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

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G166	B. WING		08	/13/2025	
YADKIN II	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE 10/13/2025	
E 015	CFR(s): 483.475(b)(1) §403.748(b)(1), §418 (1), §460.84(b)(1), §48 §483.475(b)(1), §485 [(b) Policies and procedure policies and procedure policies and procedure plan set forth in paragassessment at paragand the communication this section. The policies reviewed and upd for LTC facilities]. At procedures must add (1) The provision of sand patients whether place, include, but and (i) Food, water, medical supplies (ii) Alternate sources following: (A) Temperatures to parage (A) Temperatures to parage (B) Emergency lighting (C) Fire detection, exaystems. (D) Sewage and was *[For Inpatient Hospic Policies and procedures and procedu	1.113(b)(6)(iii), §441.184(b) 1.82.15(b)(1), §483.73(b)(1), 1.542(b)(1), §485.625(b)(1) 1.542(b)(1), §485.625(b)(1	E 01	The Safety Chairperson will in the Direct Support Supervisor Emergency Food Supplies. The team will monitor through envisors assessments bi-weekly for a days and then on a routine befuture, the Direct Support Supensure adequate emergency are always in the home.	r on he clinical vironmental period of 30 asis. In the pervisor will	10/13/25	
ABDRATORY	FCTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

IDD Regional Administrator 8/25/25

Facility ID: 922912

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 CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G166	B. WING			08/13/2025
YADKIN I	ROVIDER OR SUPPLIER		3220	ET ADDRESS, CITY, STATE, ZIP CODE & 3224 US HWY 21 IPTONVILLE, NC 27020	(4)	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE 10/13/2025
E 015	hospice employee evacuate or shelte limited to the follow (A) Food, water, in supplies. (B) Alternate sour following: (1) Temperatures: safety and for the provisions. (2) Emergency ligit (3) Fire detection, systems. (C) Sewage and with this STANDARD Based on observations of subsistaff, regardless of shelter in place, in and water, as required reparedness Plail I facility. The findion observations on 8 group home's desithe EPP subsistent following; 1 small of fruit and vegeta observations reveal of fruit and vegeta observations reveal in labeled for emanother bin. Further bottles of 101.4 Fl pantry shelf.	is and patients, whether they er in place, include, but are not wing: nedical, and pharmaceutical ces of energy to maintain the to protect patient health and safe and sanitary storage of hting. extinguishing, and alarm vaste disposal. is not met as evidenced by: ations, record review and ility failed to ensure the stence needs for clients and f whether they evacuate or cluding but not limited to, food aired by Emergency in (EPP) regulations for Yadkin	E 015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	CONSTRUCTION (X3) DATE SURVEY COMPLETED
		34G166	B. WING		08/13/2025
NAME OF PE	ROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 220 & 3224 US HWY 21 IAMPTONVILLE, NC 27020	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE 10/13/2025
E 015	o o i i i i i i i i i i i i i i i i i i	e 2 sure when the shopping will	E 015		
E 039	confirmed that the ein the home were ins	ssional (QIDP) on 8/13/25 mergency provisions present sufficient to meet the of clients and staff in the event	E 039	The QIDP and Safety Chairperson wi	II
E 039	CFR(s): 483.475(d)(c) §416.54(d)(2), §418. §460.84(d)(2), §482. §483.475(d)(2), §482. §485.542(d)(2), §482. §485.920(d)(2), §492. *[For ASCs at §416. at §485.542, OPO, "§485.727, CMHCs at §491.12, and ESRD (2) Testing. The [fact to test the emergence must do all of the following to the community-based events are community-based events are community-based events are every 2 years. (B) If the [facility natural or man-made activation of the emergence munity-based or community-based or c	2) 113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), 4.102(d)(2), §485.68(d)(2), 5.625(d)(2), §485.727(d)(2), 1.12(d)(2), §494.62(d)(2). 54, CORFs at §485.68, REHs Organizations" under tt §485.920, RHCs/FQHCs at Facilities at §494.62]: Ility] must conduct exercises by plan annually. The [facility] Ilowing: Il-scale exercise that is every 2 years; or nity-based exercise is not a facility-based functional	E 039	update the Emergency Preparedness The QIDP will train all staff on the pla Regional Administrator will monitor th Emergency Preparedness Plan every months to ensure it remains updated staff are trained. The Program Manag and Safety Chairperson will organize complete a tabletop exercise. The Sa Chairperson will monitor to ensure tal exercises are completed at least on a annual basis. The QIDP will ensure th Emergency Preparedness Plan is upo and staff are trained on the current pl and training conducted annually.	Plan. n. The e of 6 and ger 10/13/25 and fety bletop in ne dated

