STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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E 015	Continued From page 1 hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure the provision of subsistence needs for clients and staff relative to the emergency food supply. The finding is: Observation of the facilities emergency food supply on 2/10/25 revealed the emergency food supply to contain various expired food items which included 5 containers of baby food, a box of graham crackers, canned fruit cocktail, 1 large bag and 1 box of dry milk, canned tomatoes, cheese crackers, and peanut butter. Interview on 2/11/25 with the residential team leader (RTL) and program manager (PM) confirmed that the facility should inspect the food regularly and ensure that the home has an adequate supply of unexpired foods for emergencies.	E 015		
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1),	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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E 037	Continued From page 2 §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		

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	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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E 037	Continued From page 3 (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037		

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	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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E 037	Continued From page 4	E 037		

arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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E 037	Continued From page 5 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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E 037	Continued From page 6 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure direct care staff were trained on the facility's emergency preparedness plan (EPP) at least initially and biennially. The finding is: Review on 2/10/25 of the facility's EPP revealed no evidence of initial or biennial training on the EPP. Continued review of the EPP revealed no evidence that the facility reviewed or updated the plan. Interview on 2/11/25 with the residential team leader (RTL) and program manager (PM) confirmed that initial training and biennial training for current staff were not completed as required.	E 037		
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 §485.727, CMHCs at §485.920, RHCs/FQHCs at	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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E 039	Continued From page 7 §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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

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MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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E 039	Continued From page 8 *[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: (i) Participate in an annual full-scale exercise that	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 9	E 039		

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 accessible, conduct an annual individual,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 10	E 039		

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
(B) If the PACE experiences an actual natural or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 11	E 039		

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.

(B) If the [LTC facility] facility experiences an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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	E 039		

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 functional exercise following the onset of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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	E 039		

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 exercise under paragraph (d)(2)(i) of this section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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E 039	Continued From page 14	E 039		

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 OPO's] emergency plan, as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 15 *[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 biennial testing of the facility's emergency preparedness plan (EPP). The finding is: Review on 2/10/25 of the facility's EPP revealed no evidence of a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or a tabletop exercise. Interview on 2/11/25 with the program manager(PM) confirmed the facility has not conducted a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or tabletop exercise. Continued interview with the PM revealed that the facility conducted a live event on 8/26/24 that was documented as a schedfuled fire drill which is conducted monthly.	E 039		
W 104	GOVERNING BODY	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 104	Continued From page 16 CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure the interior and exterior of the facility was sanitary and orderly. The finding is: Observations during the recertification survey completed on 2/10/25-2/11/25 revealed a wooden chair to block the rear entry door in the dining room area. Continued observation revealed the chair to be wedged underneath the door knob to prevent entry from the back yard area. At no point during the observation did staff remove the door to prevent a hazard if there was an emergency evacuation. Subsequent observations revealed a dryer vent to blow lent onto the front porch area. Continued observation revealed a large amount of lent to cover the dryer vent and spread across the front porch. Interview with facility staff C and D on 2/11/25 revealed they were aware of the use of the wooden chair to block the rear entry door. Continued interview with staff C and D revealed the chair is used to block the entry due to third shift staff being fearful of a potential intruder or homeless person entering the facility while the clients are sleeping. Further interview with staff C and D revealed homeless people pass through the backyard throughout the night which raises concerns about the safety of the facility entry	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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W 104	Continued From page 17 points. Subsequent interview with staff C and D on 2/11/25 revealed they did not notice the dryer lent build up on the front porch. Continued interview with staff C and D revealed they commonly use the side entry to enter and exit the facility. Interview with the qualified intellectual disabilities professional (QIDP) on 2/11/25 revealed he was not aware of the chair being used to block the rear entry door for safety reasons. Continued interview with the QIDP revealed he was not made aware of the need to secure the rear entry doors due to concerns of potential intruders and homeless persons. Further interview with the QIDP verified staff should not use a chair to block egress in the event of an emergency evacuation at the facility. Subsequent interview with the QIDP on 2/11/25 verified maintenance staff should clean the area regularly and remove any lent from the dryer duct in the front porch area. Continued interview with the QIDP revealed staff should monitor the dryer vent to prevent a fire hazard from occurring at the facility.	W 104		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 249	Continued From page 18	W 249		

