PRINTED: 02/20/2025 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB I	NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	E CONSTRUCTION		TE SURVEY MPLETED	
		34G053	B. WING			2/44/2025
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		2/11/2025
MYRON P	OLACE			219 MYRON PLACE		
MITTON	LACE			SALISBURY, NC 28144		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID			
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 015	Subsistence Needs for	or Staff and Patients	E 045			
	CFR(s): 483.475(b)(1)	E 015	E015		
						4/12/25
	§403.748(b)(1), §418	.113(b)(6)(iii), §441.184(b)		The Safety Chairperson will in	-service	
	(1), §460.84(b)(1), §4	82.15(b)(1), §483.73(b)(1),		the Residential Team Leader	on	
	§483.475(b)(1), §485	.542(b)(1), §485.625(b)(1)		emergency food supplies. The	clinical	
				team will monitor through		
	(b) Policies and proc	edures. [Facilities] must		environmental assessments		
	develop and impleme	nt emergency preparedness		bi-weekly for a period of 30 da	ys and	
	policies and procedur	es, based on the emergency		then on a routine basis. In the	future,	
	assessment at parag	graph (a) of this section, risk		the RTL will ensure adequate		
	and the communication	raph (a)(1) of this section, on plan at paragraph (c) of		emergency food supplies are a in the home.	always	
	this section. The police	cies and procedures must		in the nome.		
	be reviewed and upda	ated every 2 years [annually				
	for LTC facilities]. At a	a minimum, the policies and				
	procedures must addr	ress the following:				
	(1) The provision of su	ubsistence needs for staff				
	and patients whether t	they evacuate or shelter in				
	place, include, but are	not limited to the following:				
		al and pharmaceutical				
	supplies					
	(ii) Alternate sources of	of energy to maintain the				
	following:					
	(A) remperatures to pr	rotect patient health and and sanitary storage of				
	provisions.	and sanitary storage of				
	(B) Emergency lighting.					
	(C) Fire detection, exti					
	systems.	J				
	(D) Sewage and waste	e disposal.				
	*[For Inpatient Hospice	e at §418.113(b)(6)(iii):]				
	Policies and procedure	es.				
	(6) The following are a	dditional requirements for				
	hospice-operated inpar	tient care facilities only.				
	The policies and proce	edures must address the				
	following:					
	(iii) The provision of su	bsistence needs for				
OR KORY DI	RECTOR'S OR PROVIDER/SU	JPPLIER 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.

DD Regional Administrator 2/25/25

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		34G053	B. WING		02/11/2025		
MYRON I	PROVIDER OR SUPPLIER		219	EET ADDRESS, CITY, STATE, ZIP CODE MYRON PLACE LISBURY, NC 28144		2/11/2025	
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 015	hospice employees evacuate or shelter i limited to the followin (A) Food, water, mer supplies. (B) Alternate source: following: (1) Temperatures to safety and for the sar provisions. (2) Emergency lighting: (3) Fire detection, experience and was This STANDARD is Based on observation failed to ensure the process for clients and emergency food supply on 2/10/25 resupply on 2/10/25 resupply to contain var which included 5 conformed that the face of firmed that the face of the supply on 2/11/25 for the supp	and patients, whether they in place, include, but are not ng: dical, and pharmaceutical s of energy to maintain the protect patient health and fe and sanitary storage of ng. Attinguishing, and alarm steed disposal. The provision of subsistence and interview, the facility provision of subsistence at staff relative to the ply. The finding is: accilities emergency food wealed the emergency food ious expired food items attainers of baby food, a box canned fruit cocktail, 1 large milk, canned tomatoes, and peanut butter. With the residential team gram manager (PM) cility should inspect the food that the home has an nexpired foods for	E 015				
	§403.748(d)(1), §416	.54(d)(1), §418.113(d)(1),					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ULDING		(X3) DATE SURVEY COMPLETED	
114145 05 5		34G053	B. WING	0	02/11/2025		
MYRON F	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 19 MYRON PLACE SALISBURY, NC 28144	1 0.	2/11/2023	
(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 CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (EACH OF THE APPRO	ULD BE	(X5) COMPLETION DATE	
	§441.184(d)(1), §460 §483.73(d)(1), §483.2 §485.68(d)(1), §485.9485.727(d)(1), §485.9491.12(d)(1). *[For RNCHIs at §403.4 Hospitals at §482.15, at §484.102, REHs at under §485.727, OPC RHC/FQHCs at §491. (1) Training programs the following: (i) Initial training in empolicies and procedure staff, individuals proviarrangement, and voluexpected roles. (ii) Provide emergency least every 2 years. (iii) Maintain document preparedness training (iv) Demonstrate staff procedures. (v) If the emergency procedures are significated must conduct training procedures. *[For Hospices at §418 hospice must do all of (i) Initial training in empolicies and procedure hospice employees, and services under arrange expected roles.	.84(d)(1), §482.15(d)(1), .875(d)(1), §484.102(d)(1), .542(d)(1), §485.625(d)(1), .920(d)(1), §486.360(d)(1), .8.748, ASCs at §416.54, ICF/IIDs at §483.475, HHAs .§485.542, "Organizations" .9. at §486.360, .12:] . The [facility] must do all of	E 037	E037 The Qualified Professional an Safety Chairperson will update Emergency Preparedness Pla Qualified Professional will traistaff on the plan. The Qualifie Professional and Safety Chair will complete a mock/tabletop exercise as part of the training Emergency Preparedness Pla Regional Administrator will mothe Emergency Preparedness every 6 months to ensure it reupdated, staff are trained, and drills/tabletop exercises are completed. The Qualified Professional will ensure the Emergency Preparedness Plaupdated, staff are rained on the current plan, and training concannually including mock drills tabletop exercises.	g for the an. The onitor s Plan emains d mock	4/12/25	