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G166	B. WING		08/13/2025	
YADKIN I	ROVIDER OR SUPPLIER		3220	EET ADDRESS, CITY, STATE, ZIP CODE 0 & 3224 US HWY 21 IPTONVILLE, NC 27020	1 33/13/2020	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
E 039	actual event. (ii) Conduct an addi years, opposite the functional exercise this section is condunct limited to the fol (A) A second full-sc community-based of functional exercise; (B) A mock disaster (C) A tabletop exercial facilitator and incluant an arrated, clinically scenario, and a set directed messages, designed to challeng (iii) Analyze the [fac maintain documental exercises, and emerifacility's] emergence *[For Hospices at 44 (2) Testing for hospication patient's home. The exercises to test the annually. The hospicing in a functional exercise (B) If the hospice eximan-made emergency plantengaging in its next community-based eximanity-based eximanity-b	tional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is lowing: ale exercise that is r individual, facility-based or drill; or ise or workshop that is led by udes a group discussion using -relevant emergency of problem statements, or prepared questions ge an emergency plan. dition of all drills, tabletop rgency events, and revise the ry plan, as needed. 8.113(d):] ices that provide care in the re hospice must conduct emergency plan at least ce must do the following: ull-scale exercise that is very 2 years; or periences a natural or cy that requires activation of the hospital is exempt from required full scale vercise or individual nal exercise following the	E 039			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	WORKE COMMON CO.		OMB I	NO. 0938-0391
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED
		34G166	B. WING			9/42/2025
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE I U	8/13/2025
YADKIN I	1 9 111			3220 & 3224 US HWY 21	DE	
IADIGIA	I & III			HAMPTONVILLE, NC 27020		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	N SHOULD BE	(X5) COMPLETION DATE
				DEFICIENCY		10/13/2025
E 039	Continued France	4				
L 003	o o minada i rom pag		E 039	9		
	(ii) Conduct an addit	tional exercise every 2 years,				
	opposite the year the	full-scale or functional				
	exercise under parag	graph (d)(2)(i) of this section				
	is conducted, that ma	ay include, but is not limited				
	to the following:					
	(A) A second full-sca	ale exercise that is				
	community-based or	a facility based functional				
	exercise; or	,				
	(B) A mock disaster	drill: or				
	(C) A tabletop exerci	ise or workshop that is led by				
	a facilitator and include	des a group discussion using				
	a narrated, clinically-	relevant emergency				
	scenario, and a set of	f problem statements,				
	directed messages of	or prepared questions				
	designed to challenge	e an emergency plan.				
	are grow to originary	s an emergency plan.				
	(3) Testing for hospic	es that provide inpatient				
	care directly. The hos	spice must conduct				
	exercises to test the	emergency plan twice per				
	year. The hospice mi	ust do the following:				
	(i) Participate in an a	nnual full-scale exercise that				
	is community-based;	or				
		ty-based exercise is not				
	accessible, conduct a	n annual individual				
	facility-based function	al exercise: or				
	(B) If the hospice expe	eriences a natural or				
	man-made emergence	y that requires activation of				
		he hospice is exempt from				
	engaging in its next re	equired full-scale community				
	based or facility-based	functional exercise				
	following the open of	the emergency event.				
	(ii) Conduct an addition	onal annual exercise that				
	may include but is the	t limited to the following:				
	(A) A second full-scal	t illilited to the following:				
	community based == =	e exercise that is				
	oversion of	facility based functional				
	exercise; or	-91.				
	(B) A mock disaster d					
	(C) A tabletop exercis	e or workshop led by a				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/ELIPPLIER/ELIP	T			OMB I	VO. 0938-0391
AND PLAN C	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		NSTRUCTION	The state of the s	TE SURVEY MPLETED
		34G166	B. WING				0//0/000
YADKIN I	PROVIDER OR SUPPLIER		•	3220	ET ADDRESS, CITY, STATE, ZIP CODE & 3224 US HWY 21 PTONVILLE, NC 27020	_10	8/13/2025
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RE	(X5) COMPLETION DATE 10/13/2025
	narrated, clinically-releand a set of problems messages, or prepare challenge an emergen (iii) Analyze the hospi maintain documentatic exercises, and emergen hospice's emergency provides the second of the following: *[For PRFTs at §441.1 §482.15(d), CAHs at §42.15(d), CAHs at §42.15(d), CAHs at §42.15(d), CAHs at §43.15(d), CAHs at §441.1 §43.15(d), CAHs at §43.15(d), CAHs at §43.15(d), CAHs at §441.1 §43.15(d), CAHs at §441.1 §43.15(d), CAHs at §441.1 §	s a group discussion using a evant emergency scenario, statements, directed d questions designed to acy plan. ce's response to and on of all drills, tabletop ency events and revise the plan, as needed. 84(d), Hospitals at 485.625(d):] The Hospital, CAH] must est the emergency plan est the emergency plan est the emergency plan est the emergency plan ency events and individual, and exercise or tal, CAH] experiences and emergency plan, the engaging in its next emunity based or individual, and exercise following the event. Iditional] annual exercise or ut is not limited to the exercise that is dividual, a facility-based aster drill; or cise or workshop that is	E	039			10/13/2025