This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure clients received a continuous active treatment program consisting of needed interventions and services as identified in the Person-Centered Plan for 1 of 4 sampled clients (#2) relative to implementing training objectives and providing adaptive equipment. The findings are:

A. The facility failed to utilize the gait vest as prescribed for client #2. For example,

Observations in the facility on 2/11/25 revealed client #2 to ambulate throughout the facility with staff assistance. Continued observation at 7:01AM revealed staff to assist client #2 to transfer from a recliner to a wheelchair without using a gait vest. Further observation revealed the gait vest to be unfastened on the left side. Additional observation revealed staff to grab client #2 by the forearms and to hold the client bent forward while the second staff fixed the client's pants. Observations at 7:30AM also revealed staff to transfer client #2 from a wheelchair to the dining room table without using the gait vest. At no point during the observation did staff fasten client #2's gait vest and use it to transfer the client from the wheelchair as prescribed.

Review of the record for client #2 on 2/11/25 revealed a PCP dated 5/28/24 which indicated staff should use the gait vest for assistance with transfers and ambulation. Continued review of the record for client #2 revealed an occupational assessment dated 2/22/24 which indicated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 249	Continued From page 19	W 249		

staff should continue using the gait vest to assist with ambulation.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/11/25 verified that all of client #2's interventions and objectives are current. Continued interview with the QIDP verified that staff should ensure that client #2's gait vest is secured and use it to assist with ambulation and transfers. Further interview with the QIDP revealed staff have been trained to use client #2's gait vest as prescribed.

B. The facility failed to provide adaptive equipment for client #2 as prescribed. For example,

Observations during the recertification survey from 2/10/25-2/11/25 revealed client #2 to participate in various activities throughout the day with staff assistance. Continued observations did not reveal staff to provide client #2 with bilateral soft hand splints.

Subsequent observations on 2/11/25 at 7:40AM revealed staff to assist client #2 with setting the table in preparation for the breakfast meal. Continued observations revealed staff to assist client #2 with participation in the breakfast meal without providing a non-skid mat and weighted utensils.

Review of the record for client #2 on 2/11/25 revealed a person-centered plan (PCP) dated 5/28/24 which indicated the client should wear bilateral hand splints daily. Continued review of the record for client #2 revealed an occupational therapy (OT) evaluation dated 2/22/24 which indicated the client uses bilateral soft hand splints

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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W 249	Continued From page 20	W 249		

with thumb and index finger placements to protect client's skin due to mouthing, biting hands and fingers. Further review of the OT evaluation revealed recommendations for client #2 to wear 1lb. wrist weights on both wrists at mealtime, in an attempt to reduce the effect of client's tremors on her eating performance.

Subsequent review of the 2/22/24 OT evaluation revealed client #2 should have the following adaptive equipment during mealtimes: weighted utensile, high sided dish, mug with lid, shirt protector, and non-skid mat.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/11/25 revealed client #2 should have bilateral soft hand splints during waking hours. Continued interview with the QIDP verified all of client #2 interventions and objectives were current. Interview with the QIDP also verified that staff should use the appropriate adaptive equipment for client #2 during mealtimes. Further interview with the QIDP revealed staff have been trained to provide client #2's hand splints during the day.

C. The facility failed to follow client #2's program goal relative to handwashing. For example,

Morning observations on 2/11/25 at 7:40AM revealed staff to assist client #2 to the dining room to prepare for the breakfast meal. Continued observations revealed staff to assist client #2 with making her plate and consuming the breakfast meal without washing her hands. At no point during the breakfast meal did staff prompt client #2 to wash her hands.