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE OF	OMB NO. 0938-0391	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	JNSTRUCTION	(X3) DATE SURVEY COMPLETED
			THE BOILDING	-	JOHN EETED
		34G053	B. WING		00/44/000
NAME OF F	PROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	02/11/2025
MYRON F	PLACE			MYRON PLACE	
			SAL	ISBURY, NC 28144	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N OUT
TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
		1	IAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE
=	counts only to the				
E 037	Continued From page		E 037		
	(iii) Provide emergend	cy preparedness training at			
	least every 2 years.				
	(iv) Periodically review	v and renearse its ness plan with hospice			
	employees (including	nonemployee staff), with			
	special emphasis place	ed on carrying out the			
	procedures necessary	to protect patients and			
	others.				
		tation of all emergency			
	preparedness training				
	(vi) if the emergency p	preparedness policies and cantly updated, the hospice			
	must conduct training	on the updated policies and			
	procedures.	on the apaated policies and			
	1 - Contract and Contract of the Contract of t				
	*[For PRTFs at §441.1	84(d):] (1) Training			
	program. The PRTF m	oust do all of the following:			
	(I) Initial training in em	ergency preparedness			
	staff, individuals provid	es to all new and existing			
	arrangement, and volu	inteers, consistent with their			
	expected roles.	with the state of			
	(ii) After initial training,	provide emergency			
	preparedness training	every 2 years.			
		knowledge of emergency			
	procedures.	totion of all annual			
1	(iv) Maintain document preparedness training.	lation of all emergency			
		eparedness policies and			
	procedures are signific	antly updated, the PRTF			
	must conduct training of	on the updated policies and			
	procedures.				
	*[For PACE at §460.84	(d):1 (1) The PACE			
	organization must do a	Il of the following:			
	(i) Initial training in eme	ergency preparedness			
1	policies and procedures	s to all new and existing			
	staff, individuals provid	ing on-site services under			

STATEMENT OF DEFICIENCIES (X1) PROVID		(X1) PROVIDER/SUPPLIER/CLIA	/V0\ M !! TID! 5 0		OMB NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G053	B. WING		02/44/2025
MYRON I	PROVIDER OR SUPPLIER		219	EET ADDRESS, CITY, STATE, ZIP CODE MYRON PLACE LISBURY, NC 28144	02/11/2025
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	arrangement, contivolunteers, consist (ii) Provide emerge least every 2 years (iii) Demonstrate st procedures, including what to do, where case of an emerge (iv) Maintain docum (v) If the emergency procedures are signust conduct training procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in policies and procedures and procedures, and vexpected role. (ii) Provide emergency least annually. (iii) Maintain docum preparedness training (iv) Demonstrate star procedures. *[For CORFs at §48 CORF must do all of (i) Provide initial traingreparedness policies and existing staff, in under arrangement, with their expected in the context of	ractors, participants, and ent with their expected roles. Ency preparedness training at a staff knowledge of emergency ing informing participants of to go, and whom to contact in incy. In entation of all training. Expreparedness policies and inficantly updated, the PACE ing on the updated policies and at §483.73(d):] (1) Training facility must do all of the emergency preparedness tures to all new and existing eviding services under colunteers, consistent with their incy preparedness training at entation of all emergency ing. Eaff knowledge of emergency entations of all emergency ing. Eaff knowledge of emergency es and procedures to all new idividuals providing services and volunteers, consistent entations and procedures to all new idividuals providing services and volunteers, consistent	E 037		