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OME	NO. 0938-0391
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G166	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	08/13/2025
YADKIN	II & III			3220 & 3224 US HWY 21	ODE	
				HAMPTONVILLE, NC 27020		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CODDECTION	
PREFIX TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
				DEFICIENC	1)	10/13/2025
E 039	Continued From page	9 6	F. C	220		
		arrated, clinically-relevant	E	139		
	emergency scenario,	and a set of problem				
	statements, directed i	messages, or prepared				
	questions designed to	challenge an emergency				
	plan.					
	(iii) Analyze the [facility's] response to and				
	maintain documentati	on of all drills, tabletop				
	exercises, and emerg	ency events and revise the				
	[facility's] emergency	plan, as needed.				
	*[For PACE at §460.8	4(d)·1				
	(2) Testing. The PACE	organization must conduct				
	exercises to test the e	mergency plan at least				
	annually. The PACE of following:	organization must do the				
	(i) Participate in an ar	nnual full-scale exercise that				
	is community-based; of	or				
	(A) When a community	y-based exercise is not				
	accessible, conduct ar	n annual individual,				
	facility-based functions	al exercise; or				
	(B) If the PACE experie	ences an actual natural or				
	the emergency plan the	that requires activation of ne PACE is exempt from				
	engaging in its next re-	quired full-scale community				
	based or individual, fac	cility-based functional				
	exercise following the	onset of the emergency				
	event.	ganay				
	(ii) Conduct an add	ditional exercise every 2				
	years opposite the yea	r the full-scale or functional				
- 1	exercise under paragra	aph (d)(2)(i) of this section				
	is conducted that may	include, but is not limited to				
	the following:					
	(A) A second full-scale	exercise that is				
	community-based or in functional exercise; or	dividual, a facility based				
	(B) A mock disaster dr	ill: or				
		or workshop that is led by				
	a facilitator and include	s a group discussion,				
						1

