PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER LIFE, INC TWIN ACRES GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES PROVIDER PLAN OF CORRECTION MUST are PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) E 039	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
LIFE, INC TWIN ACRES GROUP HOME LIFE, INC TWIN ACRES GROUP HOME CANADA DESCRIPTION			34G326	B. WING			11/	13/2024
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) E 039 EP Testing Requirements CFR(s): 483.475(d)(2), \$441.184(d)(2), \$460.84(d)(2), \$482.15(d)(2), \$483.73(d)(2), \$483.475(d)(2), \$483.475(d)(2), \$483.475(d)(2), \$483.475(d)(2), \$485.524(d)(2), \$48			UP HOME		2	767 WILDCAT ROAD	•	
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), §484.58(d)(2), §485.542(d)(2), §484.56.25(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 §485.727, CMHCs at §495.920, 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 moder 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 drilt; or	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §48 §485.542(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 emergen exercise every 2 ye (B) If the [facility natural or man-made activation of the emexempt from engage community-based of functional exercise actual event. (ii) Conduct an additional exercise this section is conducted in the formulation of the emexempt from engage community-based of functional exercise actual event. (iii) Conduct an additional exercise this section is conducted in the formulation of the emexempt from engage community-based of functional exercise (B) A mock disaster (C) A tabletop exercise (C) A tabletop exercise (C)	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), §494.62(d)(2). 3.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]: cility] must conduct exercises acy plan annually. The [facility] ollowing: ull-scale exercise that is every 2 years; or unity-based exercise is not at a facility-based functional ars; or y] experiences an actual de emergency that requires hergency plan, the [facility] is jing in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is allowing: tale exercise that is or individual, facility-based or redrill; or cise or workshop that is led by		039	TITLE		(Y6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		34G326	B. WING _		11	/13/2024
	PROVIDER OR SUPPLIER TWIN ACRES GRO	UP HOME		STREET ADDRESS, CITY, STATE, ZIP 2767 WILDCAT ROAD WILLIAMSTON, NC 27892		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		34G326	B. WING _		11	/13/2024
	PROVIDER OR SUPPLIER C TWIN ACRES GRO	UP HOME		STREET ADDRESS, CITY, STATE, ZIP 2767 WILDCAT ROAD WILLIAMSTON, NC 27892		
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	PROVIDER OR SUPPLIER TWIN ACRES GRO			STREET ADDRESS, CITY, STATE, ZIF 2767 WILDCAT ROAD WILLIAMSTON, NC 27892		
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E 039	§482.15(d), CAHs (2) Testing. The [P conduct exercises twice per year. Th do the following: (i) Participate in an is community-base (A) When a comm accessible, conduct facility-based funct (B) If the [PRTF, H actual natural or m requires activation [facility] is exempt required full-scale facility-based funct onset of the emerg (ii) Conduct an and that may include following: (A) A second full-scommunity-based functional exercise (B) A mool (C) A tabletop led by a facilitator a discussion, using a emergency scenar statements, directe questions designed plan. (iii) Analyze the maintain documen exercises, and em	at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must an annual full-scale exercise that ed; or unity-based exercise is not et an annual individual, ional exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the from engaging in its next community based or individual, ional exercise following the ency event. In [additional] annual exercise or de, but is not limited to the exercise or workshop that is not individual, a facility-based or individual, and a facility-based or individual, a facility-based or individual, and a facility-based or individualy and a facility-based or individual, and a facility-based or ind	EC	039		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER LIFE, INC TWIN ACRES GROUP HOME SULLIMINSTON, NC 27892 PAGE OF PROVIDER OR SUPPLIER LIFE, INC TWIN ACRES GROUP HOME SIMMARY STATEMENT OF DEFICIENCIES (RECALD FORTIGINARY WAS THE PRECEDED BY FULL AGAIN TAG) REQULATORY OR LSC IDENTIFYING INFORMATION) E 039 Continued From page 5 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/III) must do the following: (i) Participate in an annual full-scale exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility, facility speriences an actual natural or man-made 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: (iii) Participate in an acrea and actual natural or man-made emergency plan at least twice per year, individual, facility-based functional exercise following the onset of the emergency plan at least twice per year, individual, facility-based functional exercise following: (ii) Conduct an additional annual subsections and actual natural or man-made emergency plan at least twice per year, individual, facility-based functional exercise following: (iii) Conduct an additional annual exercise that is community-based or an individual, facility based functional exercise or individual, facility-based functional exercise or individual, facility is emergency plan at least twice per year.	CLIVILI	13 I OIT WEDICAILE	A MEDICAID SERVICES				IVID IVO.	0930-0391
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LIFE, INC TWIN ACRES GROUP HOME	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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E 039 Continued From page 5 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. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency plan, the LTC facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise following the onset of the emergency event. (iii) 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 following the onset of the emergency event. (iii) Conduct an additional annual exercise following are anarrated, clinically experiences an acrual 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 bena, an exeded. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises					V	VILLIAMSTON, NC 27892		
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. (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 requires activation 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	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF) BE	COMPLETION