Review of the record for client #2 on 2/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 249	Continued From page 21 revealed a PCP dated 5/28/24 which indicated the client has a program goal to wash her hands with 80% accuracy, given one of fewer partial physical prompts. Interview with the QIDP on 2/11/25 verified that all of client #2's program goals and objectives are current. Continued interview with the QIDP revealed staff have been trained to assist client #2 with washing her hands prior to mealtimes.	W 249		
W 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to document significant events relative to diet changes as prescribed for 1 of 4 sampled clients (#4). The finding is: Review of the record for client #4 on 2/11/25 revealed a person-centered plan (PCP) dated 2/3/25 and nutritional assessment dated 1/30/24 which indicated that the client was on the following diet: weight gain, high calorie snacks, whole consistency with juice or milk during mealtimes. Continued review of the nutritional assessment revealed recommendations to discontinue weight gain diet with juice and milk, monitor weights monthly, assess annually and as needed. Review of the nutritional assessment also revealed recommendations for client #4's weight to remain stable within 120-130 lbs. Further review of the record for client #4 revealed a weight log tracking the clients weight between 144 and 139.4 lbs, and the last weight was	W 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 253	Continued From page 22 logged at 139.4 lbs on 12/31/24. Review of the weight report did not reveal the client's weight being logged since 12/31/24. Review of the record for client #4 did not reveal documentation to support the recommendation to discontinue weight gain diet as prescribed. Interview with nursing services and the qualified intellectual disabilities professional (QIDP) on 2/11/25 revealed that the team has not discussed client #4's weight goals and prescribed recommendations. Continued interview with the QIDP revealed the team should have met to discuss and execute the diet recommendations as prescribed.	W 253		
W 341	NURSING SERVICES CFR(s): 483.460(c)(5)(ii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to implement appropriate methods of infection control for 5 of 6 clients (#1, #3, #4, #5, #6) relative to handwashing. The finding is: Afternoon observations in the facility on 2/10/25 at 5:15PM revealed staff to assist clients to the table to prepare for the dinner meal. Continued observation did not reveal staff to assist or prompt clients (#1, #3, #4, #5, and #6) to wash their hands in preparation for the dinner meal. Further observation revealed staff to assist client	W 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 341	Continued From page 23 #6 with blowing his nose without washing his hands prior to participating in the dinner meal. Observations also revealed staff to wash their gloves instead of changing them. Morning observations on 2/11/25 at 7:30AM revealed staff to prompt clients to the table to prepare for the breakfast meal. Continued observations revealed clients to prepare their plates without washing their hands prior to the breakfast meal. Subsequent observations revealed staff to prepare clients' diet consistencies using a blender. Continued observations revealed staff to touch a client's hair and resume preparing the clients' meals without changing their gloves. Interview with nursing services and the qualified intellectual disabilities professional (QIDP) on 2/11/25 revealed staff have been trained to wash their hands and change gloves to prevent cross-contamination. Continued interview with the QIDP revealed staff should prompt all clients to wash their hands prior to mealtimes.	W 341		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure that adaptive equipment was provided for 2 of 4	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 436	Continued From page 24 sampled clients (#3, #5). The findings are: A. The facility failed to provide adaptive equipment for client #3 during mealtimes as prescribed. For example, Afternoon observations in the facility on 2/10/25 at 5:30PM revealed staff to assist client #3 to the dining table to prepare for the dinner meal. Continued observations revealed staff to set the table with the following place setting: shirt protector, high sided divided dish, and regular utensils. At no point during the dinner meal did staff provide client #3 with an inner lip plate. Morning observations on 2/11/25 at 7:40AM revealed staff to assist client #3 to the dining table in preparation for the breakfast meal. Continued observations revealed staff to again assist the client with setting the place setting which did not include the inner lip plate as prescribed. Review of the record for client #3 revealed a person centered plan (PCP) dated 2/6/25 which indicated the client has the following adaptive equipment during mealtimes: shirt protector and inner lip dish. Interview with the QIDP on 2/11/25 revealed staff have been trained to use the appropriate adaptive equipment for client #3 during mealtimes. Continued interview with the QIDP verified all of client #3's interventions and objectives are current. Further interview with the QIDP verified staff should have provided client #3's adaptive equipment during mealtimes as prescribed.	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 436	Continued From page 25 B. The facility failed to provide adaptive equipment to client #5 during mealtimes. For example, Morning observations on 2/11/25 at 7:40AM revealed staff to assist client #5 to the dining table in preparation for the breakfast meal. Continued observations revealed staff to assist the client with setting the place setting which did not include the non-skid mat as prescribed. Review of the record for client #5 on 2/11/25 revealed a PCP dated 6/24/24 revealed client #5 should have the following adaptive equipment during mealtimes: high sided divided dish, shirt protector, and non-skid mat. Interview with the QIDP on 2/11/25 revealed staff have been trained to use the appropriate adaptive equipment for client #5 during mealtimes. Continued interview with the QIDP verified all of client #5's interventions and objectives are current. Further interview with the QIDP verified staff should have provided client #5 a non-skid mat during mealtimes as prescribed.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of record and interview, the facility failed to show evidence quarterly fire drills were conducted for each shift of personnel relative to first, second, and third shift. The finding is: Review of the facility fire drill reports from 2/24 through 1/25 revealed missing drills for 2/24,	W 440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

