PRINTED: 11/07/2024 FORM APPROVED OMB NO. 0938-0391

| LAND BLAN OF CORDECTION L'ÉDENTIEIGATION NUMBER L'ÉÉ | | ` ′ | IPLE CONSTRUCTION NG | ` ' | COMPLETED | |
|--|---|--|-----------------------|---|-----------|---|
| | | 34G272 | B. WING _ | | 10 | C 0/ 22/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | • | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | E 00 | 00 | | |
| E 006 | completed on 10/22 The complaint was deficiencies cited. I cited during the rec | lazards Risk Assessment | E 00 | 06 | | |
| | §460.84(a)(1)-(2), § (1)-(2), §483.475(a) §485.68(a)(1)-(2), § §485.625(a)(1)-(2), | §441.184(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a))(1)-(2), §484.102(a)(1)-(2), §485.542(a)(1)-(2), §485.727(a)(1)-(2), §486.360(a)(1)-(2), | | | | |
| | and maintain an em that must be review | n. The [facility] must develop nergency preparedness plan /ed, and updated at least every must do the following:] | | | | |
| | facility-based and c | d include a documented, community-based risk ng an all-hazards approach.* | | | | |
| | | es for addressing emergency the risk assessment. | | | | |
| | The Hospice must a emergency prepare reviewed, and upda plan must do the fo (1) Be based on an facility-based and compare the state of | §418.113(a):] Emergency Plan. develop and maintain an edness plan that must be ated at least every 2 years. The illowing: d include a documented, community-based risking an all-hazards approach. | | | | |
| L ABORATORY | | DER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | 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.

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|--------------------|-----|---|-------------------------------|----------------------------|--|
| | | 34G272 | B. WING | | | | C 22/2024 | |
| | PROVIDER OR SUPPLIER | | | 11 | REET ADDRESS, CITY, STATE, ZIP CODE 4 GREENHOUSE LANE OUTHERN PINES, NC 28387 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE | |
| E 006 | events identified by including the mana of power failures, nemergencies that wability to provide cate *[For LTC facilities Plan. The LTC facilities Plan. The LTC facilities Plan. The LTC facilian emergency prepreviewed, and updamust do the followi (1) Be based on an facility-based and cassessment, utilizing including missing recorded to the following plan must do the following the potential to effect of the potential to effect of the power facility and emergency prepared the potential to effect of power failed to develop are that was facility and emergency prepared the potential to effect of the power failed to defect of the potential to effect of power failed to effect of the power failures and the potential to effect of power failed to develop are the potential to effect of power failed to effect of the power failed to effect of the power failures are power failed to effect of the power failures are power failures. The power failures are power failures. The power failures are power failures. The power failures are power failures are power failures are power failures are power failures. The power failures are power failures are power failures are power failures are power failures. The power failures are power failures. The power failures are power failures. The power failures are pow | res for addressing emergency the risk assessment, agement of the consequences latural disasters, and other would affect the hospice's are. at §483.73(a):] Emergency lity must develop and maintain paredness plan that must be ated at least annually. The planing: and include a documented, community-based risk ag an all-hazards approach, esidents. es for addressing emergency the risk assessment. 483.475(a):] Emergency Plan. develop and maintain an edness plan that must be ated at least every 2 years. The ollowing: and include a documented, community-based risk ag an all-hazards approach, | E | 006 | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | IPLE CONSTRUCTION NG | CON | COMPLETED | | |
|--|--|---|-----------------------|---|-----------|----------------------------|--|
| | | 34G272 | B. WING_ | | | C / 22/2024 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | | , <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| E 006 | Review on 10/22/24 on 4/15/23 and did facility had evaluate event of an emerge Interview on 10/22/2 | 4 revealed the EP was written not contain evidence the ed their all-hazards risks in the ency. 24 with the Qualified | E 00 | 06 | | | |
| E 013 | revealed she did not review and did not the office, when red | Policies and Procedures | E 0 ⁻ | 13 | | | |
| | §483.475(b), §484. | 84(b), §482.15(b), §483.73(b), 102(b), §485.68(b), 625(b), §485.727(b), | | | | | |
| | develop and implent policies and proceed plan set forth in parassessment at para and the communication. The policies are processed in the policies and the policies are processed in the policies are processed in the policies and processed in the policies a | ocedures. [Facilities] must ment emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated at least every 2 years. | | | | | |