STATEMENT AND PLAN C	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF		34G166	B. WING		09/43/2005
YADKIN I			322	REET ADDRESS, CITY, STATE, ZIP CODE 20 & 3224 US HWY 21 MPTONVILLE, NC 27020	08/13/2025
(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 APPI DEFICIENCY)	OUI D RE COMPLETION
	using a narrated, clini scenario, and a set of directed messages, o designed to challenge (iii) Analyze the PACI maintain documentative exercises, and emerge PACE's emergency plates the emergency plates the emergency plates the emergency procedure. ICF/IID] must do the form of the community-based; or (A) When a community accessible, conduct arracility-based functiona (B) If the [LTC facility] actual natural or man-requires activation of the LTC facility is exempt for the community-based or an addition may include, but is not (A) A second full-scale community-based or arracted, clinically-relevant a set of problem stand a set of problem stand a set of problem stand and set of problem stand a set of probl	cally-relevant emergency problem statements, reprepared questions an emergency plan. E's response to and on 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, destaff drills using the staff dr	E 039		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDED QUEEN TO A			OMB NO. 0938-0391
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		34G166	B. WING		00/40/000
YADKIN I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	
(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 COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
	challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerge [LTC facility] facility's *[For ICF/IIDs at §483; (2) Testing. The ICF/IID to test the emergency The ICF/IID must do to the interest of	critical plan. Critic	E 03		10/13/2025

