PRINTED: 07/25/2025 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G278	B. WING			1	R / 17/2025
	PROVIDER OR SUPPLIER ERRY HOME		1	9	STREET ADDRESS, CITY, STATE, ZIP CODE 004 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540	,	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
{E 039}	previous deficiencie		{E 0:	39}			
	§460.84(d)(2), §482 §483.475(d)(2), §48 §485.542(d)(2), §48	8.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.625(d)(2), §485.727(d)(2), 91.12(d)(2), §494.62(d)(2).					
	at §485.542, OPO, §485.727, CMHCs	5.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]:					
		cility] must conduct exercises ncy plan annually. The [facility] ollowing:					
	community-based e (A) When a comm accessible, conduct exercise every 2 yet (B) If the [facility natural or man-maccestivation of the emexempt from engage community-based of functional exercise actual event. (ii) Conduct an add years, opposite the functional exercise	unity-based exercise is not t a facility-based functional					
L ABORATOR)		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G278	B. WING			R / 17/2025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540		71772023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
{E 039}	not limited to the for (A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclean anarrated, clinically scenario, and a set directed messages designed to challen (iii) Analyze the [facility's] emergence *[For Hospices at 4 (2) Testing for hospication of the emergency plane (A) When a community based of (A) When a community based of (A) When a community based of (B) If the hospice eximan-made emerge the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based functionset of the emergency planengaging in its next community-based of facility-based fun	allowing: alle exercise that is or individual, facility-based or drill; or cise or workshop that is led by udes a group discussion using y-relevant emergency of problem statements, or prepared questions ge an emergency plan. ility's] response to and ation of all drills, tabletop ergency events, and revise the ey 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 an individual facility based every 2 years; or experiences a natural or experiences a natural or ency that requires activation of extending the exercise or individual onal exercise following the	{E 0:	39}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G278	B. WING		1	R 07/17/2025	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESPONDED TO THE APPLICATION OF THE APPLICATION	ULD BE	(X5) COMPLETION DATE	
{E 039}	community-based of exercise; or (B) A mock disaster (C) A tabletop exer a facilitator and incl a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hospicare directly. The resercises to test the year. The hospice (i) Participate in an is community-based (A) When a community-based function (B) If the hospice examinates or facility-based function (B) If the hospice examinates or facility-based following the onset (ii) Conduct an additional may include, but is (A) A second full-scommunity-based of exercise; or (B) A mock disaster (C) A tabletop exertification for problem and a set of problem.	cale exercise that is or a facility based functional er drill; or roise or workshop that is led by udes a group discussion using y-relevant emergency of problem statements, or prepared questions ge an emergency plan. sices that provide inpatient hospice must conduct elemergency plan twice per must do the following: annual full-scale exercise that district an annual individual onal exercise; or experiences a natural or not that requires activation of a the hospice is exempt from a required full-scale community sed functional exercise of the emergency event. Sitional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or roise or workshop led by a des a group discussion using a relevant emergency scenario, on statements, directed ared questions designed to	{E 03	39}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG	CON	TE SURVEY MPLETED
		34G278	B. WING			R / 17/2025
	PROVIDER OR SUPPLIER ERRY HOME			STREET ADDRESS, CITY, STATE, ZIP COD 904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540	•	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{E 039}	(iii) Analyze the homaintain document exercises, and emethospice's emergent *[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [Product exercises to twice per year. The dothe following: (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the [PRTF, Homactual natural or marequires activation of [facility-based functionset of the emerging (ii) Conduct an and that may include following: (A) A second full-second full-secon	ation of all drills, tabletop argency events and revise the cy plan, as needed. 1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan at [PRTF, Hospital, CAH] must annual full-scale exercise that d; or unity-based exercise is not at 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	{E 03	,		
	functional exercise; (B) A mock (C) A tabletop eled by a facilitator a discussion, using a emergency scenari statements, directe	or individual, a facility-based or disaster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		34G278	B. WING _			R / 17/2025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540		11112020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)	OULD BE	(X5) COMPLETION DATE
{E 039}	(iii) Analyze the maintain document exercises, and emergence [facility's] emergence *[For PACE at §460 (2) Testing. The PACE following: (i) Participate in an is community-based (A) When a community-based functi (B) If the PACE expman-made emerge the emergency plar engaging in its next based or individual, exercise following the exercise under parais conducted that may be a sometiment of the following: (ii) Conduct an years opposite the exercise under parais conducted that may be a sometiment of the following: (A) A second full-second community-based of functional exercise; (B) A mock disaster (C) A tabletop exerting and exercise and inclination of the facilitator and inclination of the facilitator and inclinations.	[facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed. [8.84(d):] CE organization must conduct e emergency plan at least erganization must do the annual full-scale exercise that d; or unity-based exercise is not an annual individual, onal exercise; or eriences an actual natural or ney that requires activation of a the PACE is exempt from a required full-scale community facility-based functional the onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited to cale exercise that is or individual, a facility based or	{E 03	,		