| | procedures. The LT implement emerger procedures, based forth in paragraph (assessment at para and the communicathis section. The position of the procedures are the procedures are the procedures are the procedures. | at §483.73(b):] Policies and TC facility must develop and ncy preparedness policies and on the emergency plan set a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated at least annually. | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--------------------|-----------------|---|--------|----------------------------|
| | | 34G272 | B. WING | | | I | C 22/2024 |
| | PROVIDER OR SUPPLIER | · · | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | 1 10/2 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| E 013 | Continued From pa *Additional Require Facilities: | ge 3 ments for PACE and ESRD | ΕC |)13 | | | |
| | *[For PACE at §460 procedures. The Padevelop and implem policies and proced plan set forth in parassessment at para and the communicathis section. The paddress management equipment, power, emergencies; and rethreaten the health staff, or the public. | 0.84(b):] Policies and ACE organization must nent emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must ent of medical and nonmedical ding, but not limited to: Fire; or water failure; care-related natural disasters likely to or safety of the participants, The policies and procedures and updated at least every 2 | | | | | |
| | procedures. The di and implement eme and procedures, ba set forth in paragral assessment at para and the communica this section. The po be reviewed and up These emergencies to, fire, equipment of emergencies, water natural disasters like geographic area. This STANDARD is Based on record re- failed to develop po | es at §494.62(b):] Policies and ialysis facility must develop ergency preparedness policies ised on the emergency plan ph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated at least every 2 years. Is include, but are not limited or power failures, care-related or supply interruption, and ely to occur in the facility's exist of the section of the power failures in the facility olicies for a pandemic in the edness (EP) plan. This had the | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | TIPLE CONSTRUCTION ING | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--------------------|--|-------------------------------|----------------------------|
| | | 34G272 | B. WING | | | C 22/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | 0.02.1 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 22/2024 |
| CREST F | ROAD GROUP HOME | | | 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | | |
| (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 APPROPRIED TO T | D BE | (X5) COMPLETION DATE |
| E 013 | home (#1, #2, #3, # Review on 10/22/24 revised on 4/13/23 procedures in even Interview on 10/22/2 Intellectual Disabilit revealed their EP p on how to respond | of 6 clients residing in the 4, #5 and #6). The finding is: I of the facility's EP plan revealed no policies or t of a Pandemic. 24 with the Qualified ies Professional (QIDP) lan did not contain instructions to a pandemic. | ΕC | | | |
| E 023 | on how to respond to a pandemic. Arrangement with Other Facilities CFR(s): 483.475(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(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:] *[For Hospices at §418.113(b), PRFTs at | | | | | |
| | Facilities at §483.73 (7) [or (5)] The development of the content | tals at §482.15(b), and LTC B(b):] Policies and procedures. elopment of arrangements with d] other providers to receive t of limitations or cessation of ain the continuity of services | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDI | | (X3) DATE SURVEY COMPLETED | | | |
|---|--|---|---------------------|-------------------------------|--|------|----------------------------|
| | | 34G272 | B. WING | | | | C 22/2024 |
| | PROVIDER OR SUPPLIER | | | 114 | EET ADDRESS, CITY, STATE, ZIP CODE GREENHOUSE LANE JTHERN PINES, NC 28387 | 1077 | |
| (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 APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| E 025 | *[For PACE at §460 §483.475(b), CAHs §485.920(b) and ES Policies and proced development of arra [facilities] [or] other in the event of limits operations to maint to facility patients. *[For RNHCIs at §4 procedures. (7) The arrangements with providers to receive limitations or cessa the continuity of nor patients. This STANDARD is Based on review at to develop pre-arrance clients in the event delivered in the hon Preparedness (EP) 6 of 6 clients in the #6). The finding is: Review on 10/22/24 revised on 4/13/23 was not identified for Interview on 10/22/2/24 Intellectual Disability. | 2.84(b), ICF/IIDs at at §486.625(b), CMHCs at SRD Facilities at §494.62(b):] lures. (7) [or (6), (8)] The angements with other providers to receive patients ations or cessation of ain the continuity of services 03.748(b):] Policies and elevelopment of other RNHCIs and other expatients in the event of tion of operations to maintain and interview, the facility failed accomodations for services could not be the interview, the facility failed accomodations for services could not be the interview, the facility affected home (#1, #2, #3, #4, #5 and and of the facility's EP plan revealed alternative housing or emergency purposes. 24 with the Qualified its Professional (QIDP) of the any other material for their EP plan. | EO | | | | |
| | CFR(s): 483.475(d) | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | l ` ′ | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|--------------------|-----------------|---|------|----------------------------|