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	000 144 4 7174 7 7	(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:	A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
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E 037	(iii) Maintain docurr (iv) Demonstrate s procedures. All new and assigned spector the CORF's emergy their first workday, include instruction alarm systems and equipment. (v) If the emergen procedures are signmust conduct training procedures. *[For CAHs at §488 The CAH must do a (i) Initial training in policies and procedure reporting and exting and where necessal personnel, and gue cooperation with firm authorities, to all ne individuals providing and volunteers, con roles. (ii) Provide emerger least every 2 years. (iii) Maintain docum (iv) Demonstrate star procedures. (v) If the emergence procedures are signmust conduct training procedures. *[For CMHCs at §488]	nentation of the training. taff knowledge of emergency w personnel must be oriented iffic responsibilities regarding ency plan within 2 weeks of The training program must in the location and use of signals and firefighting cy preparedness policies and inficantly updated, the CORF ing on the updated policies and of the following: emergency preparedness lures, including prompt guishing of fires, protection, iry, evacuation of patients, sts, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, insistent with their expected	E 037			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 037	preparedness policicand existing staff, in under arrangement, with their expected redocumentation of the demonstrate staff kn procedures. Therea emergency prepared years. This STANDARD is Based on record refacility failed to ensu trained on the facility plan (EPP) at least in finding is:	es and procedures to all new dividuals providing services and volunteers, consistent roles, and maintain e training. The CMHC must nowledge of emergency after, the CMHC must provide dness training at least every 2 not met as evidenced by: views and interviews, the re direct care staff were by semergency preparedness initially and biennially. The	E 037		
E 039	no evidence of initial EPP. Continued revidence that the fact plan. Interview on 2/11/25 leader (RTL) and proconfirmed that initial for current staff were EP Testing Requirem CFR(s): 483.475(d)(2), §418. §460.84(d)(2), §482. §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	training and biennial training not completed as required. nents (2) 113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), 102(d)(2), §485.68(d)(2), 12(d)(2), §485.727(d)(2), 12(d)(2), §494.62(d)(2).		E039 Cross reference E039	4/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G053	B. WING		00/44/0005	
MYRON F	PROVIDER OR SUPPLIER		219 1	EET ADDRESS, CITY, STATE, ZIP CODE MYRON PLACE ISBURY, NC 28144	02/11/2025	
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E 039	§491.12, and ESRD (2) Testing. The [factor to test the emergency must do all of the following to the following to the following the facility of the facility natural or man-made activation of the emergency from engaging community-based or functional exercise for actual event. (ii) Conduct an additive years, opposite the yea	Facilities at §494.62]: ility] must conduct exercises by plan annually. The [facility] lowing: Ill-scale exercise that is very 2 years; or nity-based exercise is not a facility-based functional ars; or experiences an actual exemergency that requires ergency plan, the [facility] is not in its next required individual, facility-based bellowing the onset of the conal exercise at least every 2 rear the full-scale or nider paragraph (d)(2)(i) of coted, that may include, but is bright individual, facility-based or drill; or see or workshop that is led by des a group discussion using relevant emergency for problem statements, or prepared questions even emergency plan. Ity's] response to and ion of all drills, tabletop gency events, and revise the	E 039			

STATEMENT OF DEFICIENCIES		(MA) PROMPERIOUS		OMB NO. 0938-0	OMB NO. 0938-0391	
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	02/11/2025	
MYRON	PLACE			19 MYRON PLACE		
			s	SALISBURY, NC 28144		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	
PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLET	
E 039	Continued From pag	ne 8	F 000			
	*[For Hospices at 41		E 039			
	(2) Testing for hospi	ces that provide care in the				
	patient's home. The	hospice must conduct				
	exercises to test the	emergency plan at least				
	annually. The hospic	ce must do the following:				
	(i) Participate in a fu	Il-scale exercise that is				
	community based ev	ery 2 years; or				
		ity based exercise is not				
	accessible, conduct a	an individual facility based				
	functional exercise e	very 2 years; or				
	(B) If the hospice exp	periences a natural or				
	man-made emergend	cy that requires activation of				
	the emergency plan,	the hospital is exempt from				
	engaging in its next r	equired full scale				- 1
	community-based ex	ercise or individual				
	onset of the emergen	nal exercise following the				
		ional exercise every 2 years,				
	opposite the year the	full-scale or functional				
	exercise under parag	raph (d)(2)(i) of this section				
	is conducted that ma	y include, but is not limited				
	to the following:	y molade, but is not inflited				
	(A) A second full-sca	le exercise that is				
	community-based or	a facility based functional				
	exercise; or					
	(B) A mock disaster of	drill; or				
		se or workshop that is led by				
	a facilitator and include	les a group discussion using				
	a narrated, clinically-r					
	scenario, and a set of	problem statements,				
	directed messages, o	r prepared questions				
	designed to challenge	e an emergency plan.				
	(3) Testing for hospice	es that provide inpatient				
	care directly. The hos	spice must conduct				
	exercises to test the e	mergency plan twice per				
	year. The hospice mu	ust do the following:				
	(i) Participate in an ar	nnual full-scale exercise that				
		Tan oddio oxorolog triat				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF S		34G053	B. WING		02/11/2025
MYRON I			219 1	EET ADDRESS, CITY, STATE, ZIP CODE WYRON PLACE ISBURY, NC 28144	, 02.112020
(X4) ID PREFIX TAG	(EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
	is community-base (A) When a comm accessible, conduct facility-based funct (B) If the hospice of man-made emerged the emergency platengaging in its next based or facility-based following the onset (ii) Conduct an admay include, but is (A) A second full-second full-secon	ed; or unity-based exercise is not et an annual individual cional exercise; or experiences a natural or ency that requires activation of n, the hospice is exempt from et required full-scale community used functional exercise of the emergency event. ditional annual exercise that not limited to the following: ccale exercise that is or a facility based functional er drill; or recise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed. 1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must o test the emergency plan e [PRTF, Hospital, CAH] must annual full-scale exercise that	E 039		

