PRINTED: 08/15/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		34G166	B. WING _			08/13/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 270	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTION CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)	
E 015	CFR(s): 483.475(b)(§403.748(b)(1), §418 (1), §460.84(b)(1), §488 [(b) Policies and proceduplan set forth in para assessment at paragand the communicat this section. The pobe reviewed and upofor LTC facilities]. Air procedures must add (1) The provision of and patients whethe place, include, but an (i) Food, water, med supplies (ii) Alternate sources following: (A) Temperatures to safety and for the saprovisions. (B) Emergency lightitic) For Inpatient Hospit Policies and procedures	3.113(b)(6)(iii), §441.184(b) 482.15(b)(1), §483.73(b)(1), 5.542(b)(1), §485.625(b)(1) cedures. [Facilities] must ent emergency preparedness ires, based on the emergency graph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of licies and procedures must dated every 2 years [annually t a minimum, the policies and dress the following: subsistence needs for staff or they evacuate or shelter in re not limited to the following: ical and pharmaceutical sof energy to maintain the protect patient health and fe and sanitary storage of ing. ktinguishing, and alarm ste disposal.		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.

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G166	B. WING		08/13/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	, 33.10.2020
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
E 015	hospice employees evacuate or shelter limited to the follow (A) Food, water, mosupplies. (B) Alternate source following: (1) Temperatures to safety and for the sprovisions. (2) Emergency light (3) Fire detection, esystems. (C) Sewage and water, as Tanabased on observarinterviews, the faciliprovision of subsist staff, regardless of shelter in place, included and water, as requipreparedness Plant II facility. The finding Observations on 8/ group home's design the EPP subsistent following; 1 small coffruit and vegetable observations reveations reveations reveations for the soft 101.4 FL pantry shelf. Interview with the help the scheduled to shop the suppliers of the sheduled to shop the suppliers of the suppliers of the sheduled to shop the suppliers of the s	and patients, whether they in place, include, but are not ing: edical, and pharmaceutical es of energy to maintain the protect patient health and afe and sanitary storage of exting. extinguishing, and alarm este disposal. It is not met as evidenced by: etions, record review and ity failed to ensure the ence needs for clients and whether they evacuate or luding but not limited to, food red by Emergency (EPP) regulations for Yadkin	E 01	5	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G166	B. WING _			08/	13/2025
NAME OF PE	ROVIDER OR SUPPLIER		•	3220	ET ADDRESS, CITY, STATE, ZIP CODE & 3224 US HWY 21 IPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 015	Interview with the quadevelopmental profess confirmed that the emin the home were insusubsistence needs of of an emergency. EP Testing Requiremed CFR(s): 483.475(d)(2) §416.54(d)(2), §418.13 §460.84(d)(2), §482.13 §483.475(d)(2), §484.3 §485.542(d)(2), §485 §485.920(d)(2), §491 *[For ASCs at §416.5at §485.727, CMHCs at §491.12, and ESRD For the street of th	alified intellectual sional (QIDP) on 8/13/25 pergency provisions present ufficient to meet the clients and staff in the event ents 13(d)(2), §441.184(d)(2), 5(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .625(d)(2), §485.727(d)(2), .12(d)(2), §494.62(d)(2). 4, CORFs at §485.68, REHs organizations" under §485.920, RHCs/FQHCs at Facilities at §494.62]: ty] must conduct exercises or plan annually. The [facility] owing: -scale exercise that is ery 2 years; or ity-based exercise is not facility-based functional s; or experiences an actual emergency that requires gency plan, the [facility] is		015			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G166	B. WING		08/13/2025		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	JLD BE COMPLETION		
E 039	years, opposite the years, opposite the years functional exercise of this section is conducted in the section is conducted in the section is conducted in the section is community-based or functional exercise; (B) A mock disaster (C) A tabletop exercing a facilitator and inclusional exercises, and a set of directed messages, designed to challeng (iii) Analyze the [facility and the section of t	ional exercise at least every 2 year the full-scale or inder paragraph (d)(2)(i) of cted, that may include, but is owing: ale exercise that is individual, facility-based or drill; or ise or workshop that is led by ides a group discussion using relevant emergency of problem statements, or prepared questions ge an emergency plan. lity's] response to and tion of all drills, tabletop gency events, and revise the y plan, as needed. 