| | | 34G272 | B. WING | | | | C 22/2024 |
| | PROVIDER OR SUPPLIER | | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 14 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | 1072 | 2212024 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| E 039 | §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §48 §485.542(d)(2), §48 §485.920(d)(2), §48 *[For ASCs at §416 at §485.542, OPO, §485.727, CMHCs §491.12, and ESRE (2) Testing. The [facto test the emergen must do all of the formulation of the formulation of the emexempt from engage community-based of functional exercise actual event. (ii) Conduct an additional exercise this section is conduct in the formulation of the emexempt from engage community-based of functional exercise actual event. (ii) Conduct an additional exercise this section is conduct in the formulational exercise this section is conduct the formulational exercise; (B) A mock disaster | 3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.68(d)(2), 35.625(d)(2), §485.727(d)(2), 31.12(d)(2), §494.62(d)(2). 3.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at 3 Facilities at §494.62]: cility] must conduct exercises cy plan annually. The [facility] ollowing: all-scale exercise that is every 2 years; or unity-based exercise is not a facility-based functional ars; or y] experiences an actual de emergency that requires ergency plan, the [facility] is ing in its next required or individual, facility-based following the onset of the actional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of acted, that may include, but is llowing: ale exercise that is or individual, facility-based or | EC | 039 | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | l ` ′ | PLE CONSTRUCTION G | CON | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|---------------------|--|-----------|-------------------------------|--|--|
| | | 34G272 | B. WING _ | | | C / 22/2024 | | |
| | PROVIDER OR SUPPLIER ROAD GROUP HOME | | | STREET ADDRESS, CITY, STATE, ZIP CO 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| E 039 | a facilitator and incla a narrated, clinically scenario, and a set directed messages designed to challen (iii) Analyze the [facility analyze the analyze | udes a group discussion using y-relevant emergency of problem statements, or prepared questions ge an emergency plan. Sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] Dices that provide care in the energency plan at least provide care in the energency plan at least provide emergency plan at least provide exercise that is every 2 years; or unity based exercise is not at an individual facility based every 2 years; or experiences a natural or experiences a natural or exercise or individual considerational exercise following the ency event. Ititional exercise every 2 years, the full-scale or functional exercise or individual consideration of the full-scale or functional exercise or individual consideration of the full-scale or functional exercise that is or a facility based functional consideration of the full-scale or functional exercise that is or a facility based functional | E 03 | 9 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|---|----------------------------|-----------------------|
| | | 34G272 | B. WING _ | | 10 | C / 22/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | (X5) COMPLETION DATE | |
| E 039 | a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The hexercises to test the year. The hospice (i) Participate in an is community-based (A) When a community-based functi (B) If the hospice eman-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-scommunity-based of exercise; or (B) A mock disasted (C) A tabletop exerting facilitator that include narrated, clinically-rand a set of problem messages, or prepare challenge an emerging (iii) Analyze the homaintain document | of problem statements, , or prepared questions ige an emergency plan. sices that provide inpatient hospice must conduct e emergency plan twice per must do the following: hannual full-scale exercise that d; or unity-based exercise is not t an annual individual onal exercise; or experiences a natural or ency that requires activation of the hospice is exempt from the required full-scale community sed functional exercise of the emergency event. Sitional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or rcise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the | E 03 | 9 | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|-----|--|-------------------------------|----------------------------|
| | | 34G272 | B. WING | | | C 10/22/2024 | |
| | PROVIDER OR SUPPLIER | | | 1′ | TREET ADDRESS, CITY, STATE, ZIP CODE 14 GREENHOUSE LANE 5OUTHERN PINES, NC 28387 | 1072 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | 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 APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| E 039 | *[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF conduct exercises at twice per year. The do the following: (i) Participate in an is community-based (A) When a community-based function (B) If the [PRTF, Ho actual natural or marequires activation (facility-based functionset of the emerging (ii) Conduct an and that may include following: (A) A second full-scommunity-based of functional exercises (B) A mock (C) A tabletop of led by a facilitator ad discussion, using a emergency scenari statements, directed questions designed plan. (iii) Analyze the maintain document | 1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan annual full-scale exercise that d; or unity-based exercise is not annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency at [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed. | E | 039 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | CON | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--|---|-------------------------------|----------------------------|--|