STATEMENT OF DEFICIENCIES (X1) PR AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G166	B. WING		1	
NAME OF F	PROVIDER OR SUPPLIER	•	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	08/	/13/2025
YADKIN I	1 & 111		3220	# 3224 US HWY 21 #PTONVILLE, NC 27020		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE PPROPRIATE	COMPLETION DATE
E 039	to test the emergency least annually. The H	02] HA must conduct exercises	E 039			
	community-based; or (A) When a commaccessible, conduct a facility-based function or. (B) If the HHA export man-made emerge of the emergency plarengaging in its next recommunity-based or in	munity-based exercise is not in annual individual, ial exercise every 2 years; experiences an actual natural incy that requires activation in the HHA is exempt from				
	opposite the year the exercise under paragris conducted, that limited to the following (A) A second full-community-based or a functional exercise; or (B) A mock disast (C) A tabletop exeled by a facilitator and discussion, using a na emergency scenario, a statements, directed mergens designed to plan. (iii) Analyze the HHA's	aph (d)(2)(i) of this section may include, but is not is scale exercise that is in individual, facility-based er drill; or excise or workshop that is includes a group rrated, clinically-relevant and a set of problem nessages, or prepared challenge an emergency response to and maintain fills, tabletop exercises, and drevise the HHA's				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) MULTIPLE 0		OMB NO. 0938-039	1
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G166	B. WING		09/43/0005	
NAME OF F	PROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	08/13/2025	\dashv
YADKIN I	1 & 111		200000000	0 & 3224 US HWY 21 MPTONVILLE, NC 27020		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION DATE	
				DEFICIENCY)	10/13/202	5
E 039	Continued From pa	age 10	E 039			
	to test the emerger following: (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 planengaging in its next following the onset (ii) Analyze the OPO documentation of all	OPO must conduct exercises acy plan. The OPO must do the r-based, tabletop exercise or annually. A tabletop exercise is and includes a group narrated, clinically relevant or, and a set of problem d messages, or prepared to challenge an emergency periences an actual natural or noty that requires activation of a the OPO is exempt from required testing exercise of the emergency event. D's response to and maintain I tabletop exercises, and and revise the [RNHCI's and				
	exercises to test the must do the followin (i) Conduct a paper-least annually. A tak discussion led by a clinically-relevant er of problem statemer prepared questions emergency plan. (ii) Analyze the RNF maintain documenta and emergency everemergency plan, as This STANDARD is	RNHCI must conduct e emergency plan. The RNHCI g: based, tabletop exercise at eletop exercise is a group facilitator, using a narrated, nergency scenario, and a set eleto, directed messages, or designed to challenge an elective response to and tion of all tabletop exercises, eleto, and revise the RNHCI's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G166	B. WING		09/42/0005
YADKIN I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	08/13/2025
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION DATE 10/13/2025
	facility failed to condemergency prepare which effects 6 of 6 #2, #3, #4, #5 and #Review of facility on 8/13/25 recontinued review of reveal evidence of a mock drill, or a table facility's EPP. Interview with the querofessional (QIDP) evidence of a full-scaexercises, tabletop on tavailable during interview with the QI tabletop, mock drill, and available during interview with the QI tabletop, mock drill, and available during interview with the QI tabletop, mock drill, and available during interview with the QI tabletop, mock drill, and available during interview with the QI tabletop, mock drill, and the facility with the opportunity of the facility must ensure failed to ensure clien privacy for 1 samples care in Yadkin III facilim Morning observations revealed client #10 to with the door remaini	duct exercises to test the dness plan (EPP) annually clients in Yadkin II facility (#1, #6). The finding is: cumentation in Yadkin II exealed an EPP dated 3/4/24. If the facility's EPP did not in full-scale facility based, who exercise to test the stallified intellectual disabilities on 8/13/25 revealed that alle community facility based or mock drill exercises were the survey. Continued DP verified that the facility and/or full-scale exercises for completed as required. CLIENTS RIGHTS 7) The triples of all clients. If must provide each client for personal privacy, not met as evidenced by: ons and interview, the facility is have a right to personal content of the finding is: So on 8/13/25 at 7:05 AM on sit in the bathroom toileting ing open. Observations did sist the client with privacy in	W 129		The The Ing Ical India I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		IDENTIFICATION NUMBER:	1000			
34G166		34G166	B. WING		00/40/000	
YADKIN I				STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	1 00	8/13/2025
(X4) ID PREFIX TAG			ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DATE
W 129	professional (QIDP) or should have ensured of toileting. Further intervi- staff are aware that pri problem for client #10 personal care. Continu- verified staff have been	lified intellectual disabilities in 8/13/25 revealed staff client #10's privacy during view with the QIDP revealed ivacy is an ongoing during toileting and used interview with the QIDP in trained to respect the uring toileting and personal	W 129			
	CFR(s): 483.440(f)(2) At least annually, the ir must be revised, as ap process set forth in par This STANDARD is not Based on record revie facility failed to update (PCP) annually for 8 of and #6) in Yadkin II and and #11) in Yadkin III. The facility failed to clients in Yadkin II facility updated annually as recorded and PCP dated for the facility on 8/12/25 of the facility on 8/13/25 with developmental profession.	andividual program plan propriate, repeating the ragraph (c) of this section. In the tast evidenced by: we and interviews, the the person centered plan 12 sampled clients (#1, #4 doctions (#7, #8, #9, #10, The findings are: ensure the PCPs for ty (#1, #4, and #6) were quired. For example: of client #1's record 6/6/24. Ith the qualified intellectual onal (QIDP) confirmed an been completed for client	W 260	The QIDP will revise and update all at least annually and as needed bas reviews and interviews. This will be monitored by the administrator by generating and reviewing PCP dates. Therap. In the future, the QIDP will ensure all PCPs are revised and upon at least annually and as needed base QP reviews and interviews.	ed on	10/13/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/15/2025 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 34G166 B. WING 08/13/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE YADKIN II & III 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 10/13/2025 W 260 Continued From page 13 W 260 Interview on 8/13/25 with the qualified intellectual developmental professional (QIDP) confirmed an updated PCP have not been completed for client #4. 3. Review on 8/12/25 of client #6's record revealed a PCP dated 11/2/23. Interview on 8/13/25 with the qualified intellectual developmental professional (QIDP) confirmed an updated PCP have not been completed for clients #1, #4, and #6. B. The facility failed to ensure the PCPs were updated annually for clients (#7, #8, #9, #10, and #11) in Yadkin III facility. For example: 1. Review of the record on 8/13/25 for client #7 revealed a PCP dated 4/5/24. Further review of the record for client #7 did not reveal a PCP meeting or updated PCP since 4/5/24. Interview with the QIDP on 8/13/25 revealed the 4/2024 PCP for client #7 should have been updated and signed by the legal guardian and treatment team prior to the expiration date. 2. Review of the record for client #8 on 8/13/25 revealed a PCP dated 7/8/24. Further review of the record for client #8 did not reveal evidence of a PCP meeting or updated program goals since 7/8/24. Interview with the QIDP on 8/13/25 verified a PCP meeting has not been completed to review client #8's program goals. Further interview with the QIDP verified an updated PCP with appropriate

