PRINTED: 02/20/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		N 	(X3) DATE SURVEY COMPLETED		
		34G053	B. WING_			02/	11/2025	
MYRON PLA	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	(1), §460.84(b)(1), §485. §483.475(b)(1), §485. §(b) Policies and proodevelop and implement policies and procedure plan set forth in paralessessment at parage and the communication of the provision. The policies and procedures must addressed and updefor LTC facilities]. At procedures must addressed (1) The provision of seand patients whether place, include, but are (i) Food, water, medissupplies (ii) Alternate sources following: (A) Temperatures to safety and for the safety and for t	3.113(b)(6)(iii), §441.184(b) 482.15(b)(1), §483.73(b)(1), 5.542(b)(1), §485.625(b)(1) Redures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of icies and procedures must ated every 2 years [annually a minimum, the policies and liress the following: subsistence needs for staff they evacuate or shelter in e not limited to the following: cal and pharmaceutical of energy to maintain the protect patient health and fe and sanitary storage of ing. ttinguishing, and alarm te disposal.	E	015				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DAT

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G053	B. WING			02/	11/2025
NAME OF PE	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 19 MYRON PLACE CALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 015	evacuate or shelter in limited to the following (A) Food, water, med supplies. (B) Alternate sources following: (1) Temperatures to pafety and for the safe provisions. (2) Emergency lightin (3) Fire detection, extractions systems. (C) Sewage and wast This STANDARD is reased on observation failed to ensure the properson of the fact supply on 2/10/25 reased and 1 box of dry cheese crackers, and linterview on 2/11/25 yieleader (RTL) and proving supplies.	and patients, whether they place, include, but are not gradient, and pharmaceutical of energy to maintain the protect patient health and e and sanitary storage of gradients, and interview, the facility rovision of subsistence staff relative to the sly. The finding is: collities emergency food ealed the emergency food ous expired food items rainers of baby food, a box canned fruit cocktail, 1 large milk, canned tomatoes, peanut butter. with the residential team gram manager (PM) collity should inspect the food that the home has an	E	015			
E 037	EP Training Program CFR(s): 483.475(d)(1) .54(d)(1), §418.113(d)(1),	E	037			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G053	B. WING			02/11/2025
MYRON P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 037	§483.73(d)(1), §483. §485.68(d)(1), §485. §485.727(d)(1), §485. §491.12(d)(1). *[For RNCHIs at §40. Hospitals at §482.15 at §484.102, REHs a under §485.727, OP RHC/FQHCs at §49 (1) Training program the following: (i) Initial training in e policies and procedu staff, individuals pro- arrangement, and vo- expected roles. (ii) Provide emergen least every 2 years. (iii) Maintain docume preparedness trainin (iv) Demonstrate sta procedures. (v) If the emergency procedures are signi	2.84(d)(1), §482.15(d)(1), 475(d)(1), §484.102(d)(1), 5.42(d)(1), §485.625(d)(1), 5.920(d)(1), §486.360(d)(1), 43.748, ASCs at §416.54, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" Os at §486.360, 1.12:] In. The [facility] must do all of mergency preparedness ares to all new and existing viding services under olunteers, consistent with their cy preparedness training at	E 03	37		
	hospice must do all de (i) Initial training in e policies and procedu hospice employees, services under arrant expected roles.	18.113(d):] (1) Training. The of the following: mergency preparedness ares to all new and existing and individuals providing gement, consistent with their f knowledge of emergency				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	·	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 037	least every 2 years (iv) Periodically rev emergency prepare employees (includispecial emphasis p procedures necess others. (v) Maintain docum preparedness train (vi) If the emergency procedures are sign must conduct traini procedures. *[For PRTFs at §44 program. The PRT (i) Initial training in policies and procedures and procedures are staff, individuals procedures are sign policies and procedures and procedures and procedures are sign policies and procedures and procedures and procedures are sign procedures.	iew and rehearse its edness plan with hospice ng nonemployee staff), with placed on carrying out the ary to protect patients and mentation of all emergency ing. by preparedness policies and nificantly updated, the hospice ng on the updated policies and and the state of the following: emergency preparedness dures to all new and existing poviding services under yolunteers, consistent with their	E 03	37		
	procedures are signust conduct traini procedures. *[For PACE at §460 organization must of its in the policies and procedures are signusted in the procedures.	ing. y preparedness policies and nificantly updated, the PRTF ng on the updated policies and 0.84(d):] (1) The PACE do all of the following: emergency preparedness dures to all new and existing oviding on-site services under				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		34G053	B. WING _			2/11/2025
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO. 219 MYRON PLACE SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 037	volunteers, consister (ii) Provide emergend least every 2 years. (iii) Demonstrate staf procedures, including what to do, where to case of an emergency (iv) Maintain docume (v) If the emergency procedures are signif must conduct training procedures. *[For LTC Facilities a Program. The LTC fafollowing: (i) Initial training in er policies and procedustaff, individuals provarrangement, and vo	ctors, participants, and at with their expected roles. Cry preparedness training at a f knowledge of emergency grinforming participants of go, and whom to contact in cry. I will be a ficial training. I preparedness policies and ficantly updated, the PACE gron the updated policies and the system of the updated policies and the updated polici	EO	37		