| | | 34G272 | B. WING _ | | | C / 22/2024 | |
| | PROVIDER OR SUPPLIER ROAD GROUP HOME | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| E 039 | (2) Testing. The PA exercises to test the annually. The PACI following: (i) Participate in an is community-base (A) When a community-based (A) When a community-based function (B) If the PACE expressible, conduction facility-based function (B) If the PACE expressible, conduction facility-based functions are man-made emergenthe emergency plarengaging in its next based or individual, exercise following the exercise under participate is conducted that must be following: (A) A second full-second full-second functional exercises (B) A mock disasted (C) A tabletop exercise a facilitator and inclusing a narrated, clusted messages designed to challer (iii) Analyze the PA maintain document exercises, and emergace (For LTC Facilities) | CE organization must conduct be emergency plan at least a corganization must do the annual full-scale exercise that do do annual full-scale exercise that do do annual full-scale exercise is not an annual individual, and exercise; or periences an actual natural or not that requires activation of an the PACE is exempt from a required full-scale community facility-based functional the onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited to cale exercise that is or individual, a facility based or ear drill; or a cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan. CE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed. | E 03 | 9 | | | |

| STATEMENT | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | E SURVEY PLETED |
|--------------------------|---|--|-------------------|---|---|------|----------------------------|
| | | 34G272 | B. WING | i | | | 22/2024 |
| | PROVIDER OR SUPPLIER | | | 11 | TREET ADDRESS, CITY, STATE, ZIP CODE 14 GREENHOUSE LANE OUTHERN PINES, NC 28387 | 1 10 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| E 039 | test the emergency including unannour emergency procedul CF/IID] must do the (i) Participate in an is community-based (A) When a community-based function (B) If the [LTC facility-based function (B) If the [LTC facility is exemined a full-scale individual, facility-based individual, facility-based following the onset (ii) Conduct an additional exercises (B) A mock disasted (C) A tabletop exercise a facilitator includes narrated, clinically-land a set of problem essages, or prepare challenge an emergical maintain document of the community facility and maintain document in the community facility and maintain document in the community facility facility facility facility facility facility facility facility in test the emerger The ICF/IID must details and maintain document in the community facility | plan at least twice per year, aced staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or unity-based exercise is not than annual individual, onal exercise. ty] facility experiences an en-made emergency that for the emergency plan, the experience of the emergency plan, the exercise of the emergency event. In the exercise of the emergency event. In the exercise that exercise that exercise that is for an individual, facility based for exercise or workshop that is led by a group discussion, using a relevant emergency scenario, and statements, directed exercise that exercise that exercise of the emergency scenario, and statements, directed exercise or workshop that is led by the exercise of the emergency scenario, and statements, directed exercise or workshop that is led by the exercise of the emergency scenario, and statements, directed exercise or workshop that is led by the exercise of the emergency scenario, and statements, directed exercise or workshop that is led by the exercise of the exercise of the emergency scenario, and revise the exercise of the emergency plan, as needed. Example 1. The exercise of the exercise | E | 000000000000000000000000000000000000000 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ` ' | l ` ′ | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--------------------|---|------------------------------|-------------------------------|--|