7/8/25.

signatures should have been completed prior to

STATEMENT OF DEFICIENCIES		(V4) PROMERENCE OF THE PROME			OMB NO. 0938-0391	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
NAMEOR		34G166	B. WING		08/13/2025	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/13/2025	
YADKIN	II & III			3220 & 3224 US HWY 21		
497500				HAMPTONVILLE, NC 27020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE 10/13/2025	
W 260	Continued From page	e 14	W 26	0		
	revealed a PCP dated the record for client #	ord on 8/13/25 for client #9 d 11/1/23. Further review of fig. did not reveal evidence of dated program goals since				
	11/2023 PCP for clien	OP on 8/13/25 revealed the at #9 should have been by the legal guardian and to 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	P on 8/13/25 revealed the #10 should have been y the legal guardian and o the expiration date.				
	revealed a PCP dated the record for client #1	d on 8/13/25 for client #11 11/1/23. Further review of 11 did not reveal evidence pdated program goals				
W 262	11/2023 PCP for client	RING & CHANGE	W 262	The Behavior Analyst will re-inservice support staff on client #5 BSP. The administrator will in-service QIDP on		
	The committee should monitor individual prog	review, approve, and rams designed to manage		reviewing and approving consents with guardian and HRC annually and/or PF all people supported including client ##2, #3, #4, #5, and #6. The QIDP will	RN of	

STATEMENT OF DEFICIENCIES		(V4) PROMPERIOUS				OMB NO. 0938-0391		
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		E SURVEY MPLETED		
34G166			B. WING			8/13/2025		
NAME OF PROVIDER OR SUPPLIER YADKIN II & III				STREET ADDRESS, CITY, STATE, ZIP COD 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	08/13/2025 DDE			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE 10/13/2025		
	inappropriate behaving the opinion of the client protection and This STANDARD is Based on observation interview, the facility updated, written informan rights commit behavior support pla refrigerator, pantry dictients (#1, #2, #3, #facility. The findings of the committen of the	ior and other programs that, committee, involve risks to rights. not met as evidenced by: on, record review and failed to ensure that rmed consent from the ttee (HRC) were secured for ns (BSP), locks on the oor and knives for 6 of 6 4, #5, and #6) at Yadkin II are: group home during the //12/25 - 8/13/25 revealed ator door, keypad on the d knives. Continued d staff to unlock the ry door when items were leals. Further observations ait on staff to open the ock the pantry door or obtain of of client #1's record did not be signed by HRC relative to gerator door, pantry door and	W 262	This will be monitored by the completing quarterly QP reclinical team completing rouseviews. In the future, the Computer the support staff are people supported BSP. The ensure guardian and HRC approve consents annually	views, and the utine chart QIDP will e trained on e QIDP will review and			

