		AND HUMAN SERVICES			0	-	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G269	B. WING_			06/2	24/2025
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				22 HICKORY AVE ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §482 §485.542(d)(2), §48 §485.542(d)(2), §48 *[For ASCs at §416 at §485.542, OPO, §485.727, CMHCs §491.12, and ESRE (2) Testing. The [fact to test the emergend must do all of the foc (i) Participate in a foc community-based eff (A) When a commaccessible, conduct exercise every 2 yea (B) If the [facilit	(2) 3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.68(d)(2), 35.625(d)(2), §485.727(d)(2), 91.12(d)(2), §494.62(d)(2). 5.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]: cility] must conduct exercises acy plan annually. The [facility] bllowing: ull-scale exercise that is every 2 years; or unity-based exercise is not t a facility-based functional	EO	39			
	activation of the em exempt from engage community-based of functional exercise actual event. (ii) Conduct an add years, opposite the	argency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of					
LABORATOR	this section is cond not limited to the fo (A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise	ucted, that may include, but is llowing: cale exercise that is or individual, facility-based or	NATURE		TITLE		(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/25/2025

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.

		AND HUMAN SERVICES				FORM	06/25/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G269	B. WING	;		06/:	24/2025
NAME OF F	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (iii) Analyze the [fac maintain document exercises, and emer [facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based ef (A) When a commu- accessible, conduct functional exercise (B) If the hospice ex- man-made emerge the emergency plar engaging in its next community-based functionset of the emergency (ii) Conduct an add opposite the year the exercise under para is conducted, that no to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaster (C) A tabletop exert	udes a group discussion using y-relevant emergency of problem statements, , or prepared questions ige an emergency plan. Sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not t an individual facility based every 2 years; or xperiences a natural or ncy that requires activation of n, the hospital is exempt from the following the exercise or individual onal exercise following the ency event. ditional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	E	039			

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		AND HUMAN SERVICES				FORM	06/25/2025 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G269	B. WING	i		06/;	24/2025
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				22 HICKORY AVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The h exercises to test the year. The hospice (i) Participate in an is community-based (A) When a commu- accessible, conduc- facility-based functi (B) If the hospice et man-made emerge the emergency plan engaging in its next based or facility-base following the onset (ii) Conduct an ado may include, but is (A) A second full-s- community-based or exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the ho- maintain document	y-relevant emergency of problem statements, or prepared questions age an emergency plan. bices that provide inpatient hospice must conduct e emergency plan twice per must do the following: annual full-scale exercise that d; or unity-based exercise is not an annual individual ional exercise; or xperiences a natural or ency that requires activation of n, the hospice is exempt from t required full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or rcise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. spice's response to and tation of all drills, tabletop ergency events and revise the	E	039			

Facility ID: 931971

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		AND HUMAN SERVICES				FORM	06/25/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATI	E SURVEY IPLETED
		34G269	B. WING	i		06/2	24/2025
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	*[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF conduct exercises to twice per year. The do the following: (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based functi (B) If the [PRTF, Ho actual natural or ma- requires activation of [facility] is exempt for required full-scale of facility-based function (ii) Conduct an and that may include following: (A) A second full-second functional exercise; (B) A mock (C) A tabletop of led by a facilitator at discussion, using a emergency scenario statements, directe questions designed plan. (iii) Analyze the maintain document	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared t o challenge an emergency e [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	E	039			

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		AND HUMAN SERVICES				FORM	: 06/25/2025 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION G	(X3) DAT	TE SURVEY MPLETED
L		34G269	B. WING	;		06/	/24/2025
NAME OF F	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	 (2) Testing. The PA(exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a community-based function (B) If the PACE expressible, conduct facility-based function (B) If the PACE expression (B) If the PACE expression (C) and the emergency planent engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the years opposite the year opposite the year community-based of functional exercise; (B) A second full-second full-second full-second full-second full-second functional exercise; (B) A mock disaster (C) A tabletop exert a facilitator and inclusing a narrated, cliscenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain documenta exercises, and emere PACE's emergency 	CE organization must conduct e emergency plan at least E organization must do the annual full-scale exercise that d; or unity-based exercise is not t an annual individual, ional exercise; or periences an actual natural or oncy that requires activation of n, the PACE is exempt from t required full-scale community facility-based functional he onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited to cale exercise that is or individual, a facility based ; or er drill; or rcise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, , or prepared questions age an emergency plan. ACE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed.	EC	039	9		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/25/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G269	B. WING	i		06/:	24/2025
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the [LTC facility actual natural or marequires activation of LTC facility is exem requires activation of LTC facility is exem required a full-scale individual, facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically-r and a set of probler messages, or prepa- challenge an emerg (iii) Analyze the [LT and maintain docum exercises, and emergen [LTC facility] facility/ *[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergen The ICF/IID must do	plan at least twice per year, iced staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or inity-based exercise is not t an annual individual, onal exercise. ty] facility experiences an an-made emergency that of the emergency plan, the pt from engaging its next e community-based or ased functional exercise of the emergency event. litional annual exercise that not limited to the following: cale exercise that is or an individual, facility based or er drill; or cise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. C facility] facility's response to nentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises icy plan at least twice per year.	E	039			