| | | 34G272 | B. WING | | 10 | C // 22/2024 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP (114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| E 039 | is community-base (A) When a commaccessible, conducted facility-based functional exercise emergency event. (ii) Conduct an addinational exercise emergency event. (iii) Conduct an addinational exercise emergency event. (iii) Conduct an addinational exercise (B) A second full-scommunity-based functional exercise (C) A tabletop exercise a facilitator and incusing a narrated, oscenario, and a sed directed messaged designed to challe (iii) Analyze the IC maintain document exercises, and em ICF/IID's emergen *[For HHAs at §48 (d)(2) Testing. The to test the emerge least annually. The (i) Participate in a community-based; (A) When a coaccessible, conducted in a community-based; (A) When a coaccessible, conducted in a community-based; (b) When a coaccessible, conducted in a community-based; (c) When a coaccessible, conducted in a community-based; (c) When a coaccessible, conducted in a community-based; (d) When a coaccessible, conducted in a community-based; (e) When a coaccessible, conducted in a community-based; (f) When a coaccessible, conducted in a community-based; (g) When a coaccessible, conducted in a coaccessibl | ed; or annual individual, tional exercise; or. experiences an actual natural or ency that requires activation of an, the ICF/IID is exempt from at required full-scale or individual, facility-based e following the onset of the ditional annual exercise that a not limited to the following: cale exercise that is or an individual, facility-based e; or er drill; or recise or workshop that is led by cludes a group discussion, clinically-relevant emergency et of problem statements, as, or prepared questions nge an emergency plan. F/IID's response to and attation of all drills, tabletop regency events, and revise the cy plan, as needed. 4.102] HHA must conduct exercises ncy plan at et HHA must do the following: full-scale exercise that is | E | 039 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|-----|---|-------------------------------|----------------------------|
| | | 34G272 | B. WING | | | (| |
| NAME OF F | DOVIDED OF OURDUIED | 349272 | D. WINO | | TREET ADDRESS OFT OTATE 7/D SORE | 10/2 | 22/2024 |
| | PROVIDER OR SUPPLIER ROAD GROUP HOME | | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 14 GREENHOUSE LANE COUTHERN PINES, NC 28387 | | |
| (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 |
| E 039 | or man-made emer of the emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an addition opposite the year the exercise under parais conducted, that limited to the follow (A) A second functional exercise; (B) A mock disaided functional exercise; (B) A mock disaided by a facilitator and discussion, using a emergency scenarious statements, directed questions designed plan. (iii) Analyze the HH. documentation of a emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The to test the emergency following: (i) Conduct a paper workshop at least as | experiences an actual natural regency that requires activation lan, the HHA is exempt from a required full-scale or individual, facility based following the onset of the ditional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ing: all-scale exercise that is or an individual, facility-based or exercise or workshop that is and 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 and revise the HHA's a needed. | E | 039 | | | |
| | discussion, using a emergency scenario | narrated, clinically relevant o, and a set of problem d messages, or prepared | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | . , | IPLE CONSTRUCTION NG | CON | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|-----------------------|---|-------------------------------|----------------------------|--|
| | | 34G272 | B. WING _ | | | C / 22/2024 | |
| | PROVIDER OR SUPPLIER ROAD GROUP HOME | | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| E 039 | questions designed plan. If the OPO ex man-made emerge the emergency plar engaging in its next following the onset (ii) Analyze the OPO documentation of a 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 RNH maintain document and emergency ever emergency plan, as This STANDARD is Based on record refailed to conduct at exercise or mock demergency prepared potential to affect al #5 and #6). The fine Review on 10/22/22 from 4/13/23 did not record refailed to conduct at the exercise or mock demergency prepared potential to affect al #5 and #6). The fine | to challenge an emergency periences an actual natural or ncy that requires activation of a the OPO is exempt from a required testing exercise of the emergency event. D's response to and maintain and revise the [RNHCl's and plan, as needed. 748]: RNHCl must conduct the emergency plan. The RNHCl and plan, as needed. 748]: RNHCl must conduct the emergency plan. The RNHCl and plan, as needed. 748]: RNHCl must conduct the emergency plan. The RNHCl and plan, as needed. 748]: RNHCl must conduct the emergency plan. The RNHCl and plan and a set pletop exercise is a group facilitator, using a narrated, and a set ents, directed messages, or designed to challenge an ents, directed messages, or designed to challenge an ents, and revise the RNHCl's and revise the RNHCl's and revise the RNHCl's and interview, the facility the plan and interview, the facility that the life of the clients (#1, #2, #3, #4, ding is: 4 revealed the facility's EP plan at include training exercises to staff for an emergency with | E 03 | 39 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|------------------------|--|-------------------------------|----|----------------------------|
| | | 34G272 | B. WING | | | | 22/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | ODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | SHOULD | BE | (X5) COMPLETION DATE |