STATEMENT OF DEFICIENCIES		(Y4) PROVIDER/OURS (EVA			OMB NO. 0938-0391
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF		34G166	B. WING		08/13/2025
YADKIN	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	00/13/2023
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
W 262	Continued From page 16 C. Review on 8/13/25 of client #3's record did not reveal consents were signed by HRC relative to locks on the refrigerator door, pantry door and knives.		W 26	2	10, 10, 2020
	by the guardian on 10 the record did not reve HRC. Further review r	Medication consents signed /25/23. Continued review of eal consents were signed by evealed consents for the or door, pantry and knives			
	E. Review on 8/13/25 of client #5's record revealed a BSP and Medication consents signed by the guardian on 7/29/25. 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 7/29/25. Additional review did not reveal consents were signed by HRC. E. Review on 8/13/25 of client #6's record revealed consents were last signed by HRC on 7/25/24 relative to the locks on the refrigerator door, pantry door and knives. Continued review did not reveal updated consents.				
	developmental profess current human rights co- clients #1, #2, #3, #4, # located during the surv with the QIDP verified I	ey. Continued interview			
W 263	PROGRAM MONITOR	ING & CHANGE	W 263	The Behavior Analyst will re-in support staff on client #5 BSP	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G166		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DAT	(X3) DATE SURVEY	
			A. BUILDING			IPLETED	
		B. WING		O.F	3/13/2025		
YADKIN	PROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP COD 220 & 3224 US HWY 21 IAMPTONVILLE, NC 27020	E	713/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETION DATE 10/13/2025	
	CFR(s): 483.440(f)(3 The committee should are conducted only we consent of the client, minor) or legal guard. This STANDARD is Based on observation interviews, the facility restrictive techniques reviewed annually by sampled clients (#1,# facility. The findings: Observations in the guardian revealed to prepare more vealed to prepare more vealed to prepare more vealed clients to we refrigerator and pantry needed to prepare more vealed clients to we refrigerator door, unlocknives when needed. A. Review on 8/13/25 revealed consents for door, pantry and knive the guardian on 3/26/ revealed updated consents were guardian relative to the door, pantry and knive the guardian relative to the door, pantry and knive the guardian relative to the door, pantry and knive the guardian relative to the door, pantry and knive the guardian relative to the door, pantry and knive the guardian relative to the door, pantry and knive the guardian relative to the door, pantry and knive the guardian relative to the door, pantry and knive the guardian relative to the door, pantry and knive the guardian relative to the door, pantry and knive the guardian relative to the door, pantry and knive the guardian relative to the door.	Id insure that these programs with the written informed a parents (if the client is a lian. not met as evidenced by: ons, record review and y failed to ensure that is were monitored and of the legal guardian for 4 dra, #4 and #6) at Yadkin II are: group home during the 1/2/25 - 8/13/25 revealed for door, keypad on the ed knives. Continued do staff to unlock the reals. Further observations ait on staff to unlock the ock the pantry door or obtain of client #1's record the locks on the refrigerator res were verbal consented by 24. Continued review resents were not available to of client #3's record did not signed by the legal e locks on the refrigerator res.	W 263	The administrator will in set on reviewing and approving guardian and HRC annually of all people supported incli #2, #3, #4, #5, and #6. The review and approve consent guardian and HRC for client #2, #3, #4, #5, and #6. This monitored by the QIDP comquarterly QP reviews, and the future, the QIDP will ensupport staff are trained on supported BSP. The QIDP in guardian and HRC review a consents annually and PRN	g consents with and/or PRN uding client #1, QIDP will ats with t #1, will be apleting the clinical art reviews. In sure the people will ensure approve	10/13/25	

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU			OMB NO. 0938-0391	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G166	B. WING		08/42/2025	
YADKIN	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020	08/13/2025	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE 10/13/2025	
W 263	guardian relative to the door, pantry door and D. Review on 8/13/25 revealed consents for door, pantry and knive the guardian on 3/26/revealed updated conreview. Interview on 8/13/25 vereing developmental profession consent limita #4, and #6 could not be survey. Continued interevealed limitation consented to the control of the survey.	ne locks on the refrigerator it knives. To of client #6's record of the locks on the refrigerator es were verbal consented by 24. Continued review esents were not available to with the qualified intellectual sional (QIDP) revealed that the tion forms for clients #1, #3, we located during the erview with the QIDP esent forms for all clients gned by the legal guardian	W 263	Nursing will re-inservice support staff	fon	
	that all drugs are adm the physician's orders. This STANDARD is n Based on observation interview, the facility fa were administered in a orders. This affected 1 observed during medic Yadkin II facility. The fi Observations on 8/13/2 client #2 to enter the make his morning medic observations revealed	dministration must assure inistered in compliance with on the met as evidenced by: a, record review and alled to ensure medications accordance with physician's sampled client (#2) cation administration at inding is: 25 at 7:10 AM revealed medication room with staff to cations. Continued client #2 was administered ons; Eliquis 5mg, Farxiga	***************************************	med administration protocol, includin client #2 medication Metformin which should be taken with food or after ear This will be monitored by the clinical team completing 2 med pass observations a week for a period of omonth and then on routine basis. In t future, the QIDP will ensure support s follow med administration protocols.	10/13/25 he 10/13/25	