	least annually. (iii) Maintain docume preparedness training (iv) Demonstrate staff procedures. *[For CORFs at §485 CORF must do all of (i) Provide initial train preparedness policie and existing staff, incunder arrangement, a with their expected ro	5.68(d):](1) Training. The the following: sing in emergency s and procedures to all new dividuals providing services and volunteers, consistent				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		. ,	(X3) DATE SURVEY COMPLETED		
		34G053	B. WING _			2/11/2025
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO 219 MYRON PLACE SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
E 037	(iv) Demonstrate state procedures. All new pand assigned specific the CORF's emerger their first workday. The include instruction in alarm systems and sequipment. (v) If the emergency procedures are significant must conduct training procedures. *[For CAHs at §485.6] The CAH must do all (i) Initial training in expolicies and procedure proting and extinguand where necessary personnel, and guest cooperation with firefauthorities, to all new individuals providing and volunteers, constroles. (ii) Provide emergency procedures. (iii) Maintain docume (iv) Demonstrate state procedures. (v) If the emergency procedures are significant conduct training procedures. *[For CMHCs at §488]	ntation of the training. If knowledge of emergency personnel must be oriented to responsibilities regarding acy plan within 2 weeks of the training program must the location and use of tignals and firefighting If preparedness policies and ficantly updated, the CORF If on the updated policies and If of the following: If mergency preparedness If of the following prompt It ishing of fires, protection, If of the prevention, and If ighting and disaster	E 03	37		

PRINTED: 02/20/2025 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 19 MYRON PLACE ALISBURY, NC 28144		
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E 037	and existing staff, ind under arrangement, a with their expected ro documentation of the demonstrate staff knot procedures. Thereaft emergency prepared years. This STANDARD is roughly become the facility failed to ensure trained on the facility plan (EPP) at least in finding is: Review on 2/10/25 of no evidence of initial EPP. Continued reviee vidence that the facility plan. Interview on 2/11/25 of leader (RTL) and progressions.	s and procedures to all new ividuals providing services and volunteers, consistent ales, and maintain training. The CMHC must avaledge of emergency arer, the CMHC must provide an area to the compact of	E	037			
E 039	§460.84(d)(2), §482.1 §483.475(d)(2), §484 §485.542(d)(2), §485 §485.920(d)(2), §491 *[For ASCs at §416.5 at §485.542, OPO, "C	113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .625(d)(2), §485.727(d)(2), .12(d)(2), §494.62(d)(2). 4, CORFs at §485.68, REHs	E	039			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G053	B. WING		02/11/2025	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
E 039	(2) Testing. The [fact to test the emergence must do all of the following to test the emergence must do all of the following to the following text of the facility natural or man-made activation of the emergence munity-based of functional exercise factual event. (ii) Conduct an addity years, opposite the functional exercise this section is conducted in the following text of functional exercise of functional exercise of the following text of the following text of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusional exercise; (C) A tabletop exercise a facilitator and inclusional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusional exercise; (B) A mock disaster (C) A tabletop exercise (B) A mock disast	Facilities at §494.62]: ility] must conduct exercises by plan annually. The [facility] llowing: Ill-scale exercise that is every 2 years; or nity-based exercise is not a facility-based functional ears; or experiences an actual exemple emergency that requires ergency plan, the [facility] is ng in its next required remindividual, facility-based following the onset of the exercise at least every 2 experiences at least e	E 03	9		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G053	B. WING			02/	11/2025
NAME OF P	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 19 MYRON PLACE ALISBURY, NC 28144		
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E 039	patient's home. The exercises to test the exercises to test the exannually. The hospic (i) Participate in a ful community based every (A) When a community accessible, conduct a functional exercise every man-made emergency plan, and the exercise under paragic community-based function on the following: (A) A second full-scar community-based or exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and include a narrated, clinically-recently, and a set of directed messages, of designed to challenge (3) Testing for hospical care directly. The hospical plan is the exercises to test the exercises.	B.113(d):] these that provide care in the chospice must conduct the emergency plan at least the must do the following: I-scale exercise that is the provide exercise is not the individual facility based every 2 years; or the eriences a natural or every 2 years; or the eriences a natural or every 2 years; or the every 2 years; or the every 2 years; or the every 2 years are every 2 years and every 2 years following the every 2 years, full-scale or functional the every 2 years, full-scale or functional the exercise that is the every 2 years are full-scale or functional the exercise that is the every event. In the every 2 years, full-scale or functional the every 2 years, ful	E	039			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G053	B. WING		c	2/11/2025	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 219 MYRON PLACE SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