8.113(d):] ices that provide care in the hospice must conduct emergency plan at least ce must do the following: ull-scale exercise that is yery 2 years; or nity based exercise is not an individual facility based every 2 years; or periences a natural or cy that requires activation of the hospital is exempt from required full scale kercise or individual anal exercise following the	E 03	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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NAME OF PE	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	(ii) Conduct an additiopposite the year the exercise under paragis conducted, that mato the following: (A) A second full-scacommunity-based or exercise; or (B) A mock disaster of (C) A tabletop exercial facilitator and include a narrated, clinically-scenario, and a set or directed messages, of designed to challenge (3) Testing for hospic care directly. The homeover exercises to test the expear. The hospice mover is community-based; (A) When a community-based; (A) When a community-based function (B) If the hospice expear man-made emergency plan, engaging in its next rebased or facility-based following the onset of (ii) Conduct an additional may include, but is not (A) A second full-scale	full-scale or functional raph (d)(2)(i) of this section by include, but is not limited a facility based functional drill; or see or workshop that is led by des a group discussion using relevant emergency of problem statements, or prepared questions an emergency plan. The set that provide inpatient spice must conduct emergency plan twice per ust do the following: Innual full-scale exercise that or ty-based exercise is not an annual individual hal exercise; or reriences a natural or sy that requires activation of the hospice is exempt from equired full-scale community and functional exercise that or the emergency event. In annual annual exercise that ot limited to the following:	E	039		
	(B) A mock disaster (C) A tabletop exerci	drill; or se or workshop led by a				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
E 039	facilitator that include narrated, clinically-re and a set of problem messages, or preparchallenge an emerge (iii) Analyze the hosp maintain documentate exercises, and emerge hospice's emergency *[For PRFTs at §441.§482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The lot the following: (i) Participate in an ais community-based; (A) When a communaccessible, conduct a facility-based function (B) If the [PRTF, Hospactual natural or man requires activation of [facility] is exempt from the emergency (ii) Conduct an longer of the emergency (iii) Conduct an longer of the emergency (iiii) Conduct an longer of the emergency (iiiiii) Conduct an longer of the emergency (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	levant emergency scenario, statements, directed ed questions designed to ncy plan. Dice's response to and ion of all drills, tabletop gency events and revise the plan, as needed. 184(d), Hospitals at §485.625(d):] TF, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must annual full-scale exercise that or ity-based exercise is not an annual individual, anal exercise; or pital, CAH] experiences an emade emergency plan, the m engaging in its next mmunity based or individual, anal exercise following the exercise that is individual, a facility-based or disaster drill; or tercise or workshop that is	E	039					

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E 039	emergency scenarios statements, directed questions designed plan. (iii) Analyze the maintain documenta exercises, and emergencises, and emergencises, and emergencises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the PACE expressible, conduct facility-based function (B) If the PACE expressible, conduct facility-based or individual, exercise following the emergency planengaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the yexercise under parais conducted that mathe following: (A) A second full-socommunity-based or functional exercise; (B) A mock disaster (C) A tabletop exercise.	narrated, clinically-relevant a, and a set of problem I messages, or prepared to challenge an emergency [facility's] response to and ation of all drills, tabletop gency events and revise the ty plan, as needed. [84(d):] E organization must conduct emergency plan at least to organization must do the annual full-scale exercise that t; or nity-based exercise is not an annual individual, anal exercise; or eriences an actual natural or to that requires activation of the PACE is exempt from required full-scale community facility-based functional the onset of the emergency additional exercise every 2 tear the full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited to tale exercise that is r individual, a facility based or	E 03	9			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		34G166	B. WING		08/13/2025
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	, 00.10.2020