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
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	facility-based function (B) If the [PRTF, Hos actual natural or man requires activation of [facility] is exempt fro required full-scale con facility-based function onset of the emergen (ii) Conduct an [a and that may include, following: (A) A second full-sca community-based or i functional exercise; on (B) A mock of (C) A tabletop exc led by a facilitator and discussion, using a na emergency scenario, a emergency scenario, a statements, directed in questions designed to plan. (iii) Analyze the [f maintain documentation exercises, and emerge [facility's] emergency p *[For PACE at §460.84 (2) Testing. The PACE exercises to test the el annually. The PACE o following: (i) Participate in an an is community-based; of (A) When a community accessible, conduct ar facility-based functional	nal exercise; or pital, CAH] experiences an -made emergency that the emergency plan, the m engaging in its next munity based or individual, nal exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based clisaster drill; or ercise or workshop that is includes a group arrated, clinically-relevant and a set of problem nessages, or prepared challenge an emergency acility's] response to and on of all drills, tabletop ency events and revise the blan, as needed. 4(d):] corganization must conduct mergency plan at least rganization must do the anual full-scale exercise that or y-based exercise is not annual individual,	E 039			

ANU PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
	the emergency plan, engaging in its next r based or individual, f exercise following the event. (ii) Conduct an a years opposite the years opposite the years conducted that may the following: (A) A second full-sca community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and includusing a narrated, cliniscenario, and a set of directed messages, of designed to challenge (iii) Analyze the PAC imaintain documentatic exercises, and emerge PACE's emergency planticluding unannounce emergency procedure (C) The [LTC facilities at (2) The [LTC facilities at (2) The [LTC facilities at (2) The procedure emergency procedure (ii) Participate in an aris community-based; of (A) When a community accessible, conduct at facility-based functions	cy that requires activation of the PACE is exempt from equired full-scale community acility-based functional conset of the emergency dditional exercise every 2 for the full-scale or functional raph (d)(2)(i) of this section y include, but is not limited to le exercise that is individual, a facility based or drill; or see or workshop that is led by less a group discussion, cally-relevant emergency is problem statements, or prepared questions an emergency plan. E's response to and for of all drills, tabletop ency events and revise the an, as needed. §483.73(d):] nust conduct exercises to an at least twice per year, do staff drills using the seed that for y-based exercise is not an annual individual,	E 039			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDED OUR DESIGNATION			OMB NO. 0938-0391	
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		COMPLETED	
		34G053	B. WING		00/44/0007	
NAME OF I	PROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	02/11/2025	
MYRON	PLACE			MYRON PLACE		
	MYRON PLACE		SAL	ISBURY, NC 28144		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	d turn	
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
E 039	actual natural or mar requires activation of LTC facility is exemp required a full-scale individual, facility-bas following the onset of (ii) Conduct an addit may include, but is not (A) A second full-scale community-based or functional exercise; of (B) A mock disaster (C) A tabletop exercial facilitator includes a narrated, clinically-reland a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume	n-made emergency that If the emergency plan, the It from engaging its next community-based or It for emergency event. It ional annual exercise that It ional exercise that It is ional exercise that is It is in the ional exercise It is in the	E 039			
	[LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/II to test the emergency The ICF/IID must do t (i) Participate in an an is community-based; (A) When a communit accessible, conduct a facility-based function (B) If the ICF/IID expe man-made emergency the emergency plan, ti engaging in its next re community-based or in	emergency plan, as needed. 3.475(d)]: ID must conduct exercises plan at least twice per year. the following: nual full-scale exercise that or ty-based exercise is not n annual individual, al exercise; or. riences an actual natural or y that requires activation of the ICF/IID is exempt from				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/20/2025 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 34G053 B. WING 02/11/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE **MYRON PLACE** SALISBURY, NC 28144 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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

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

or functional

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		34G053	B. WING		02/11/2025	
MYRON PLACE SLIMMARY STATEMENT OF DESIGNATION			219 (EET ADDRESS, CITY, STATE, ZIP CODE MYRON PLACE ISBURY, NC 28144	02/11/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENT	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
	limited to the follow (A) A second fucommunity-based of functional exercise; (B) A mock disis (C) A tabletop of led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HH/I documentation of all emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The Composition of the total the emergency events are led by a facilitator and discussion, using a remergency scenario statements, directed questions designed plan. If the OPO expending in its next following the onset of commentation of all documentation of all	nat may include, but is not ing: all-scale exercise that is or an individual, facility-based or aster drill; or exercise or workshop that is not includes a group narrated, clinically-relevant or, and a set of problem demessages, or prepared to challenge an emergency A's response to and maintain and I drills, tabletop exercises, and and revise the HHA's needed. 360] DPO must conduct exercises by plan. The OPO must do the exercise or annually. A tabletop exercise is not includes a group narrated, clinically relevant or, and a set of problem exercise is not include and a set of problem exercise and a set of problem exercises and an emergency eriences an actual natural or cy that requires activation of the OPO is exempt from required testing exercise of the emergency event. It's response to and maintain tabletop exercises, and and revise the [RNHCI's and	E 039			