E 039	accessible, conduct a facility-based function (B) If the hospice expression man-made emergency plan, engaging in its next robused or facility-based following the onset of (ii) Conduct an addit may include, but is not (A) A second full-scat community-based or exercise; or (B) A mock disaster (C) A tabletop exercise facilitator that include narrated, clinically-reand a set of problem messages, or prepar challenge an emerge (iii) Analyze the hospimaintain documentate exercises, and emergency	ity-based exercise is not an annual individual nal exercise; or periences a natural or cy that requires activation of the hospice is exempt from required full-scale community and functional exercise of the emergency event. It ional annual exercise that not limited to the following: ale exercise that is a facility based functional drill; or ise or workshop led by a rese a group discussion using a levant emergency scenario, statements, directed ed questions designed to rency plan. Dice's response to and revise the replan, as needed.	E 03	39			
	conduct exercises to twice per year. The do the following: (i) Participate in an a is community-based;	§485.625(d):] FF, Hospital, CAH] must test the emergency plan [PRTF, Hospital, CAH] must annual full-scale exercise that or ity-based exercise is not					

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		34G053	B. WING _			2/11/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 219 MYRON PLACE SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 039	actual natural or mar requires activation of [facility] is exempt from required full-scale confacility-based function onset of the emerger (ii) Conduct and and that may include following: (A) A second full-scale community-based or functional exercise; of (B) A mock (C) A tabletop existed by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. (iii) Analyze the maintain documental exercises, and emerge [facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE exercises to test the annually. The PACE following: (i) Participate in an ais community-based; (A) When a community-based; (A) When a community-based function facility-based functions.	nal exercise; or spital, CAH] experiences an analysis and emergency that if the emergency plan, the omengaging in its next immunity based or individual, nal exercise following the ney event. [additional] annual exercise or , but is not limited to the ale exercise that is individual, a facility-based or disaster drill; or sercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency [facility's] response to and ion of all drills, tabletop gency events and revise the plan, as needed. 84(d):] E organization must conduct emergency plan at least organization must do the annual full-scale exercise is not an annual individual,	EO	39		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G053	B. WING		02/11/2025
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
E 039	the emergency plan engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the yexercise under parais conducted that methe following: (A) A second full-socommunity-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, cliscenario, and a set directed messages, designed to challent (iii) Analyze the PA maintain documentate exercises, and eme PACE's emergency *[For LTC Facilities (2) The [LTC facility test the emergency procedus ICF/IID] must do the (i) Participate in an is community-based (A) When a community-based (A) When a community-based functions are serviced in the community-based functions	recy that requires activation of the pace is exempt from required full-scale community facility-based functional the onset of the emergency additional exercise every 2 rear the full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited to eale exercise that is rindividual, a facility based or ridill; or cise or workshop that is led by undes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. CE's response to and ation of all drills, tabletop regency events and revise the plan, as needed. at §483.73(d):] I must conduct exercises to plan at least twice per year, ced staff drills using the res. The [LTC facility, e following: annual full-scale exercise that lt; or nity-based exercise is not an annual individual,	E 03	9	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	` '	
		34G053	B. WING			02/11/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	COMPLETE 02/11/2 S, CITY, STATE, ZIP CODE CE C 28144 ROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETION DATE
E 039	requires activation of LTC facility is exemply required a full-scale individual, facility-bate following the onset of (ii) Conduct an addit may include, but is read (A) A second full-scale community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator includes narrated, clinically-read a set of problem messages, or preparchallenge an emerginal (iii) Analyze the [LTC and maintain docume exercises, and emer [LTC facility] facility's and the emergency of the ICF/IID must docume to the incommunity-based (A) When a community-based function (B) If the ICF/IID expenses in the emergency plantaging in its next community-based or community-based	n-made emergency that If the emergency plan, the It from engaging its next community-based or sed functional exercise If the emergency event. Itional annual exercise that not limited to the following: ale exercise that is If an individual, facility based or If drill; or Itiose or workshop that is led by If a group discussion, using a Itility are delevant emergency scenario, If statements, directed If a questions designed to