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E 039	scenario, and a set of directed messages, of designed to challeng (iii) Analyze the PAC maintain documentate exercises, and emergency pacetises, and emergency procedurates the emergency procedurates the emergency procedurates the emergency procedurates. (A) The [LTC facility] test the emergency procedurates (I) Participate in an assist community-based; (A) When a communaccessible, conduct a facility-based function (B) If the [LTC facility actual natural or man requires activation of LTC facility is exemping required a full-scale of individual, facility-based following the onset of (ii) Conduct an additional may include, but is not (A) A second full-scale of functional exercise; of (B) A mock disaster (C) A tabletop exercise a facilitator includes a narrated, clinically-reand a set of problem	ically-relevant emergency f problem statements, or prepared questions e an emergency plan. E's response to and ion of all drills, tabletop gency events and revise the plan, as needed. It §483.73(d):] must conduct exercises to plan at least twice per year, ed staff drills using the es. The [LTC facility, following: annual full-scale exercise that or ity-based exercise is not an annual individual, hal exercise. I facility experiences an in-made emergency that the emergency plan, the trom engaging its next community-based or sed functional exercise f the emergency event. ional annual exercise that ot limited to the following: ale exercise that is an individual, facility based or drill; or ise or workshop that is led by a group discussion, using a levant emergency scenario,	E 03	39	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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E 039	and maintain docume exercises, and eme [LTC facility] facility' *[For ICF/IIDs at §44 (2) Testing. The ICF to test the emergency of the ICF/IID must do (i) Participate in an ais community-based (A) When a community-based function (B) If the ICF/IID exyman-made emerger the emergency planengaging in its next community-based of functional exercise of the emergency event. (ii) Conduct an adding include, but is in (A) A second full-secommunity-based of functional exercise; (B) A mock disaster (C) A tabletop exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, clist scenario, and a set directed messages, designed to challeng (iii) Analyze the ICF maintain documents.	cency plan. C facility] facility's response to mentation of all drills, tabletop regency events, and revise the semergency plan, as needed. 33.475(d)]: (IIID must conduct exercises by plan at least twice per year. of the following: annual full-scale exercise that lit; or mity-based exercise is not an annual individual, onal exercise; or. Decriences an actual natural or not that requires activation of the ICF/IID is exempt from required full-scale individual, facility-based following the onset of the stional annual exercise that not limited to the following: ale exercise that is in an individual, facility-based or drill; or size or workshop that is led by undes a group discussion, mically-relevant emergency of problem statements, or prepared questions ge an emergency plan. (IIID's response to and attion of all drills, tabletop regency events, and revise the	E 03	9		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	*[For HHAs at §484.1 (d)(2) Testing. The HH to test the emergency least annually. The H (i) Participate in a full- community-based; or (A) When a commaccessible, conduct a facility-based function or. (B) If the HHA ex or man-made emerge of the emergency plan engaging in its next re community-based or if functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under parage is conducted, that limited to the following (A) A second full- community-based or a functional exercise; or (B) A mock disass (C) A tabletop ex led by a facilitator and discussion, using a ra emergency scenario, statements, directed in questions designed to plan. (iii) Analyze the HHA'	29 02] HA must conduct exercises plan at HA must do the following: escale exercise that is munity-based exercise is not annual individual, all exercise every 2 years; experiences an actual natural ency that requires activation and, the HHA is exempt from equired full-scale individual, facility based llowing the onset of the enal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section at may include, but is not greated exercise that is an individual, facility-based for the ercise or workshop that is a includes a group earrated, clinically-relevant and a set of problem messages, or prepared to challenge an emergency is response to and maintain		039	DEFICIENCY)		
	emergency events, as emergency plan, as n						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G166	B. WING			08/	13/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	3220	EET ADDRESS, CITY, STATE, ZIP CODE 0 & 3224 US HWY 21 MPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE .	(X5) COMPLETION DATE