| E 039 W 331 | Intellectual Disabilit revealed she did no materials on their E | 24 with the Qualified ies Professional (QIDP) of have any additional P plan and could not acquire als from the corporate office. ES | E 0 | | | | |
| | The facility must proservices in accorda This STANDARD is Based on observat interviews, the facili services were provi client needs as rela administration and | ovide clients with nursing nce with their needs. s not met as evidenced by: ion, record review and ity failed to ensure nursing ded in accordance to the | | | | | |
| | | /24 of client #5's medication rds (MAR) revealed multiple edications: | | | | | |
| | 200mg on 6/22/24, 7/31/24, 8/10/24, 8/ 8/15/24, 8/16/24, 8/ 9/26/24 and 9/30/24 | oses of Lamotrigine (Lamictal) 6/27/24, 7/28/24, 7/30/24, 12/24, 8/23/24, 8/14/24, 17/24, 9/13/24, 9/15-9/16/24, 4 due to it being out of stock. 5 was sent to the emergency tivity. | | | | | |
| | 2mg on 6/12/24, 6/2 | 5 missed doses of Risperidone 27/24, 6/30/24, 7/11/24, /24, 8/11/24, 8/12/24 and | | | | | |
| | | of the Policy for Medication revised 8/11/24 revealed all | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|------------------------|---|-------------------------------|------|----------------------------|
| | | 34G272 | B. WING | | | | C 22/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | ODE | 10/2 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD | BE | (X5) COMPLETION DATE |
| W 331 | within 30 days of the The first medication member; the staff in shift until medication attended. The secon for a staff member will result in terminal (RN) and/or design medication administ properly. Interview on 10/22/2 (HM) and Qualified Professional (QIDP consultant and does month. They reveal doing training on 8/admitted on 10/14/2 conducted monthly as the HM, to ensure ordered. The QIDP of multiple medication and had to order a spharmacy. The QID were supposed to medication ran out. medication administ could not explain we gaps in the same madministered if the The QIDP also acknower still missed in after staff were retrated in the staff were retrained in the | cation administration training eir employment start date. In error reported for a staff nember will be pulled from administration training is and medication error reported within six months of the error ation. The Registered Nurse ee will ensure that all tration policies are followed 24 with the Home Manager Intellectual Disabilities) revealed their RN is a so not visit the home every ed the RN was in the home 13/24 and when client #3 was 24. The QIDP revealed she reviews of the MAR, as well be medications were given as acknowledged she was aware on errors due to not available as day supply from the explained the med techs sotify them 5 days before the Staff were retrained on tration on 8/7/24. The QIDP thy there were intermittent anoth of the medication being stock had been replenished. The explained medication doses September 2024 for client #5 ained. She further confirmed and been suspended from | W 3 | 31 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---------------------|---|-------------------------------|----------------------------|--|
| | | 34G272 | B. WING _ | | 10 | C / 22/2024 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | | ,,_, | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE | |
| W 331 | in the medication rovanilla nutritional survanilla Review on 10/22/24 from 11/9/23 for clie placed her on an 18 weight gain. In add Quarterly Nursing A 217 lbs. and Height weight change. The note revealed clienhealth. There were indicated staff were weight loss and epidemic placed for 10/22/24 from 7/11/24 for clie weight was 110 lbs she was eating less gastrointestinal issurvanilla weight loss and weight loss and weight loss and weight loss and epidemic placed for twi intake and epidemic | ent drink sent by the pharmacy from and a half-opened case of applement drink. 4 of client #6's quarterly review revealed on 3/7/23 th was 194 lbs., on 6/20/23 is., on 12/11/23 she weighed weight remained stable for 24. On 6/12/24 client #6 4 of a nurse progress note ent #6 revealed the dietician 800 calories diet due to recent ition, the April-July 2024 assessment listed client #6 at 84"; noting no significant at 9 July 2024 nurse progress the was in overall stable no other nurse's notes that a communicating continued sodes of diarrhea. 4 of the nutritional evaluation ent #6 revealed her current and height 4'10". It was noted is possibly due to use. A nutritional supplement ce daily due to decrease in oss. 24 with Staff D revealed client reated episodes of diarrhea utritional supplements, which etimes. Staff D acknowledged | W 33 | 1 | | | |
| | Interview on 10/22/ | 24 with the HM revealed client | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---------------------|---|-------------------------------|------|----------------------------|
| | | 34G272 | B. WING _ | | | 10/2 | 2 2/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | ODE | 10/2 | |
| (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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | BE | (X5) COMPLETION DATE |
| W 331 | year she has worke remained the same #6 was compliant w supplement drinks. | ge 18 er. The HM remarked in the ed with client #6, she has size. The HM revealed client with consuming her nutritional | W 3: | 31 | | | |