Itility facility's response to Itility facility's response to Itility facility's response to Itility facility, tabletop Itility facility, and revise the Itility emergency plan, as needed. Itility must conduct exercises Itility planet twice per year. If the following: Innual full-scale exercise that Itility hased exercise is not an annual individual, Itility hased exercise is not an annual individual, Itility hased exercise an actual natural or Itility hased exercise an actual natural or Itility hased exercise an actual natural or Itility has exempt from	E 03			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	may include, but is r (A) A second full-sca community-based or functional exercise; (B) A mock disaster (C) A tabletop exerc a facilitator and inclu using a narrated, clii scenario, and a set of directed messages, designed to challeng (iii) Analyze the ICF maintain documenta exercises, and emer ICF/IID's emergency *[For HHAs at §484. (d)(2) Testing. The H to test the emergency least annually. The H (i) Participate in a fur community-based; or (A) When a con accessible, conduct facility-based function. (B) If the HHA or man-made emergency of the emergency plengaging in its next community-based or functional exercise f emergency event. (ii) Conduct an addit opposite the year the	cional annual exercise that not limited to the following: ale exercise that is an individual, facility-based or drill; or ise or workshop that is led by udes a group discussion, nically-relevant emergency of problem statements, or prepared questions ge an emergency plan. IlD's response to and an annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation and the HHA is exempt from required full-scale or individual, facility based following the onset of the	E 03	9	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		34G053	B. WING _			02/11/2025
NAME OF PE	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	Continued From pa	ge 14	EC	39		
	is conducted, the limited to the following: (A) A second functional exercise; (B) A mock disactional exercise; (B) A mock disaction and discussion, using an emergency scenario statements, directed questions designed plan. (iii) Analyze the HH. documentation of all emergency events, emergency plan, as a semergency plan, as semergency scenarios, directed questions designed plan. If the OPO experience of the emergency plan in the opposite of the opposit	nat may include, but is not ing: ill-scale exercise that is or an individual, facility-based or exercise or workshop that is not includes a group narrated, clinically-relevant or, and a set of problem d messages, or prepared to challenge an emergency A's response to and maintain I drills, tabletop exercises, and and revise the HHA's eneeded. 5.360] OPO must conduct exercises cy plan. The OPO must do the e-based, tabletop exercise is				
	following the onset (ii) Analyze the OPO documentation of al	of the emergency event. D's response to and maintain I tabletop exercises, and and revise the [RNHCI's and				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		34G053	B. WING		02/11/2025	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	1
E 039	must do the following (i) Conduct a paper-least annually. A table discussion led by a facilinically-relevant em of problem statemen prepared questions of emergency plan. (ii) Analyze the RNH maintain documentat and emergency ever emergency plan, as a This STANDARD is Based on record rev failed to conduct bies emergency prepared is: Review on 2/10/25 o no evidence of a full- facility-based training scale-community or facility-based training scale-community or facility-based training conducted a full-scal training, a second full facility-based training exercise. Continued revealed that the face 8/26/24 that was doc	NHCI must conduct emergency plan. The RNHCI g: pased, tabletop exercise at etop exercise is a group acilitator, using a narrated, rergency scenario, and a set ts, directed messages, or designed to challenge an acilitation of all tabletop exercises, ats, and revise the RNHCI's needed. The facility is needed. The facility is ness plan (EPP). The finding a second full facility-based training or top exercise. With the program med the facility has not e community or go recommunity or go or mock drill, or tabletop interview with the PM allity conducted a live event on sumented as a schedfuled	E 03	39		
W 104	fire drill which is cond GOVERNING BODY		W 10	04		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION	_	(X3) DATE : COMPI	
		34G053	B. WING _			02/	11/2025
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY 219 MYRON PLACE SALISBURY, NC 281			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 104	budget, and operating. This STANDARD is Based on observation interviews, the gover failed to exercise ger direction over the fact interior and exterior cand orderly. The find Observations during completed on 2/10/25 chair to block the rear room area. Continue chair to be wedged uprevent entry from the during the observation to prevent a hazard if evacuation. Subsequent observation revealed cover the dryer vent and co	must exercise general policy, g direction over the facility. not met as evidenced by: on, record review and ning body and management deral policy and operating ility by failing to assure the of the facility was sanitary ing is: the recertification survey 5-2/11/25 revealed a wooden or entry door in the dining and observation revealed the inderneath the door knob to be back yard area. At no point on did staff remove the door of there was an emergency tions revealed a dryer vent to not porch area. Continued a large amount of lent to and spread across the front staff C and D on 2/11/25 ware of the use of the k the rear entry door. with staff C and D revealed lock the entry due to third all of a potential intruder or ering the facility while the Further interview with staff C eless people pass through	W	104			
