Risperidone ER bi-monthly injections, Clonazepam, Lithium Carb and Gabapentin. There was no record that client #3's BSP had been reviewed and approved by the facility's HRC. Interview on 9/3/24 with the QIDP confirmed there was still no HRC consent for client #1, #2, or #3's BSP's.	{W 262}		
{W 263}	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a restrictive Behavior Support Plan (BSP) used to administer behavioral medications and behavior techniques, had the written consent of the guardian. This affected 1 of 3 audit clients (#1). The finding is: Record review on 6/4/24 of client #1's BSP from 5/5/23 revealed a goal to decrease episodes of	{W 263}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 263}	Continued From page 19 inappropriate behaviors to 15 per month for during the review period. Inappropriate targeted behaviors were defined as non-compliance, aggression, self-injurious behaviors, public masturbation and taking food that does not belong to him. Medications used to treat his behaviors were Fluvoxamine Mal and Quetiapine Fumarate. The last consent to authorize the BSP was signed by the guardian on 8/2/22. Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed the consents for the BSP's should be updated annually. A follow-up survey was conducted on 9/3/24. Record review on 9/3/24 of client #1's BSP from 5/5/23 revealed a goal to decrease episodes of inappropriate behaviors to 15 per month for during the review period. Inappropriate targeted behaviors were defined as non-compliance, aggression, self-injurious behaviors, public masturbation and taking food that does not belong to him. Medications used to treat his behaviors were Fluvoxamine Mal and Quetiapine Fumarate. The last consent to authorize the BSP was signed by the guardian on 8/2/23. Interview on 9/3/24 with the QIDP revealed the consent for client #1's BSP was signed on 8/2/23 and has not been updated since. The QIDP also confirmed consents should be updated annually.	{W 263}		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum	W 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 323	Continued From page 20	W 323		

includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure 3 of 3 audit clients (#1, #2 and #3) received an annual physical exam from the doctor. The findings are:

A. Record review on 9/3/24 of client #1's medical chart revealed no evidence of an annual physical exam during a 12 months period. An additional review revealed a medical consultation form for client #1 on 6/5/24 where the doctor diagnosed him with a Stage II decubitus ulcer on right buttocks and prescribed occlusive dressing. The consult also revealed the nurse reviewed the report (date unknown) and instructed staff to treat sore with medication and bandage, after the medication was delivered from pharmacy. Another medical consultation form completed by the qualified intellectual disabilities professional (QIDP) on 8/5/24 revealed a request for the doctor to make a nutritionist referral. The doctor's response was orders for nutritionist and dermatologist. The doctor added, "pressure ulcer to sacrum healing well" and client #1's weight and height was recorded.

B. Record review on 9/3/24 of client #2's medical chart revealed no evidence of an annual physical exam during a 12 months period.

C. Record review on 9/3/24 of client #3's medical chart revealed no evidence of an annual physical exam during a 12 months period.

Interview on 9/3/24 with the QIDP revealed the doctor has not examined any of the clients at the facility. The QIDP acknowledged he requests referrals for the doctor and refills, on the medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 323	Continued From page 21 consultation forms. The doctor reviews the forms and writes orders; signs and returns the form to him.	W 323		
{W 331}	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 2 of 3 audit clients (#1 and #3) received the necessary ongoing nursing services to prevent declines in skin conditions. The findings are: A. Review on 6/4/24 of client #1's nursing notes revealed on 10/28/23 a discoloration of unusual texture was first noticed on his right buttocks that was determined to be an abscess. On 11/28/23, new physician's orders revealed to apply a protective cream to buttocks twice a day. There was no documentation on the chart the abscess was still being treated or had worsened. On 6/5/24, client #1 returned from a doctor's appointment with a consultant report that diagnosed him as having a stage II pressure ulcer on right buttocks. Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed there was no nurse working in the home but there was a contract nurse who came to the home every month. The QIDP acknowledged, staff have been trained to contact him for nursing concerns. On 6/1/24, he received a call from staff who was concerned about skin breakdown on client #1's right buttocks and sent a photograph to the QIDP. The QIDP revealed the buttock appeared to have	{W 331}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 22	{W 331}		

a hole and he was worried that client #1 developed a pressure ulcer and made immediate arrangements to get an appointment for client #1 to see the doctor. The QIDP acknowledged the nurse was notified on 6/5/24 of client #1's pressure ulcer on buttocks.