		I VILDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G053	B. WING		02/11/2025
MYRON F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
E 039	*[RNCHIs at §403.7 (d)(2) Testing. The Rexercises to test the must do the following (i) Conduct a paper-least annually. A tab discussion led by a folinically-relevant emof problem statemen prepared questions demergency plan. (ii) Analyze the RNH maintain documental and emergency plan, as a This STANDARD is Based on record reversely and the statement of the sta	48]: kNHCl must conduct emergency plan. The RNHCl g: based, tabletop exercise at letop exercise is a group acilitator, using a narrated, hergency scenario, and a set ts, directed messages, or designed to challenge an Cl's response to and tion of all tabletop exercises, hts, and revise the RNHCl's	E 039		
	no evidence of a full- facility-based training scale-community or f mock drill, or a tablet	, a second full acility-based training or			
W 104	conducted a full-scale training, a second ful facility-based training exercise. Continued in revealed that the faci	ned the facility has not e community or facility-based I scale-community or or mock drill, or tabletop interview with the PM lity conducted a live event on umented as a schedfuled fucted monthly.	W 104		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		34G053	B. WING		02	2/11/2025
NAME OF PROVIDER OR SUPPLIER MYRON PLACE		21	REET ADDRESS, CITY, STATE, ZIP CODE 9 MYRON PLACE ALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 104	CFR(s): 483.410(a The governing bod budget, and operations STANDARD Based on observatinterviews, the governing failed to exercise and orderly. The fill observations during completed on 2/10 chair to block the room area. Continued interior and exterior and orderly. The fill observations during the observation from during the observation reveal cover the dryer very porch. Interview with facility revealed they were wooden chair to block the chair is used to shift staff being feathomeless person of clients are sleeping and D revealed how the backyard throughts.	dy must exercise general policy, ting direction over the facility. is not met as evidenced by: ation, record review and verning body and management general policy and operating facility by failing to assure the or of the facility was sanitary	W 104	W 104 The Qualified Professional will in-service all staff on proper ulocking doors and ensuring sawithin the home for staff and F Supported as well as keeping from the dryer duct clear. The team will monitor through environmental assessments 1 week for a period of 30 days athen on a routine basis. In the the Qualified Professional will all staff are trained on environ safety factors.	se of fety People lint clinical x a and future, ensure	4/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
		34G053	B. WING		02/44/2025
NAME OF PROVIDER OR SUPPLIER MYRON PLACE			219 1	EET ADDRESS, CITY, STATE, ZIP CODE MYRON PLACE ISBURY, NC 28144	02/11/2025
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
W 104	points. Subsequent intervi 2/11/25 revealed the build up on the from with staff C and D and the side entry to end the side entry door for a side entry door for interview with the C made aware of the doors due to concern the side entry to entry the side entry door for interview with the C made aware of the doors due to concern the side entry the side entry the side entry the side entry to entry the side	ew with staff C and D on ney did not notice the dryer lent of porch. Continued interview revealed they commonly use ofter and exit the facility. Jualified intellectual disabilities on 2/11/25 revealed he was nair being used to block the safety reasons. Continued DIDP revealed he was not need to secure the rear entry orns of potential intruders and Further interview with the should not use a chair to block of an emergency evacuation	W 104		
	verified maintenance regularly and remove in the front porch at the QIDP revealed vent to prevent a firefacility. PROGRAM IMPLEI CFR(s): 483.440(d) As soon as the interformulated a client's each client must receive treatment program of interventions and sean diffequency to sur		W 249		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	E CONSTRUCTION	(X3) DAT	E SURVEY
		J. J. W. HON WOMBER.	A. BUILDING_		CON	MPLETED
		34G053	B. WING		0:	2/11/2025
NAME OF PROVIDER OR SUPPLIER MYRON PLACE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 119 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 249	This STANDARD is Based on observati interviews, the facilit received a continuor consisting of needed as identified in the P4 sampled clients (# training objectives a equipment. The find A. The facility failed prescribed for client Observations in the client #2 to ambulate staff assistance. Cor 7:01AM revealed staff assistance. Cor 7:01AM revealed staff assistance agait vest. Fut the gait vest to be ur Additional observations taff to transfer client #2 by the forearms a forward while the seepants. Observations staff to transfer client dining room table with no point during the oclient #2's gait vest a from the wheelchair after the seepants. Review of the record revealed a PCP date staff should use the gate staff should use the gate of the record for client #2 record for clien	e not met as evidenced by: ons, record reviews and ty failed to ensure clients us active treatment program d interventions and services derson-Centered Plan for 1 of 2) relative to implementing and providing adaptive ings are: to utilize the gait vest as #2. For example, facility on 2/11/25 revealed throughout the facility with attinued observation at aff to assist client #2 to are to a wheelchair without other observation revealed afastened on the left side. For revealed staff to grab client and to hold the client bent cond staff fixed the client's at 7:30AM also revealed the treatment of the thout using the gait vest. At bservation did staff fasten and use it to transfer the client	W 249	W 249 A-C The Qualified Professional will in-service all staff on the adapt equipment needs and program People Supported. The clinical will monitor through interaction assessments 1x a week for a p 30 days and then on a routine I In the future, the Qualified Professional will ensure all staf trained on the programs and ac equipment needs of People Supported.	s of team eriod of pasis.	4/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING		TE SURVEY MPLETED	