		out the night which raises afety of the facility entry					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		34G053	B. WING _			02/11/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 104	2/11/25 revealed they build up on the front put with staff C and D reventhe side entry to enter the chair rear entry door for sa interview with the QID made aware of the ner doors due to concern homeless persons. For QIDP verified staff she egress in the event of at the facility.	with staff C and D on a did not notice the dryer lent corch. Continued interview realed they commonly use and exit the facility. Alified intellectual disabilities on 2/11/25 revealed he was a being used to block the fety reasons. Continued DP revealed he was not reed to secure the rear entry of potential intruders and further interview with the ould not use a chair to block fran emergency evacuation	W 1	04		
W 249	verified maintenance regularly and remove in the front porch are the QIDP revealed st. vent to prevent a fire facility. PROGRAM IMPLEM CFR(s): 483.440(d)(1) As soon as the interd formulated a client's i each client must receive treatment program cointerventions and seriand frequency to sup) isciplinary team has ndividual program plan, ive a continuous active	W 2	249		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OATE SURVEY OMPLETED
		34G053	B. WING _			02/11/2025
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 219 MYRON PLACE SALISBURY, NC 28144		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
W 249	Continued From page	ge 18	W 2	49		
	Based on observatinterviews, the faciliar received a continuor consisting of neede as identified in the F4 sampled clients (# training objectives a equipment. The find A. The facility failed prescribed for client Observations in the client #2 to ambulat staff assistance. Co 7:01AM revealed st transfer from a recliusing a gait vest. Futhe gait vest to be unadditional observations forward while the sepants. Observations staff to transfer client dining room table with no point during the client #2's gait vest from the wheelchair Review of the record revealed a PCP dat staff should use the transfers and ambular record for client #2's gait test.	to utilize the gait vest as at #2. For example, facility on 2/11/25 revealed to throughout the facility with sortinued observation at aff to assist client #2 to mer to a wheelchair without curther observation revealed infastened on the left side. If it is it is it is in the cond staff fixed the client is at 7:30AM also revealed in the three three three in a wheelchair to the ithout using the gait vest. At observation did staff fasten and use it to transfer the client				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	l ' '	TE SURVEY MPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	with ambulation. Interview with the q professional (QIDP) client #2's intervent current. Continued verified that staff sh gait vest is secured ambulation and trar the QIDP revealed client #2's gait vest B. The facility failed equipment for client example, Observations during from 2/10/25-2/11/2 participate in variou with staff assistance not reveal staff to prosoft hand splints. Subsequent observiewed in preparation	e using the gait vest to assist ualified intellectual disabilities on 2/11/25 verified that all of ions and objectives are interview with the QIDP ould ensure that client #2's and use it to assist with insfers. Further interview with staff have been trained to use as prescribed. It o provide adaptive if #2 as prescribed. For g the recertification survey for revealed client #2 to s activities throughout the day e. Continued observations did rovide client #2 with bilateral ations on 2/11/25 at 7:40AM sist client #2 with setting the for the breakfast meal.	W 2	49		
	client #2 with partic	ions revealed staff to assist ipation in the breakfast meal non-skid mat and weighted				
	revealed a person-o 5/28/24 which indica bilateral hand splint the record for client therapy (OT) evalua	d for client #2 on 2/11/25 centered plan (PCP) dated ated the client should wear s daily. Continued review of #2 revealed an occupational ation dated 2/22/24 which uses bilateral soft hand splints				

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 219 MYRON PLACE SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
W 249	protect client's skin of and fingers. Further revealed recommend 1lb. wrist weights on an attempt to reduce on her eating perform. Subsequent review of revealed client #2 shadaptive equipment utensile, high sided of protector, and non-sill. Interview with the quiprofessional (QIDP) should have bilateral waking hours. Continuerified all of client #0 objectives were currealso verified that state adaptive equipment mealtimes. Further in revealed staff have be #2's hand splints dur. C. The facility failed goal relative to hand Morning observation revealed staff to assist room to prepare for the Continued observation that the breakfast meal was to point during the prompt client #2 to we want to the prompt client #2 to we want to the prompt client #2 to we want to prom	k finger placements to lue to mouthing, biting hands review of the OT evaluation dations for client #2 to wear both wrists at mealtime, in the effect of client's tremors nance. If the 2/22/24 OT evaluation ould have the following during mealtimes: weighted dish, mug with lid, shirt kid mat. alified intellectual disabilities on 2/11/25 revealed client #2 soft hand splints during nued interview with the QIDP 2 interventions and lent. Interview with the QIDP of should use the appropriate for client #2 during neen trained to provide client ing the day. It follow client #2's program washing. For example, so on 2/11/25 at 7:40AM st client #2 to the dining he breakfast meal. ons revealed staff to assist a her plate and consuming inthout washing her hands. Se breakfast meal did staff	W 24	9			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G053	B. WING			02/11/2025		