| W 361 | client #6 had started diarrhea several mobelieved it was a bette nurse had visited 10/14/24 as was avishe acknowledged but was unaware it QIDP revealed she nutritionist last week in the nutritional supclient #6 to have dia QIDP the drinks we caused diarrhea. The QIDP also condiscrepancy in the vithat was recorded in PHARMACY SERV CFR(s): 483.460(i) The facility must profor the provision of and biologicals to its biologicals may be contract pharmacista licensed pharmacista licensed pharmacista several model. | d to experience episodes of onths and initially it was chavior. The QIDP revealed of the home on 8/14/24 and ailable by request. Further, the diarrhea was still occurring was held in the evening. The took client #6 to visit a new k and she explored if the milk oplement drinks were causing arrhea. The nutritionist told the re not made with milk or ne nutritional supplement was ay due to weight at 106 lbs. firmed the nutritionist noticed a weight and height for client #6 in her medical record. ICES | W 36 | 31 | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | | LE CONSTRUCTION | COMPLETED | | |
|--|--|--|--------------------|-----------------|---|-------|----------------------------|
| | | 34G272 | B. WING | i | | | C 22/2024 |
| | PROVIDER OR SUPPLIER | | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | 1 101 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| W 361 | system to ensure m dispense to 1 of 6 a is: Review on 10/22/24 administration recomissed doses of mode 200mg on 6/22/24, 7/31/24, 8/10/24, 8/8/15/24, 8/16/24, 8/9/26/24 and 9/30/24 In addition, client #5/2 2mg on 6/12/24, 6/2/8/13/24. Interview on 10/22/2/(HM) revealed on 8 medication administration administration administration administration and medication administration and medication administration and medication administration and medication and medication and medication administration and medication being and been replenished. The control of the c | redications were available to audit clients (#5). The finding a for client #5's medication rds (MAR) revealed multiple redications: reses of Lamotrigine (Lamictal) 6/27/24, 7/28/24, 7/30/24, 12/24, 8/23/24, 8/14/24, 17/24, 9/13/24, 9/15-9/16/24, 4 due to it being out of stock. 5 missed doses of Risperidone 27/24, 6/30/24, 7/11/24, 1/24, 8/11/24, 8/12/24 and 24 with the Home Manager 1/7/24 staff were retrained on tration. 24 with the Qualified reserved monthly reviews of the endications and had to order a 3 repharmacy. The QIDP is were required to notify the substraction of the department of the same month of the diministered if the stock had the QIDP confirmed they did pharmacy to receive | W | 361 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|-----------------------|---|-------------------------------|----------------------------|
| | | 34G272 | B. WING _ | | 10 | C / 22/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | • | , 22, 2027 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| W 363 W 363 | DRUG REGIMEN F CFR(s): 483.460(j)(The pharmacist muclients' drug regime and interdisciplinary This STANDARD in Based on record repharmacist failed to completing quarterly (QDRR) that 1 of 6 missing multiple do finding is: Review on 10/22/24 administration recomposed doses of muclient #5 missed do 200mg on 6/22/24, 7/31/24, 8/10/24, 8/ 9/26/24 and 9/30/24 In addition, client #8 2mg on 6/12/24, 6/3 8/13/24. Additional review of Summary Report of treated in the emer- Review on 10/22/24 Medication Regimerevealed on 9/5/24 noted. Interview on 10/22/24 | REVIEW (2) Ist report any irregularities in ens to the prescribing physician y team. Is not met as evidenced by: eview and interview, the oralert the physician after y medication regimen reviews audit clients (#5) were uses of medications. The | W 36 | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | l ` ′ | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--------------------|----------------|---|-----|----------------------------|
| | | 34G272 | B. WING | | | | C 22/2024 |
| | PROVIDER OR SUPPLIER | | | 11 | REET ADDRESS, CITY, STATE, ZIP CODE 4 GREENHOUSE LANE OUTHERN PINES, NC 28387 | 107 | LLILULA |
| (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 APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| W 363 | report drug irregula response. The cons medications taken f have a recommend laboratory tests. | ge 21 rities to the physician for a sultant also acknowledged that for a seizure disorder may ation to the doctor to conduct | W 3 | 363 | | | |
| W 472 | Intellectual Disabilit revealed she condu MAR, as well as the | ies Professional (QIDP) icted monthly reviews of the home manager, to detect On 8/7/24 staff were retrained inistration. | W 4 | 172 | | | |
| | This STANDARD is Based on observat interview, the facility clients (#1, #2, #3, #3) | ed in appropriate quantity. s not met as evidenced by: ion, record review and y failed to ensure 6 of 6 audit #4, #5 and #6) received an y of food. The finding is: | | | | | |
| | 10/21/24 at 5:20pm beans and turkey be one can of corn in a heating up the food table for family size | rvations in the home on , Staff C prepared corn, green urgers. There appeared to be a midsize pot on the stove, . The food was placed on the dining at 6:05pm. Clients #1, e to receive corn and had cup of corn each. | | | | | |