E 039	*[For OPOs at §486 (d)(2) Testing. The Oto test the emergence following: (i) Conduct a paperworkshop at least at led by a facilitator at discussion, using a emergency scenario statements, directed questions designed plan. If the OPO expendence emergency plan engaging in its next following the onset of (ii) Analyze the OPO documentation of all emergency events, a OPO's] emergency expendence of the PO's of the PO	ge 10 2360] DPO must conduct exercises by plan. The OPO must do the based, tabletop exercise or annually. A tabletop exercise is and includes a group marrated, clinically relevant or and a set of problem I messages, or prepared to challenge an emergency periences an actual natural or acy that requires activation of the OPO is exempt from required testing exercise of the emergency event. D's response to and maintain tabletop exercises, and and revise the [RNHCI's and olan, as needed.		039	DEFICIENCY)		
	least annually. A tab discussion led by a clinically-relevant er of problem statemer prepared questions emergency plan. (ii) Analyze the RNH maintain documenta and emergency eve emergency plan, as This STANDARD is	based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, nergency scenario, and a set of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G166	B. WING			08/	13/2025
NAME OF PI	ROVIDER OR SUPPLIER		1	3	STREET ADDRESS, CITY, STATE, ZIP CODE 220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	emergency prepared which effects 6 of 6 c #2, #3, #4, #5 and #6 Review of facility doc facility on 8/13/25 rev Continued review of treveal evidence of a facility's EPP. Interview with the quaprofessional (QIDP) cevidence of a full-sca exercises, tabletop or not available during thinterview with the QID tabletop, mock drill, a Yadkin II were not con PROTECTION OF CICFR(s): 483.420(a)(7) The facility must ensurable to the facility with the opportunity for This STANDARD is repaired to ensure client privacy for 1 sampled care in Yadkin III facilim Morning observations revealed client #10 to with the door remaining the results of the sample	act exercises to test the mess plan (EPP) annually lients in Yadkin II facility (#1,). The finding is: umentation in Yadkin II ealed an EPP dated 3/4/24. The facility's EPP did not full-scale facility based, op exercise to test the salified intellectual disabilities on 8/13/25 revealed that the community facility based of mock drill exercises were the survey. Continued the properties of the survey. Continued the properties of all clients. The finding is: under the rights of all clients. The presonal privacy. The finding is: under the facility is have a right to personal client (#10) during personal client (#10) during personal ity. The finding is: under the pathroom toileting and open. Observations did ist the client with privacy in		129			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G166	B. WING _		08	/13/2025	
NAME OF PROVIDER OR SUPPLIER YADKIN II & III			•	STREET ADDRESS, CITY, STATE, ZIP COI 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020			
(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 CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 129	professional (QIDP) of should have ensured toileting. Further inter staff are aware that problem for client #10 personal care. Continuerified staff have been	alified intellectual disabilities on 8/13/25 revealed staff client #10's privacy during view with the QIDP revealed rivacy is an ongoing of during toileting and used interview with the QIDP en trained to respect the	W	129			
W 260	verified staff have been trained to respect the privacy of all clients during toileting and personal care.		W	260			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
W 260	developmental profesupdated PCP have new 14. 3. Review on 8/12/25 revealed a PCP date. Interview on 8/13/25 developmental profesupdated PCP have new 14, #4, and #6. B. The facility failed the updated annually for 15 meeting or updated for the record for client 16 meeting or updated for line with the QII 17 meeting or updated for line from 17 meeting or updated for line from 18 meeting or updated for line from 18 meeting or updated and signed for line from 18 meeting or updated for line from 18 meeting has not been 18 meeting h	with the qualified intellectual ssional (QIDP) confirmed an ot been completed for client of of client #6's record of 11/2/23. with the qualified intellectual ssional (QIDP) confirmed an ot been completed for clients of ensure the PCPs were clients (#7, #8, #9, #10, and lity. For example: ord on 8/13/25 for client #7 of 4/5/24. Further review of the formula for t	W 26				

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(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
W 260	Continued From page	14	W 26	ס	
	revealed a PCP dated the record for client #	rd on 8/13/25 for client #9 d 11/1/23. Further review of 9 did not reveal evidence of dated program goals since			
	11/2023 PCP for clier	OP on 8/13/25 revealed the it #9 should have been by the legal guardian and the expiration date.			