NAME OF PE	ROVIDER OR SUPPLIER		•	21	TREET ADDRESS, CITY, STATE, ZIP CODE 19 MYRON PLACE ALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 249	the client has a progr with 80% accuracy, g physical prompts.	d 5/28/24 which indicated am goal to wash her hands iven one of fewer partial DP on 2/11/25 verified that all	w:	249				
W 253	current. Continued in revealed staff have be		W	253				
	are related to the clie and assessments. This STANDARD is r Based on record revi facility failed to docum	ument significant events that nt's individual program plan not met as evidenced by: iew and interviews, the nent significant events es as prescribed for 1 of 4 The finding is:						
	revealed a person-ce 2/3/25 and nutritional which indicated that t following diet: weight whole consistency wire mealtimes. Continued assessment revealed discontinue weight gamonitor weights montineeded. Review of the also revealed recommunity weight to remain stab Further review of the a weight log tracking	gain, high calorie snacks, th juice or milk during d review of the nutritional recommendations to ain diet with juice and milk, thly, assess annually and as e nutritional assessment nendations for client #4's						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
W 253	logged at 139.4 lbs of weight report did not being logged since 1 record for client #4 d to support the recommodified weight gain diet as publication line lectual disabilities 2/11/25 revealed that client #4's weight goor recommendations. Or QIDP revealed the todiscuss and execute as prescribed. NURSING SERVICE CFR(s): 483.460(c)(s) Nursing services must other members of the appropriate protective measures that include control of communication including the instruct imethods of infection. This STANDARD is Based on observation failed to implement a infection control for 5 #6) relative to handword Afternoon observation at 5:15PM revealed stable to prepare for the observation did not reprompt clients (#1, #their hands in prepare).	on 12/31/24. Review of the reveal the client's weight 2/31/24. Review of the id not reveal documentation mendation to discontinue rescribed. If services and the qualified is professional (QIDP) on the team has not discussed als and prescribed continued interview with the earn should have met to the diet recommendations. If services and the qualified is professional (QIDP) on the team has not discussed als and prescribed continued interview with the earn should have met to the diet recommendations. If services and the qualified is professional (QIDP) on the team has not discussed als and prescribed continued interview with the earn should have met to the diet recommendations.	W 25		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G053	B. WING	B. WING		02/	11/2025
NAME OF PI	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 19 MYRON PLACE SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
W 436	hands prior to participobservations also revigloves instead of chain Morning observations revealed staff to promprepare for the break observations revealed plates without washind breakfast meal. Subsequent observations prepare clients' diet of blender. Continued of touch a client's hair a clients' meals without Interview with nursing intellectual disabilities 2/11/25 revealed staff their hands and changeross-contamination. QIDP revealed staff swash their hands priod SPACE AND EQUIPM CFR(s): 483.470(g)(2) The facility must furniand teach clients to use the aring and other corand other devices idea interdisciplinary team This STANDARD is reasonable and observation interviews, the facility	pose without washing his pating in the dinner meal. Wealed staff to wash their inging them. If on 2/11/25 at 7:30AM and clients to the table to fast meal. Continued dictients to prepare their githeir hands prior to the dispersional staff to consistencies using a abservations revealed staff to consistencies using a abservations revealed staff to conditional resume preparing the changing their gloves. If services and the qualified a professional (QIDP) on the fave been trained to washing ge gloves to prevent Continued interview with the chould prompt all clients to the found prompt all clients to the favored to make informed the factor of dentures, eyeglasses, munications aids, braces, intified by the client. The factor of the conditional record review and the factor of the conditional record review and the factor of the client. The factor of the client and the conditional record review and the conditional record review and the conditional record		341			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		34G053	B. WING _			2/11/2025		
NAME OF PROVIDER OR SUPPLIER MYRON PLACE				STREET ADDRESS, CITY, STATE, ZIP CO 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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 436	6 Continued From page 24 sampled clients (#3, #5). The findings are:		W 4	36				
	A. The facility failed t equipment for client # prescribed. For exam	#3 during mealtimes as						
	at 5:30PM revealed significant distribution of the distribution of	divided dish, and regular during the dinner meal did 3 with an inner lip plate. s on 2/11/25 at 7:40AM st client #3 to the dining or the breakfast meal. ons revealed staff to again setting the place setting						
	person centered plan	for client #3 revealed a n (PCP) dated 2/6/25 which as the following adaptive ealtimes: shirt protector and						
	have been trained to equipment for client # Continued interview v client #3's interventio current. Further inter- staff should have pro	DP on 2/11/25 revealed staff use the appropriate adaptive #3 during mealtimes. with the QIDP verified all of ins and objectives are view with the QIDP verified vided client #3's adaptive ealtimes as prescribed.						