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		AND HUMAN SERVICES				FORM /	06/25/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE	E SURVEY PLETED
		34G269	B. WING			06/2	24/2025
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	is community-based (A) When a commu accessible, conduct facility-based function (B) If the ICF/IID ex- man-made emerged the emergency plane engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and incl using a narrated, cli scenario, and a set directed messages, designed to challen (iii) Analyze the ICF maintain documenta exercises, and emer ICF/IID's emergenc *[For HHAs at §484 (d)(2) Testing. The to test the emergen least annually. The (i) Participate in a fu community-based; of (A) When a cor accessible, conduct	d; or unity-based exercise is not t an annual individual, onal exercise; or. periences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from required full-scale or individual, facility-based following the onset of the itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based or r drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, , or prepared questions ige an emergency plan. [/IID's response to and ation of all drills, tabletop ergency events, and revise the ey plan, as needed. A.102] HHA must conduct exercises hyper at HHA must do the following: ull-scale exercise that is	E	039			

		AND HUMAN SERVICES				FORM	06/25/2025 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		34G269	B. WING	;		06/:	24/2025		
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
HICKOR	Y II GROUP HOME		322 HICKORY AVE SANFORD, NC 27330						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
E 039	 (B) If the HHA or man-made emery of the emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi opposite the year the exercise under parais conducted, that limited to the followin (A) A second functional exercise; (B) A mock disa (C) A tabletop eled by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HHL documentation of a emergency plan, as *[For OPOs at §486 (d)(2) Testing. The following: (i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenario following: 	experiences an actual natural gency that requires activation lan, the HHA is exempt from crequired full-scale or individual, facility based following the onset of the itional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section it may include, but is not ing: Ill-scale exercise that is or an individual, facility-based or aster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared t o challenge an emergency A's response to and maintain II drills, tabletop exercises, and and revise the HHA's s needed.		039					

Facility ID: 931971

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 06/25/2025 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G269	B. WING	i		06/	/24/2025
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME				322 HICKORY AVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
E 039	plan. If the OPO ex man-made emerge the emergency plan engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followir (i) Conduct a paper least annually. A tak discussion led by a clinically-relevant er of problem stateme prepared questions emergency plan. (ii) Analyze the RNH maintain document and emergency even emergency plan, as This STANDARD is Based on documer facility failed to ensu community/facility-b tabletop exercise to Preparedness (EP) finding is: Review on 6/24/25 2/3/25) did not inclu- community/facility-b tabletop exercise. H	to challenge an emergency periences an actual natural or ncy that requires activation of a, the OPO is exempt from required testing exercise of the emergency event. D's response to and maintain Il tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: -based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set nts, directed messages, or designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's a needed. s not met as evidenced by: nt review and interviews, the ure a full scale based exercise, mock drill or test their Emergency plan was conducted. The	E	039	3		

		AND HUMAN SERVICES			FORM	06/25/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G269	B. WING _		06/2	24/2025
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y II GROUP HOME			322 HICKORY AVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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
E 039	been conducted on event. Further revie document did not in specific emergency statements, directe questions designed plan. Interview on 6/24/29 Disabilities Profess additional information QIDP CFR(s): 483.430(a) Each client's active integrated, coordina qualified intellectua This STANDARD is Based on record re Qualified Intellectua (QIDP) failed to en behaviors were suff determine progress clients. The finding Review on 6/23 - 6/ Behavior Support P current BSP dated address target beha inappropriate verba and noncompliance progress notes revi 2024 - May 2025 di client's noncompliance Interview on 6/24/29	2/13/25 for a bad weather w of the single page oclude staff in attendence, any scenarios, problem d messages or prepared to challenge their emergency 5 with the Qualified Intellectual ional (QIDP) revealed no on was available for review. 6 treatment program must be ated and monitored by a I disability professional who- s not met as evidenced by: eview and interview, the al Disabilities Professional sure client #1's target ficiently monitored to a. This affected 1 of 3 audit is: 24/25 of client #1's previous Plan (BSP) dated 4/8/24 and 4/7/25 revealed objectives to aviors of self-injury, lizations, physical aggression a. Additional review of monthly ewed by the QIDP for April d not include a review of the nce behaviors. 5 with the QIDP indicated hains a target behavior for	E 03	39		
	Behavior Support P current BSP dated a address target beha inappropriate verba and noncompliance progress notes revi 2024 - May 2025 di client's noncomplian Interview on 6/24/22 noncompliance rem	Plan (BSP) dated 4/8/24 and 4/7/25 revealed objectives to aviors of self-injury, lizations, physical aggression e. Additional review of monthly ewed by the QIDP for April d not include a review of the nce behaviors. 5 with the QIDP indicated				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		TE SURVEY MPLETED
		34G269	B. WING		0.6	/24/2025
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		/24/2025
HICKOR	Y II GROUP HOME			22 HICKORY AVE ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETIO DATE
W 159	past 13 months alc	ong with other target behaviors.	W 159			
W 352		edged this was an oversight. E DENTAL DIAGNOSTIC (2)	W 352			
	include periodic ex performed at least This STANDARD is Based on record re failed to ensure clie comprehensive des periodic examination annually. This affect finding is:	is not met as evidenced by: eview and interview, the facility ent #2 received ntal services including a on and diagnosis at least cted 1 of 3 audit clients. The				
	a dental report date the report noted a ' recommendations' teeth extractions".	of client #2's record revealed ed 3/28/25. Additional review of 'dental check" and included for "cleaningfillingswisdom Further review of the record periodic examination and n completed.				
	revealed no curren	5 with the facility's nurse t information regarding a client #2 could be provided.				

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