| | sheet revealed the | of the Menu Cycle 1 spread portion size for corn should be r diet and 6 ounces for a high | | | | | |
| | | 24 with the Home Manager erday she observed Staff C | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | 1, , | TE SURVEY MPLETED |
|--------------------------|--|--|--|--|--------|----------------------------|
| | | 34G272 | B. WING | | 10 | C 0/ 22/2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | | 7212027 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA | ULD BE | (X5) COMPLETION DATE |
| W 472 | can of corn. The HI expressed the food some of the clients Interview on 10/22/2 Intellectual Disabilit | ge 22 instructed her to add another M acknowledged Staff C might be wasted because did not like vegetables. 24 with the Qualified ies Professional (QIDP) been trained when preparing | W 4 | 72 | | |
| W 487 | meals to cook enouportions are request DINING AREAS AN CFR(s): 483.480(d) The facility must as enough food. This STANDARD is Based on observatinterview, the facility clients (#6) received. | igh food in case second ited. ID SERVICE | W 4 | 87 | | |
| | 10/21/24 at 6:20pm green beans and tu | rvations in the home on , client #6 received corn, rkey burger on a bun. Client than 75% of her meal before | | | | |
| | there was an unopenutritional supplement | n/22/24 at 8:00am revealed ened case of a chocolate ent drink sent by the pharmacy from and a half opened case of applement drink. | | | | |
| | medication regimer her admission weig she weighed 174 lb | 4 of client #6's quarterly n review revealed on 3/7/23 ht was 194 lbs, on 6/20/23 s, on 12/11/23 she weighed weight remained stable at 130 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION NG | ` ´cor | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|---|-----------|-------------------------------|--|
| | | 34G272 | B. WING_ | | | C / 22/2024 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387 | | ,22,2024 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| W 487 | Review on 10/22/24 from 11/9/23 for clie placed her on a 180 weight gain. The Jurevealed client #6 v. The note also recoinches and weight at Review on 10/22/24 from 7/11/24 for clie weight was 110 lbs she was eating less gastrointestinal issue was ordered for twi intake and weight lenew dietary orders nutritional supplem weekly weights due was recorded at 10 lnterview on 10/22/did not get a supple breakfast today. Interview on 10/22/46 had fruit, scrampancakes for today client #6 had an ord supplement drinks there were patterns it seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledged she supplement since it bowel accidents over the seemed to cause acknowledg | On 6/12/24 client #6 weighed 4 of a nurse progress note ent #6 revealed the dietician 00 calories diet due to recent uly 2024 nurse progress note vas in overall stable health. rded client #6's height at 84 at 217 lbs. 4 of the nutritional evaluation ent #6 revealed her current and height 4'10". It was noted is possibly due to ues. A nutritional supplement ce daily de to decrease in oss. In addition, client #6 had from 10/17/24 to increase the ent drink to 3x a day with e to weight loss. Her weight 6 lbs. 24 with Client #6 revealed she ement after dinner or after 24 with Staff D revealed client bled eggs and sausage with 's breakfast. Staff D revealed der to receive two nutritional at 4:00pm and 8:00pm, but of her refusing them because diarrhea. Staff D does not always give the 8pm t leads to more incontinence of | W 48 | 37 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---|-----|--|-----------------|----------------------------|
| | | 34G272 | | | | C 10/22/2024 | |
| NAME OF PROVIDER OR SUPPLIER CREST ROAD GROUP HOME | | | | 114 | EET ADDRESS, CITY, STATE, ZIP CODE GREENHOUSE LANE JTHERN PINES, NC 28387 | • | - |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| W 487 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 (HM) revealed client #6 was a picky eater. The HM remarked in the year she has worked with client #6, she has remained the same size. The HM revealed client #6 was compliant with consuming her nutritional supplement drinks. The HM acknowledged staff did not record if client #6 consumed the nutritional supplements. Interview on 10/22/24 with the Qualified intellectual Disabilities Professional (QIDP) revealed client #6 had started to experience episodes of diarrhea several months ago and initially it was believed it was a behavior. The QIDP also shared client #6 had recent dental surgery and had seen a gastrointestinal doctor ast month for the diarrhea and was cleared from naving a new condition. The QIDP acknowledged she knew the diarrhea was still occurring but was unaware it was held in the evening. The QIDP revealed she took client #6 to visit a new nutritionist last week and she explored if the milk in the nutritional supplement drinks were causing client #6 to have diarrhea. The nutritionist told the QIDP the drinks were not made with milk or caused diarrhea. The nutritional supplement was ncreased to 3x a day due to weight at 106 lbs. The QIDP also confirmed the nutritionist noticed a discrepancy in the weight and height for client #6 that was recorded in her medical record. | | W | 187 | | | |