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		34G053	B. WING _			02/	11/2025
	NAME OF PROVIDER OR SUPPLIER MYRON PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144			
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W 436	Continued From page 25		W	136			
	B. The facility failed to equipment to client #9 example,	o provide adaptive 5 during mealtimes. For					
	revealed staff to assist table in preparation for Continued observation the client with setting not include the non-since Review of the record revealed a PCP dated should have the follows:	ns revealed staff to assist the place setting which did kid mat as prescribed. for client #5 on 2/11/25 d 6/24/24 revealed client #5 wing adaptive equipment					
W 440	during mealtimes: hig protector, and non-sk Interview with the QID have been trained to equipment for client # Continued interview vicient #5's intervention current. Further intervitatif should have promat during mealtimes EVACUATION DRILL CFR(s): 483.470(i)(1) at least quarterly for each this STANDARD is represented to show were conducted for each training protection.	th sided divided dish, shirt id mat. DP on 2/11/25 revealed staff use the appropriate adaptive to divide the appropriate adaptive to divide the QIDP verified all of an and objectives are view with the QIDP verified vided client #5 a non-skid as prescribed. Seach shift of personnel. The appropriate the cord and interview, the evidence quarterly fire drills	W	140			
	is: Review of the facility	fire drill reports from 2/24 d missing drills for 2/24,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G053	B. WING _			02/	11/2025
NAME OF PROVIDER OR SUPPLIER MYRON PLACE		•	219	REET ADDRESS, CITY, STATE, ZIP CODE 9 MYRON PLACE ALISBURY, NC 28144			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 440	confirmed facility fire conducted quarterly f interview with the pro there was no addition	gram manager on 2/11/25 drills should have been or each shift. Continued gram manager confirmed al documentation to reflect	W	140			
W 460	the missing drills that were conducted during the review year.		W	460			
	Based on observation interview, the facility of prescribed diets for 2 and #5). The findings A. The facility failed to prescribed diet for click example: Observations in the gradient street of the chicken tenders, onion cream, water, and minuted at 5:40 PM revealed of dinner meal. At no time was staff observed to yogurt, pudding, or appreciate the facility of the chicken tenders. At no time was staff observed to yogurt, pudding, or appreciate the facility of the facility o	o provide specially ent #2 during mealtimes. For roup home on 2/10/25 at dinner meal consisted of n rings, green beans, ice lk. Continued observations client #2 to consume her ne during the dinner meal provide client #2 with 4oz. oplesauce.					

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NAME OF PROVIDER OR SUPPLIER MYRON PLACE				219 MYRON	RESS, CITY, STATE, ZIP CODE PLACE Y, 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	diet to include 4oz. you applesauce with lunch applesauce with lunch linterview with the pro 2/11/25 confirmed the #2. Continued interviethe staff should have prescribed diet to inclipudding, or applesaure. B. The facility failed to prescribed diet for clie example: Observations in the great state of the chicken tenders, onion cream, water, and min at 5:40 PM revealed the chicken tenders, onion cream, water, and min at 5:40 PM revealed dinner meal. At no time was staff observed to pudding, yogurt, or applesauce of the to include 1/2 cup applesauce with lunch linterview with the pro 2/11/25 confirmed the #5. Continued interview the staff should have	the P.O. revealed client #2's agurt, pudding, or h and dinner. gram manager (PM) on the P.O. to be current for client are with the PM confirmed provided client #2 with ude the 4oz. of yogurt, and the provided specially and the formulation of the provided specially and the formulation of the provided specially and the formulation of the provided specially are dinner meal consisted of an rings, green beans, ice also consume her the during the dinner meal provide client #5 to consume her the during the dinner meal provided client #5 with ½ cup applesance. 2/11/25 for client #5 are order (P.O.) dated 2/11/25. The P.O. revealed client #5's pudding, yogurt, or h and dinner. gram manager (PM) on the P.O. to be current for client are with the PM confirmed provided client #5 with ude the ½ cup pudding,	W 4					
vv 4/3	CFR(s): 483.480(b)(2	()(ii)	VV 4	13				

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W 473	Continued From pag	ge 28	W 4	73			
	This STANDARD is Based on observati failed to ensure food appropriate tempera	d at appropriate temperature. not met as evidenced by: on and interview, the facility I was served at an iture for 6 of 6 clients (#1, #2, ing in the facility. The finding					
	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 7:30 AM 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.						