		34G053	B. WING			2/11/2025
MYRON PLACE			219 N	ET ADDRESS, CITY, STATE, ZIP CODE MYRON PLACE ISBURY, NC 28144	THE RESERVE THE PERSON NAMED IN COLUMN 2 I	2111/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	staff should continuith ambulation. Interview with the professional (QIDF client #2's intervent current. Continued verified that staff signitives is secured ambulation and traithe QIDP revealed client #2's gait vest. B. The facility failed equipment for client example, Observations during from 2/10/25-2/11// participate in various with staff assistance not reveal staff to passistance of the preparation of	qualified intellectual disabilities P) on 2/11/25 verified that all of tions and objectives are Interview with the QIDP hould ensure that client #2's d and use it to assist with insfers. Further interview with staff have been trained to use	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	34G053	B. WING		03	2/11/2025
NAME OF PROVIDER OR SUPPLIER MYRON PLACE		219 (EET ADDRESS, CITY, STATE, ZIP CODE MYRON PLACE ISBURY, NC 28144	, ,	1112020
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
and fingers. Further revealed recommendation on her eating performants subsequent review of the revealed client #2 should adaptive equipment durutensile, high sided dishiprotector, and non-skid should have bilateral so waking hours. Continue verified all of client #2 in objectives were current. also verified that staff shadaptive equipment for mealtimes. Further inter revealed staff have been #2's hand splints during	nger placements to to mouthing, biting hands view of the OT evaluation ons for client #2 to wear th wrists at mealtime, in e effect of client's tremors nce. ne 2/22/24 OT evaluation d have the following ing mealtimes: weighted n, mug with lid, shirt mat. led intellectual disabilities 2/11/25 revealed client #2 ft hand splints during d interview with the QIDP neterventions and Interview with the QIDP nould use the appropriate client #2 during view with the QIDP n trained to provide client the day. lollow client #2's program thing. For example, n 2/11/25 at 7:40AM lient #2 to the dining preakfast meal. revealed staff to assist r plate and consuming but washing her hands. eakfast meal did staff her hands.	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		34G053	B. WING		02	2/11/2025	
NAME OF PROVIDER OR SUPPLIER MYRON PLACE		21	TREET ADDRESS, CITY, STATE, ZIP CODE 19 MYRON PLACE ALISBURY, NC 28144				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 249	revealed a PCP date the client has a progressivith 80% accuracy, gophysical prompts. Interview with the QII of client #2's program current. Continued in revealed staff have be #2 with washing her PROGRAM DOCUM CFR(s): 483.440(e)(2) The facility must doctor are related to the clies and assessments. This STANDARD is Based on record revealed and assessments. This STANDARD is Based on record reveality failed to docur relative to diet chang sampled clients (#4). Review of the record revealed a person-ce 2/3/25 and nutritional which indicated that it following diet: weight whole consistency will mealtimes. Continue assessment revealed discontinue weight gamonitor weights monneeded. Review of the also revealed recommend.	d 5/28/24 which indicated ram goal to wash her hands given one of fewer partial DP on 2/11/25 verified that all a goals and objectives are nterview with the QIDP een trained to assist client hands prior to mealtimes. ENTATION 2) ument significant events that ent's individual program plan and interviews, the ment significant events es as prescribed for 1 of 4. The finding is: for client #4 on 2/11/25 entered plan (PCP) dated assessment dated 1/30/24.	W 249	W 253 The Qualified Professional will in-service all staff on the diet or of People Supported. The clinic team will monitor through mealt assessments 1x a week for a prof 30 days and then on a routin basis. In the future, the Qualific Professional will ensure all staff trained on prescribed diet order People Supported.	cal ime eriod e ed are	4/12/25	
	a weight log tracking	record for client #4 revealed the clients weight between nd the last weight was					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION		0938-0391
AND PLAN (F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SI COMPLE	
		34G053	B. WING		02/44	1/2025
MYRON	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	1 02/11	1/2025
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 253	logged at 139.4 lbs weight report did no being logged since record for client #4 to support the recommendations. Interview with nursing intellectual disabilities 2/11/25 revealed that client #4's weight go recommendations. QIDP revealed the total discuss and executed as prescribed. NURSING SERVICE CFR(s): 483.460(c)(c) Nursing services must other members of the appropriate protective measures that including the instruction including the instruction including the instruction control for 5 based on observation failed to implement a infection control for 5 table to prepare for the observation did not reprompt clients (#1, #3) their hands in prepare	on 12/31/24. Review of the of reveal the client's weight 12/31/24. Review of the did not reveal documentation numendation to discontinue prescribed. In g services and the qualified es professional (QIDP) on at the team has not discussed eals and prescribed continued interview with the earn should have met to e the diet recommendations ES (5)(ii) Inst include implementing with the interdisciplinary team, we and preventive health the but are not limited to able diseases and infections, ition of other personnel	W 341	W 341 The nurse will in-service all staff handwashing protocols. The cliniteam will monitor through mealtin assessments 1x a week for a per of 30 days and then on a routine basis. In the future, the nurse with ensure all staff are trained on handwashing protocols.	on -	/12/25