	revealed a PCP dated the record for client #	rd on 8/13/25 for client #10 d 3/14/24. Further review of 10 did not reveal evidence oals or PCP meeting since			
	3/2024 PCP for client	OP on 8/13/25 revealed the #10 should have been by the legal guardian and on the expiration date.			
	revealed a PCP dated the record for client #	rd on 8/13/25 for client #11 I 11/1/23. Further review of 11 did not reveal evidence updated program goals			
W 262	11/2023 PCP for clier	RING & CHANGE	W 26:	2	
		d review, approve, and grams designed to manage			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G166		` ′	PLE CONSTRUCTION G	, , ,	(X3) DATE SURVEY COMPLETED		
			B. WING		0	8/13/2025		
NAME OF PROVIDER OR SUPPLIER YADKIN II & III				STREET ADDRESS, CITY, STATE, ZIP CO 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	DDE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
W 262	Continued From page 15 inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that updated, written informed consent from the human rights committee (HRC) were secured for behavior support plans (BSP), locks on the refrigerator, pantry door and knives for 6 of 6 clients (#1, #2, #3, #4, #5, and #6) at Yadkin II facility. The findings are: Observations in the group home during the survey period from 8/12/25 - 8/13/25 revealed locks on the refrigerator door, keypad on the entry door and locked knives. Continued observations revealed staff to unlock the refrigerator and pantry door when items were needed to prepare meals. Further observations revealed clients to wait on staff to open the refrigerator door, unlock the pantry door or obtain knives when needed. A. Review on 8/13/25 of client #1's record did not reveal consents were signed by HRC relative to the locks on the refrigerator door, pantry door and knives. B. Review on 8/13/25 of client #2's record revealed a BSP and Medication consents signed by the guardian on 7/15/25. Continued review of the record did not reveal consents were signed by HRC. Further review revealed consents for the locks on the refrigerator door, pantry and knives were signed by the guardian on 8/8/25. Additional review did not reveal consents were signed by HRC. Further review revealed consents were signed by HRC.		W 21	62				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
34G166			B. WING _		08/13/2025		
NAME OF PROVIDER OR SUPPLIER YADKIN II & III				STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	·		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
W 262	C. Review on 8/13/25 reveal consents were locks on the refrigerat knives. D. Review on 8/13/25 revealed a BSP and Mby the guardian on 10 the record did not rev HRC. Further review locks on the refrigerat were not signed by HE. Review on 8/13/25 revealed a BSP and Mby the guardian on 7/2 the record did not rev HRC. Further review locks on the refrigerat were signed by the guardian on 7/2 the record did not rev HRC. Further review locks on the refrigerat were signed by the guardian are signed by HRC. E. Review on 8/13/25 revealed consents were 7/25/24 relative to the door, pantry door and did not reveal updated. Interview on 8/13/25 revealed consents were signed by the guardian review of the door, pantry door and did not reveal updated. Interview on 8/13/25 revealed consents were signed by the guardian to the door, pantry door and did not reveal updated. Interview on 8/13/25 revealed consents were signed by the guardian to the door, pantry door and did not reveal updated. Interview on 8/13/25 revealed consents were revealed consents were signed by HRC.	of client #3's record did not signed by HRC relative to for door, pantry door and of client #4's record Medication consents signed Medication consents signed Medication consents for the for door, pantry and knives RC. of client #5's record Medication consents signed Medication consents signed Medication consents signed Medication consents for the feal consents were signed by revealed consents for the for door, pantry and knives for client #6's record for locks on the refrigerator knives. Continued review	W 2	62			