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W 440	Continued From page 26 3/24, and 4/24. Interview with the program manager on 2/11/25 confirmed facility fire drills should have been conducted quarterly for each shift. Continued interview with the program manager confirmed there was no additional documentation to reflect the missing drills that were conducted during the review year.	W 440		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interview, the facility failed to provide specially prescribed diets for 2 of 4 sampled clients (#2 and #5). The findings are: A. The facility failed to provide specially prescribed diet for client #2 during mealtimes. For example: Observations in the group home on 2/10/25 at 5:23 PM revealed the dinner meal consisted of chicken tenders, onion rings, green beans, ice cream, water, and milk. Continued observations at 5:40 PM revealed client #2 to consume her dinner meal. At no time during the dinner meal was staff observed to provide client #2 with 4oz. yogurt, pudding, or applesauce. Review of records on 2/11/25 for client #2 revealed a physician's order (P.O.) dated 2/11/25.	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 460	Continued From page 27 Continued review of the P.O. revealed client #2's diet to include 4oz. yogurt, pudding, or applesauce with lunch and dinner. Interview with the program manager (PM) on 2/11/25 confirmed the P.O. to be current for client #2. Continued interview with the PM confirmed the staff should have provided client #2 with prescribed diet to include the 4oz. of yogurt, pudding, or applesauce. B. The facility failed to provide specially prescribed diet for client #5 during mealtimes. For example: Observations in the group home on 2/10/25 at 5:23 PM revealed the dinner meal consisted of chicken tenders, onion rings, green beans, ice cream, water, and milk. Continued observations at 5:40 PM revealed client #5 to consume her dinner meal. At no time during the dinner meal was staff observed to provide client #5 with ½ cup pudding, yogurt, or applesauce. Review of records on 2/11/25 for client #5 revealed a physician's order (P.O.) dated 2/11/25. Continued review of the P.O. revealed client #5's diet to include ½ cup pudding, yogurt, or applesauce with lunch and dinner. Interview with the program manager (PM) on 2/11/25 confirmed the P.O. to be current for client #5. Continued interview with the PM confirmed the staff should have provided client #5 with prescribed diet to include the ½ cup pudding, yogurt, or applesauce.	W 460		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii)	W 473		