B. During observations in the home on 6/4/24 at 5:45pm, client #1 wore an surgical shoe on his right foot.

Record review on 6/4/24 revealed on 5/1/24, client #3 was evaluated for right foot pain, was picking the skin on the great toe and received an x-ray and ultrasound. Client #3 was diagnosed with soft tissue injury and was noted to have displaced soft tissue flap on the tip of his right great toe. No fracture was detected from tests. Client #3 was placed on antibiotic for an infection to great toe. On 5/30/24, client #3 was sent to the emergency room due to the fat layer on great toe exposed. Client #3 was diagnosed with a right pressure ulcer on toe. Client #3's dressing should be changed daily, with antibiotic ointment applied, covered with bandage and he should continue to wear surgical shoe. Client #3 needs to follow-up with his podiatrist in 4 weeks.

Interview on 6/5/24 with Staff A revealed client #1 would remove the bandage on great toe and did not always like to wear the surgical shoe. Staff A acknowledged she passed medications on day shift and was cleaning the wound on great toe that originated from a hang nail for client #3. Staff A revealed she was not told client #3's toe injury had worsened to an ulcer.

Interview on 6/5/24 with the QIDP revealed the nurse was contracted and did not spend a lot of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 23	{W 331}		

time in the home.

A follow-up visit was conducted on 9/3/24.

A. Record review on 9/3/24 of client #1 Nursing Monthly Assessment revealed the following: On 6/24/24, 7/19/24 and 8/12/24, the nurse completed an assessment without providing wound care services.

Record review on 9/3/24 of client #1's medical chart revealed a medical consultation form from 6/5/24 where the doctor diagnosed him with a Stage II decubitus ulcer on right buttocks and prescribed occlusive dressing. The consult also revealed the nurse reviewed the report (date unknown) and instructed staff to treat sore with medication and bandage, after the medication was delivered from pharmacy. Another medical consultation form completed by the qualified intellectual disabilities professional (QIDP) on 8/5/24 revealed a request for the doctor to make a nutritionist referral. The doctor's response was orders for nutritionist and dermatologist. The doctor added, "pressure ulcer to sacrum healing well".

Interview on 9/3/24 with the home manager revealed client #1's pressure ulcer healed.

Interview on 9/3/24 with the QIDP revealed their contract nurse made monthly visits to the home. The QIDP revealed the nurse was not providing wound care and there were no nursing notes on the measurements of client #1's pressure ulcer and progress notes that indicated it was healed.

B. Record review on 9/3/24 of client #3's Nursing Monthly Assessment revealed on 8/12/24, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 331}	Continued From page 24 nurse made a monthly visit to the home. The nurse's note revealed there were no indicators of pain or wound care for client #3. Interview on 9/3/24 with the home manager revealed client #3 was on a community outing for lunch and was unavailable to examine his toe with the pressure ulcer. Interview on 9/3/24 with the QIDP revealed client #3 was still getting wound care from the direct care professionals and he did not have any skin care documentation for the ulcer.	{W 331}		
W 347	NURSING STAFF CFR(s): 483.460(d)(5) Non-licensed nursing personnel who work with clients under a medical care plan must do so under the supervision of licensed persons. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication technicians were supervised by a licensed nurse in order to perform wound care treatments for pressure ulcers for 2 of 3 audit clients (#1 and #3). The findings are: A. Record review on 9/3/24 revealed a medical consultation form on 6/5/24, client #1 was diagnosed with a Stage II decubitus ulcer on right buttocks and prescribed occlusive dressing. The consult also revealed the nurse reviewed the report (date unknown) and instructed staff to treat sore with medication and bandage, after the medication was delivered from pharmacy. There were no notes of any treatments prescribed and the skin condition of the pressure ulcer over a 3 months period. The record lacked documentation	W 347		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G239	A. BUILDING _____ B. WING _____	R 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

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W 347	Continued From page 25 the pressure ulcer on the right buttock was healed. Record review on 9/3/24 of client #1's monthly nursing assessments, on 6/24/24, 7/19/24 and 8/12/24; revealed the nurse did not perform wound care services for client #1 during the visits. Interview on 9/3/24 with the home manager revealed client #1's pressure ulcer healed and direct care professionals applied medications for treatment. Interview on 9/3/24 with the QIDP revealed their contract nurse made monthly visits to the home. The QIDP revealed the nurse was not providing wound care and there were no nursing notes on the measurements of client #1's pressure ulcer and progress notes that indicated it was healed. B. Record review on 9/3/24 of client #3's monthly nursing assessment on 8/12/24, revealed there were no indicators of pain or wound care provided by the nurse. Interview on 9/3/24 with the home manager revealed client #3 received wound care from direct support professionals. Interview on 9/3/24 with the QIDP revealed client #3 was still getting wound care from the direct care professionals and he did not have any skin care documentation for the ulcer.	W 347		