W 263	by the HRC annually. PROGRAM MONITO	RING & CHANGE	W 2	63			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCT	(X3) DATE SURVEY COMPLETED			
		34G166	B. WING _				8/13/2025
NAME OF PE	ROVIDER OR SUPPLIER			3220 & 3224 U	ESS, CITY, STATE, ZIP CODE IS HWY 21 ILLE, NC 27020	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECT EACH CORRECTIVE ACTION SHOU DSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
W 263	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 2	263			
		25 of client #4's record did not re not signed by legal					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G166	B. WING			08/	13/2025
NAME OF PROVIDER OR SUPPLIER YADKIN II & III				32	TREET ADDRESS, CITY, STATE, ZIP CODE 220 & 3224 US HWY 21 AMPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 263	D. Review on 8/13/25 revealed consents for door, pantry and knive the guardian on 3/26/revealed updated correview. Interview on 8/13/25 developmental profescurrent consent limita #4, and #6 could not survey. Continued intrevealed limitation cowill be updated and sannually. DRUG ADMINISTRACFR(s): 483.460(k)(1) The system for drug at that all drugs are admitted the physician's orders. This STANDARD is reason based on observation interview, the facility for were administered in orders. This affected observed during med Yadkin II facility. The Observations on 8/13 client #2 to enter the take his morning med observations revealed.	the locks on the refrigerator lands. The locks on the refrigerator es were verbal consented by 24. Continued review isents were not available to with the qualified intellectual isional (QIDP) revealed that tion forms for clients #1, #3, be located during the erview with the QIDP insent forms for all clients igned by the legal guardian. TION TI		263			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G166	B. WING			08/13/2025	
NAME OF PROVIDER OR SUPPLIER YADKIN II & III			•	3	TREET ADDRESS, CITY, STATE, ZIP CODE 220 & 3224 US HWY 21 IAMPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 368	10mg, Tamsulosin 0.4 Myrbetriq 25mg and Further observations his medications follow Review on 8/13/25 of orders dated 7/15/25 be taken with food or irritation and/or GI ble Interview on 8/13/25 client #2's Metformin been administered wi meal as prescribed. INFECTION CONTROCFR(s): 483.470(I)(1) The facility must prov to avoid sources and This STANDARD is represented to ensure the process-contamination of audited client (#10) infinding is: Observations in the growal to the content of the content o	etoprolol 50mg, Loratadine Amg, Omeprazole 20mg, POT CL MICRO 20mg. revealed client #2 to take wed by a cup of water. I client #2's physician's revealed Metformin should after a meal to minimize Gl eeding. with the facility nurse verified medication should have th food or after his breakfast OL ide a sanitary environment transmission of infections. not met as evidenced by: ns and interviews, the facility otential for was prevented relative to 1 n Yadkin III facility. The roup home on 8/13/25 at nt #10 to sit in the bathroom de door open. Further AM revealed client #10 to leave out of the bathroom whing her hands. Continued de client #10 to lay in her bed.		368 454			
	oubsequent observat	ions at 7:50 AM revealed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G166	B. WING _)8/13/202 5
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020		
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 454	staff to call client #10 medication administration without hands. Interview with the quaprofessional (QIDP) of should have monitore to ensure that she will hands. Further intervistaff have been trained.	to the medication room for ation. Further observations participate in medication to washing or sanitizing her alified intellectual disabilities on 8/13/25 revealed staffed client #10 in the bathroom ped herself and washed her new with the QIDP verified and to make sure clients washed ting and prior to medication	W 4	2.54		