	directed messages designed to challen	of problem statements, , or prepared questions ge an emergency plan. CE's response to and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER AVENT FERRY HOME			STREET ADDRESS, CITY, STATE, ZI 904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540		71172020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{E 039}	maintain document exercises, and emergancy are [For LTC Facilities (2) The [LTC facility test the emergency including unannour emergency proced ICF/IID] must do the (i) Participate in aris community-base (A) When a community-base (A) When a community-based facility-based function LTC facility is exemined a full-scale individual, facility-be following the onset (ii) Conduct an additional exercise (B) A mock disaste (C) A tabletop exercise (B) A mock disaste (B) A	ation of all drills, tabletop ergency events and revise the plan, as needed. at §483.73(d):] must conduct exercises to plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or unity-based exercise is not an annual individual, in all exercise. ity] facility experiences an an-made emergency plan, the put from engaging its next exercise of the emergency event. In a community-based or ased functional exercise of the emergency event. In a community-based or an individual, facility based is a group discussion, using a relevant emergency scenario, in statements, directed ared questions designed to		39}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540		
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{E 039}	Continued From pa	ge 6	{E 03	9}		
	to test the emerger The ICF/IID must d (i) Participate in an is community-based (A) When a community-based functional exercise emergency plar engaging in its next community-based of functional exercise emergency event. (ii) Conduct an add may include, but is (A) A second full-so community-based of functional exercise; (B) A mock disaste (C) A tabletop exercise a facilitator and inclusing a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the ICF maintain document exercises, and emerger includes at §484 (d)(2) Testing. The to test the emerger	F/IID must conduct exercises acy plan at least twice per year. To the following: annual full-scale exercise that did; or unity-based exercise is not an annual individual, onal exercise; or experiences an actual natural or noty that requires activation of an the ICF/IID is exempt from a required full-scale or individual, facility-based following the onset of the exercise that not limited to the following: all exercise that is or an individual, facility-based for a drill; or cise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan. F/IID's response to and ation of all drills, tabletop ergency events, and revise the exp plan, as needed. 1.102] HHA must conduct exercises				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION NG	, ,	COMPLETED	
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{E 039}	community-based; (A) When a cor accessible, conduct facility-based function. (B) If the HHA or man-made emer of the emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an addiopposite the year the exercise under parais conducted, that limited to the follow (A) A second functional exercise; (B) A mock disactional exercise; (B) A mock disactional exercise; (C) A tabletop eled by a facilitator and discussion, using a emergency scenaristatements, directed questions designed plan. (iii) Analyze the HH documentation of a emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The	all-scale exercise that is or mmunity-based exercise is not tan annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation lan, the HHA is exempt from required full-scale or individual, facility based following the onset of the ditional exercise every 2 years, are full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ing: all-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 II drills, tabletop exercises, and and revise the HHA's reeded.	{E 03	9}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	TE SURVEY MPLETED
		34G278	B. WING _			R / 17/2025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540		
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{E 039}	(i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenari statements, directe questions designed plan. If the OPO ex man-made emerge the emergency plar 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 followin (i) Conduct a paper least annually. A tal discussion led by a clinically-relevant erof problem stateme prepared questions emergency plan. (ii) Analyze the RNI maintain document and emergency ever emergency plan, as This STANDARD is Based on document facility failed to ens drill or an annual ta and included in the	and includes a group narrated, clinically relevant o, and a set of problem d messages, or prepared to challenge an emergency periences an actual natural or ncy that requires activation of a trequired testing exercise of the emergency event. O's response to and maintain ll tabletop exercises, and and revise the [RNHCl's and plan, as needed. 748]: RNHCl must conduct e emergency plan. The RNHCl ng: -based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or designed to challenge an HCl's response to and ation of all tabletop exercises, ents, and revise the RNHCl's	{E 03	9}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540		1172020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{E 039}	Review on 5/12/25 annual tabletop, full being completed will literview on 5/13/25 confirmed she was documentation detaplan. Interview on 5/13/25 disabilities profession unable to show documentation exercises to test the literature on 7/17/25 Correction (POC) discale drill was completed in the red not Manger for reference completion. The Director and/or Representative will such events is main bi-annually. Interview on 7/17/25 Intellectual Disabilities profession was added to the literature of lite	there was no evidence of a scale exercise or mock drill the in the past year. 5, the program manager unable to show ailing any exercises to test EP 5, the qualified intellectual conal confirmed the facility was umentation detailing any eir EP plan. by completed on 7/17/25 of the facility's Plan of ated 7/11/25 revealed a full	{E 03	39}		
{W 460}		that were completed. TION SERVICES	{W 46	50}		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		34G278	B. WING		07	//17/2025	
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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{W 460}	Each client must re well-balanced diet i specially-prescribed This STANDARD i	ceive a nourishing, ncluding modified and d diets. s not met as evidenced by:	{W 46	00}			
	interviews, the facil	tions. record review and ity failed to ensure 1 of 4 audit d his specially prescribed diet nding is:					
	client #3 was at the	home on 5/12//25 at 5:30pm, table to begin dinner. Client pasta (whole noodles), mixed ole dinner rolls.					
	#3 received oatmea	n on 5/13/25 at 7:00am client al regular consistency, whole as and chunks of cut up					
	evaluation dated 6/	5/12/25 of client #3 nutritional 18/24 revealed regular diet red meat or chocolate.					
		5 the program manager as regular and was unaware of ped.					
		5 the qualified intellectual onal confirmed the diet was					
	The follow up surve revealed:	ey completed on 7/17/25					
	Correction (POC) d	of the facility's Plan of lated 7/11/25 revealed the ce staff regarding Clients diets					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540	ZIP CODE	1172020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{W 460}	as identified in the revaluation. The Quarent Professional (QIDP interior kitchen cabi QIDP will monitor was Interview on 7/17/28 there was no document of the province of the	most current nutritional alified Intellectual Disabilities) will post diets sheets in the inets for quick reference. The reekly for compliance. 5 with the QIDP revealed that nentation that the dietitian e also confirmed there were	{W 46	30}			