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		34G053	B. WING			2/11/2025
MYRON P	ROVIDER OR SUPPLIER		219	REET ADDRESS, CITY, STATE, ZIP COD MYRON PLACE LISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
W 436	hands prior to par Observations also gloves instead of Morning observations revealed staff to prepare for the broobservations reve plates without was breakfast meal. Subsequent observations revealed staff to prepare clients' die blender. Continue touch a client's had clients' meals with Interview with nursintellectual disability 2/11/25 revealed staff their hands and chards and chards and chards and chards and chards and chards and their hands (SPACE AND EQUITMENT). 483.470(s) The facility must find teach clients the choices about the hearing and other and other devices interdisciplinary te This STANDARD Based on observations.	s nose without washing his ticipating in the dinner meal. It revealed staff to wash their changing them. Ons on 2/11/25 at 7:30AM rompt clients to the table to eakfast meal. Continued aled clients to prepare their shing their hands prior to the extractions revealed staff to et consistencies using a ed observations revealed staff to	W 436			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLETI	
34G053 B. WING	1441000
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	/11/2025
MYRON PLACE 219 MYRON PLACE SALISBURY, NC 28144	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436 Continued From page 24 sampled clients (#3, #5). The findings are: W 436 A-B The Qualified Professional will	4/12/25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Since Delication and Control of the	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		34G053	B. WING		02/11/2025	
MYRON P	ROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	02)1172020	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
W 436	B. The facility failed equipment to client example, Morning observation revealed staff to asstable in preparation Continued observation the client with setting not include the non-revealed a PCP data should have the foll during mealtimes: In protector, and non-setting mealtimes: In protector, and non-setting mealtimes in protector, and non-setting mealtimed to the equipment for client Continued interview client #5's intervent current. Further interview that the staff should have proposed in the staff should ha	It to provide adaptive #5 during mealtimes. For Ins on 2/11/25 at 7:40AM sist client #5 to the dining for the breakfast meal. tions revealed staff to assist ag the place setting which did skid mat as prescribed. In or client #5 on 2/11/25 and 6/24/24 revealed client #5 and adaptive equipment aligh sided divided dish, shirt askid mat. In DP on 2/11/25 revealed staff a use the appropriate adaptive at #5 during mealtimes. In with the QIDP verified all of a with the QIDP verified and ovided client #5 a non-skid as as prescribed. LLS	W 436	W 440 The safety chairperson will in-set the Residential Team Leader (RT on completing Fire Drills as required The RTL will complete fire drills a scheduled. The safety chairperso will monitor through monthly safety meetings. In the future, the safety chairperson and RTL will ensure a fire drills are completed as required.	L) ed. s n y	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G053	B. WING		Ι,	2/11/2025	
MYRON F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	1 0	2/11/2025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 440	3/24, and 4/24. Interview with the proconfirmed facility fire conducted quarterly interview with the prothere was no addition	ogram manager on 2/11/25 drills should have been for each shift. Continued ogram manager confirmed hal documentation to reflect t were conducted during the	W 440				
	FOOD AND NUTRIT CFR(s): 483.480(a)(1) Each client must rece well-balanced diet in specially-prescribed of the specially-prescribed of the specially-prescribed diets for 2 and #5). The findings A. The facility failed to prescribed diet for clie example: Observations in the g 5:23 PM revealed the chicken tenders, onio cream, water, and mil at 5:40 PM revealed of dinner meal. At no tim was staff observed to yogurt, pudding, or approximate the service of records on the service well as the service of the service o	eive a nourishing, cluding modified and diets. not met as evidenced by: ons, record reviews, and failed to provide specially of 4 sampled clients (#2 are: o provide specially ent #2 during mealtimes. For roup home on 2/10/25 at a dinner meal consisted of n rings, green beans, ice lik. Continued observations client #2 to consume her ne during the dinner meal provide client #2 with 4oz. oplesauce.	W 460	W 460 A-B The nurse will in-service all staff or prescribed diet orders. The clinicateam will monitor through mealting assessments 1x a week for a per 30 days and then on a routine bate in the future, the nurse will ensure staff are trained on prescribed diestorders for People Supported.	al ne lod of sis. e all	4/12/25	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		34G053	B. WING		02/11/2025
NAME OF PROVIDER OR SUPPLIER MYRON PLACE			219	REET ADDRESS, CITY, STATE, ZIP CODE MYRON PLACE LISBURY, NC 28144	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
W 460	diet to include 4oz applesauce with lu Interview with the 2/11/25 confirmed #2. Continued inte the staff should ha prescribed diet to pudding, or apples B. The facility faile prescribed diet for example: Observations in the 5:23 PM revealed chicken tenders, of cream, water, and at 5:40 PM revealed dinner meal. At no	of the P.O. revealed client #2's yogurt, pudding, or unch and dinner. program manager (PM) on the P.O. to be current for client erview with the PM confirmed to provided client #2 with include the 4oz. of yogurt, sauce. In the provided client #2 with include the 4oz. of yogurt, sauce. In the provided specially client #5 during mealtimes. For the group home on 2/10/25 at the dinner meal consisted of the provided client #5 to consume her to time during the dinner meal control to the provide client #5 with ½ cup	W 460		
W 473	revealed a physici Continued review diet to include ½ capplesauce with lu Interview with the 2/11/25 confirmed #5. Continued int the staff should ha	program manager (PM) on the P.O. to be current for client erview with the PM confirmed ave provided client #5 with include the ½ cup pudding, nuce.	W 473		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G053				ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		34G053	B. WING		02	2/11/2025	
MYRON P	ROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 119 MYRON PLACE SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 473	Food must be served. This STANDARD Based on observations appropriate temper (#3, #4, #5, #6) resides: Morning observations at 6:45 AM revealed if sausage patties and aluminum foil in the observations at 7:3 the clients' plates we sausage patties. For food to remain on the sausage patties and the clients' plates we sausage patties. For food to remain on the sausage patties and the clients' plates we sausage patties.	red at appropriate temperature. is not met as evidenced by: atton and interview, the facility of was served at an reture for 6 of 6 clients (#1, #2, iding in the facility. The finding ones in the facility on 2/11/25 at two glass containers with dipieces of toast covered by a kitchen. Continued 60AM revealed staff to prepare without reheating the toast and curther observation revealed the he kitchen countertop for ninutes prior to the breakfast	W 473	W 473 The Qualified Professional will in-service all staff on following mealtimes and ensuring food is warm. The clinical team will mothrough mealtime assessments week for a period of 30 days aron a routine basis. In the future Qualified Professional will ensustaff are trained on following mealtimes and ensuring food is	onitor 5 1x a nd then e, the ire all	4/12/25	
W 474	professional (QIDP should have kept the tobe served and reinterview with the Otrained to prepare appropriate temper clients. MEAL SERVICES CFR(s): 483.480(b) Food must be served developmental level This STANDARD is Based on observatinterviews, the facil form consistent with	ed in a form consistent with the	W 474	W 474 A-C Cross reference W 473		4/12/25	

STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA	2000 1 11 11 11 11 11 11		OMB NO. 0938-039
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	ONSTRUCTION	(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	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
W 474	Observations in the 5:26 PM revealed to chicken tenders, or cream, water, and rat 5:40 PM revealed dinner meal in whole during the dinner measist the client to provide the 7:30 AM revealed to turkey sausage patt water, and milk. Co AM revealed client is meal in whole consibreakfast meal was client to provide the Review of client #11 person-centered pla Review of the PCP assessment dated to prescribed an 1800 encourage seconds portions of desserts. Interview with the pre 2/11/25 confirmed courrent. Further interviewd prescribed.	It to follow client #1's diet as ample: If group home on 2/10/25 at the dinner meal consisted of alion rings, green beans, ice milk. Continued observations diction client #1 to consume his the consistency. At no time eal was staff observed to provide a ¼" consistency. If group home on 2/11/25 at the breakfast meal consisted of clies, 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. If group home on 2/11/25 revealed a an (PCP) dated 7/23/24. If group home on 2/11/25 revealed a nutritional 1/30/24 for client #1 to be calorie, ½" diet consistency, of vegetables only, ½ If ogram manager (PM) on alient #1's prescribed diet is rview with the PM confirmed iets should be followed as	W 474	DEPICIENCY)	
	prescribed. For example prescribed.	to follow client #5's diet as mple:			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 34G053 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) COMPLETIO DATE	
W 474	Continued From page 30	W 474			
	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				

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PRINTED: 02/20/2025 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 34G053 B. WING 02/11/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE **MYRON PLACE** SALISBURY, NC 28144 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 474 Continued From page 31 W 474 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 1/2-1" 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, 1/2-1" 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.