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		34G326	B. WING		11,	/13/2024
	PROVIDER OR SUPPLIER TWIN ACRES GRO			STREET ADDRESS, CITY, STATE, ZIP 2767 WILDCAT ROAD WILLIAMSTON, NC 27892		
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	PROVIDER OR SUPPLIER TWIN ACRES GRO	UP HOME		2	TREET ADDRESS, CITY, STATE, ZIP CODE 767 WILDCAT ROAD VILLIAMSTON, NC 27892		
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	PROVIDER OR SUPPLIED TWIN ACRES GR			STREET ADDRESS, CITY, STATE, ZIP 2767 WILDCAT ROAD WILLIAMSTON, NC 27892		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 039	questions designed plan. If the OPO of man-made emergency planter emergency planter emergency in the emergency engaging in its net following the onset (ii) Analyze the Oldocumentation of emergency event OPO's] emergency event (OPO's] emergency exercises to test to must do the follow (i) Conduct a papeleast annually. A to discussion led by clinically-relevant of problem statem prepared question emergency plan. (ii) Analyze the RI maintain docume and emergency emergency plan. This STANDARD Based on docum facility failed to encommunity/facility tabletop exercise. Review on 11/12/22024) did not inclic community/facility tabletop exercise.	ed to challenge an emergency experiences an actual natural or gency that requires activation of an, the OPO is exempt from ext required testing exercise et of the emergency event. PO's response to and maintain all tabletop exercises, and so, and revise the [RNHCI's and cy plan, as needed. 3.748]: RNHCI must conduct the emergency plan. The RNHCI ving: er-based, tabletop exercise at abletop exercise is a group a facilitator, using a narrated, emergency scenario, and a set nents, directed messages, or as designed to challenge an NHCI's response to and entation of all tabletop exercises, vents, and revise the RNHCI's as needed. is not met as evidenced by: ent review and interviews, the isure a full scale rebased exercise, mock drill or to test their Emergency P) plan was conducted. The	EC	039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		34G326	B. WING		11.	/13/2024
	PROVIDER OR SUPPLIER TWIN ACRES GRO	JP HOME		STREET ADDRESS, CITY, STATE, ZIP COI 2767 WILDCAT ROAD WILLIAMSTON, NC 27892	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	emergency plan ha 3/13/24. However, 1 any specific emerge statements, directe questions designed plan. Interview on 11/13// Intellectual Disabilit confirmed all of the were reviewed/disc conduct regular fire facility exercise to the for review. INDIVIDUAL PROCE CFR(s): 483.440(c) The individual progeopportunities for clieself-management. This STANDARD is	card had been conducted on the document did not include ency scenarios, problem did messages or prepared to challenge their emergency (24 with the Qualified ies Professional (QIDP) ir emergency plan hazards ussed in March 2024 and staff (disaster drills. However, no est the EP plan was available (BRAM PLAN (6)(vi)) Tram plan must include ent choice and so not met as evidenced by:	E 0			
	interviews, the facil was provided oppoself-management. clients. The finding Observation on 11/client #6 assisting t kitchen prior to eati blended together at items. During lunch the day program, cl consumed spaghet pureed together an salad dressing addimixture. During din	ions, record review and ty failed to ensure client #6 tunities for choice and This affected 1 of 5 audit is: 12/24 and 11/13/24 revealed to blend her own food in the ng her meals. All food was once time, excluding dessert observations on 11/12/24 at ient #6 was served and ti, tossed salad, and crackers d moistened with milk, with led to the top of the pureed her observations at the home, d consumed baked chicken,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G326	B. WING		11/	/13/2024
	PROVIDER OR SUPPLIER TWIN ACRES GRO			STREET ADDRESS, CITY, STATE, Z 2767 WILDCAT ROAD WILLIAMSTON, NC 27892		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 247	together with milk during breakfast of and consumed cepureed together with separately after pure Review on 11/12/2 program plan (IPP prescribed regular food texture should changed a couple her tenancy to eat consistency. Food pieces, but may be preference to inclusive should be moisten seconds. Gassy for Interview on 11/13 normally blend click her dessert separamilk and she "see salad, we put it all toppings on it to milk toppings on it to milk separately in the pureed and placed whether to mix or Interview on 11/13 Intellectual Disabili revealed staff may blender because in	and collard greens pureed in the blender. On 11/13/24 bservations, she was served real and peanut butter toast ith milk. No food was served ureeing. 24 of client #6's individual 1), dated 5/7/24, revealed a diet with no added sugar. Here of the finely chopped but has of times over the year due to or not eat, depending on should be no larger than 1/4" as modified further per here of the pureed if desired. Foods ed, and she may have boods should be avoided. 24 with Staff A revealed staff and #6's food together and leave ate. Her food is blended with ms" to like it. If the meal is in the blender and try to put take it taste better. 24 with the Nurse revealed reed together for client #6 not always wanted her food ast. However, it could be don the plate for her to choose	W 2	247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G326	B. WING_		11	/13/2024
	PROVIDER OR SUPPLIER TWIN ACRES GRO			STREET ADDRESS, CITY, STATE, ZIP C 2767 WILDCAT ROAD WILLIAMSTON, NC 27892		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
W 455 W 455	INFECTION CONTECTR(s): 483.470(l). There must be an prevention, control and communicable This STANDARD Based on observation and prevention an	TROL (1) active program for the , and investigation of infection e diseases. is not met as evidenced by: ations and interviews, the facility sanitary environment was ransmission of possible	W 45			
	Intellectual Disabil	/24 with the Qualified ities Professional (QIDP) uld discard touched food and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G326	B. WING			11/1	3/2024
NAME OF PROVIDER OR SUPPLIER LIFE, INC TWIN ACRES GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2767 WILDCAT ROAD WILLIAMSTON, NC 27892			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 455	Continued From pa offer fresh food in the	ge 12 ne place of contaminated food.	W	1 55	DETICIENCY		