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W 473	Continued From page 28 Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served at an appropriate temperature for 6 of 6 clients (#1, #2, #3, #4, #5, #6) residing in the facility. The finding is: Morning observations in the facility on 2/11/25 at 6:45 AM revealed two glass containers with sausage patties and pieces of toast covered by aluminum foil in the kitchen. Continued observations at 7:30AM revealed staff to prepare the clients' plates without reheating the toast and sausage patties. Further observation revealed the food to remain on the kitchen countertop for approximately 45 minutes prior to the breakfast meal. Interview with the qualified intellectual disabilities professional (QIDP) on 2/11/25 revealed staff should have kept the food warm until it was ready to be served and reheat as necessary. Continued interview with the QIDP revealed staff have been trained to prepare and serve menu items at an appropriate temperature prior to serving to the clients.	W 473		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve food in a form consistent with the developmental level of 3 of 4 sampled clients (#1, 5, and #6). The findings	W 474		

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W 474	Continued From page 29	W 474		

are:

A. The facility failed to follow client #1's diet as prescribed. For example:

Observations in the group home on 2/10/25 at 5:26 PM revealed the dinner meal consisted of chicken tenders, onion rings, green beans, ice cream, water, and milk. Continued observations at 5:40 PM revealed client #1 to consume his dinner meal in whole consistency. At no time during the dinner meal was staff observed to assist the client to provide a ¼" consistency.

Observations in the group home on 2/11/25 at 7:30 AM revealed the breakfast meal consisted of turkey sausage patties, sliced toast, fruit cocktail, water, and milk. Continued observations at 7:50 AM revealed client #1 to consume his breakfast meal in whole consistency. At no time during the breakfast meal was staff observed to assist the client to provide the meal in a ¼" consistency.

Review of client #1's record on 2/11/25 revealed a person-centered plan (PCP) dated 7/23/24. Review of the PCP revealed a nutritional assessment dated 1/30/24 for client #1 to be prescribed an 1800 calorie, ¼" diet consistency, encourage seconds of vegetables only, ½ portions of desserts.

Interview with the program manager (PM) on 2/11/25 confirmed client #1's prescribed diet is current. Further interview with the PM confirmed specially modified diets should be followed as prescribed.

B. The facility failed to follow client #5's diet as prescribed. For example:

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W 474	Continued From page 30 Observations in the group home on 2/11/25 at 7:30 AM revealed the breakfast meal consisted of turkey sausage patties, sliced toast, fruit cocktail, water, and milk. Continued observations revealed client #5 to consume her breakfast meal in a chopped consistency. Further observations revealed staff to provide the client with toast and turkey sausage chopped together with limited liquids to soften the food. At no time during the breakfast meal was staff observed to assist client #5 to provide the meal in a ground consistency. Review of client #5's record on 2/11/25 revealed a PCP dated 5/27/22. Review of the PCP revealed a nutritional assessment dated 1/30/25 for client #5 to be prescribed a ground consistency diet, weight gain, sugar-free beverages and desserts. Interview with the PM on 2/11/25 confirmed client #5's prescribed diet. Further interview with the PM confirmed specially modified diets should be followed as prescribed. C. The facility failed to follow client #6's diet as prescribed. For example: Observations in the group home on 2/10/25 at 5:23 PM revealed the dinner meal to consist of chicken tenders, onion rings, green beans, ice cream, water, and milk. Continued observations at 5:40 PM revealed client #6 to consume his dinner meal in whole consistency. At no time during the dinner meal was staff observed to assist the client to provide the meal in a ½-1" consistency. Observations in the group home on 2/11/25 at 8:15 AM revealed the breakfast meal consisted of	W 474		

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W 474	Continued From page 31 turkey sausage patties, sliced toast, fruit cocktail, water, and milk. Continued observations revealed client #6 to consume his breakfast meal in whole consistency. At no time during the breakfast meal was staff observed to assist client #6 to provide a ½-1" consistency meal. Review of client #6's record on 2/11/25 revealed a PCP dated 7/26/24. Review of the PCP revealed a nutritional assessment dated 1/30/24 for client #6 to be prescribed an 1800 calorie weight loss diet, heart healthy, ½-1" diet consistency. Interview with the PM on 2/11/25 confirmed client #6's prescribed diet. Further interview with the PM confirmed specially modified diets should be followed as prescribed.	W 474		