W 474	professional (QIDP) should have kept the to be served and rel interview with the Q trained to prepare a	ualified intellectual disabilities on 2/11/25 revealed staff e food warm until it was ready neat as necessary. Continued IDP revealed staff have been not serve menu items at an ture prior to serving to the	W 4	74			
	developmental level This STANDARD is Based on observati interviews, the facilit form consistent with	d in a form consistent with the of the client. not met as evidenced by: ons, record reviews, and y failed to serve food in a the developmental level of 3 (#1, 5, and #6). The findings					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G053	B. WING		02/11/2025	
NAME OF PROVIDER OR SUPPLIER MYRON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
W 474	Observations in the 5:26 PM revealed the chicken tenders, on cream, water, and nat 5:40 PM revealed dinner meal in whole during the dinner meassist the client to posservations in the 7:30 AM revealed the turkey sausage patt water, and milk. Con AM revealed client ameal in whole consist breakfast meal was client to provide the Review of client #1's person-centered pla Review of the PCP assessment dated apprescribed an 1800 encourage seconds portions of desserts Interview with the prescribed.	group home on 2/10/25 at the dinner meal consisted of ion rings, green beans, ice milk. Continued observations of client #1 to consume his the consistency. At no time the eal was staff observed to provide a ½" consistency. The breakfast meal consisted of ies, sliced toast, fruit cocktail, intinued observations at 7:50 that to consume his breakfast stency. At no time during the staff observed to assist the meal in a ½" consistency. The provide a ½" consistency of vegetables only, ½ the consume his breakfast stency. At no time during the staff observed to assist the meal in a ½" consistency. The provided a nutritional consistency of vegetables only, ½ the consistency, of vegetables only, ½ the confirmed iets should be followed as	W 474			
	prescribed. For exa	to follow client #5's diet as mple:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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Continued From pa	ge 30	W 4	74			
7:30 AM revealed the turkey sausage path water, and milk. Conclient #5 to consume chopped consistence revealed staff to produce turkey sausage chooliquids to soften the breakfast meal was #5 to provide the milk PCP dated 5/27/22 and utritional assess #5 to be prescribed weight gain, sugardinaterview with the Pith sprescribed diet PM confirmed specifollowed as prescribed. C. The facility failed prescribed. For example, on the size of provided the process of the size of prescribed to the size of prescribed to the size of prescribed to prescribe dieter to prescri	the breakfast meal consisted of ties, sliced toast, fruit cocktail, intinued observations revealed to the her breakfast meal in a cy. Further observations ovide the client with toast and opped together with limited to food. At no time during the estaff observed to assist client to eal in a ground consistency. Is record on 2/11/25 revealed a consistency of the PCP revealed ment dated 1/30/25 for client a ground consistency diet, free beverages and desserts. If M on 2/11/25 confirmed client to the field ment diet with the sially modified diets should be beed. If to follow client #6's diet as ample: If group home on 2/10/25 at the dinner meal to consist of					
	Continued From particles and particles are summary of the provided the provided the provided the process and particles are summary of the provided t	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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"	A BUILDIN 34G053 B. WING ROVIDER OR SUPPLIER LACE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 30 W 4 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	A BUILDING 34G953 ROWIDER OR SUPPLIER LACE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION) Continued From page 30 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 paties, 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 patient be 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 nutritional assessment dated 1/30/25 for client #5 to be prescribed aground 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 tient #6' to consume his during the dinner meal to consist of chicken tenders, onion rings, green beans, ice cream, water, and milk. Continued observations at 5:40 PM revealed tient #6' to consume his 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		

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W 474	Continued From pag turkey sausage pattic water, and milk. Conclient #6 to consume consistency. At no time was staff observed to 1/2-1" consistency me Review of client #6's PCP dated 7/26/24. a nutritional assessmus #6 to be prescribed a diet, heart healthy, 1/2 Interview with the PM #6's prescribed diet.	e 31 es, sliced toast, fruit cocktail, tinued observations revealed his breakfast meal in whole me during the breakfast meal passist client #6 to provide a eal. record on 2/11/25 revealed a Review of the PCP revealed ment dated 1/30/24 for client an 1800 calorie weight loss 6-1" diet consistency. M on 2/11/25 confirmed client Further interview with the ally modified diets should be		474				