TIFICATION NUMBER:			(X3) DATE SURVEY	
IDENTIFICATION NUMBER: A. BUILDING 34G166 B. WING		A. BUILDING		
		STREET ADDRESS, CITY, STATE, ZIP CODE	08/13/2025	
PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD D	BE COMPLETION DATE 10/13/2025	
eprazole 20mg, MICRO 20mg. client #2 to take cup of water. Is physician's Metformin should eal to minimize Gl acility nurse verified on should have rafter his breakfast tary environment ion of infections. evidenced by: erviews, the facility rated relative to 1 I facility. The e on 8/13/25 at it in the bathroom n. Further ed client #10 to of the bathroom ands. Continued	W 454	Nursing will re-inservice support starmed administration protocol, includir ensuring people supported hands ar sanitized prior to med administration. This will be monitored by the clinical team completing 2 med pass observations a week for a period of month and then on routine basis. In	ff on angular one the	
	34G166 DF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION) 50mg, Loratadine eprazole 20mg, MICRO 20mg. client #2 to take cup of water. 's physician's Metformin should eal to minimize GI acility nurse verified on should have after his breakfast with a stern his breakfast of the province of infections. Sevidenced by: erviews, the facility or need relative to 1 in facility. The se on 8/13/25 at seit in the bathroom en. Further ed client #10 to of the bathroom ands. Continued to to lay in her bed.	DF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION) W 368 50mg, Loratadine eprazole 20mg, MICRO 20mg, client #2 to take cup of water. 's physician's Metformin should eal to minimize GI acility nurse verified on should have r after his breakfast W 454 Itary environment sion of infections. evidenced by: erviews, the facility r nted relative to 1 I facility. The e on 8/13/25 at sit in the bathroom en. Further ed client #10 to of the bathroom ands. Continued 0 to lay in her bed.	STREET ADDRESS, CITY, STATE, ZIP CODE 3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020 PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) W 368 50mg, Loratadine eprazole 20mg, MICRO 20mg, client #2 to take cup of water. 's physician's Metformin should eal to minimize GI acility nurse verified an should have after his breakfast W 454 Nursing will re-inservice support state med administration protocol, including ensuring people supported hands are sanitized prior to med administration. This will be monitored by the clinical team completing 2 med pass observations a week for a period of month and then on routine basis. In future, the QIDP will ensure support follow med administration protocols. I facility. The e on 8/13/25 at ait in the bathroom and S. Continued 0 to lay in her bed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G166		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	<u>)1</u>
		34G166	B. WING			
NAME OF PROVIDER OR SUPPLIER YADKIN II & III			3220	EET ADDRESS, CITY, STATE, ZIP CODE & 3224 US HWY 21 MPTONVILLE, NC 27020	08/13/2025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	CTION (X5) ULD BE COMPLETION DATE 10/13/202	LETION ATE	
W 454	staff to call client #10 medication administration without hands. Interview with the quaprofessional (QIDP) of should have monitore to ensure that she wiphands. Further intervies taff have been traine	to the medication room for ation. Further observations of participate in medication to washing or sanitizing her salified intellectual disabilities on 8/13/25 revealed staff diction of dient #10 in the bathroom obed herself and washed her ew with the QIDP verified dient to make sure clients washing and prior to medication	W 454	DEFICIENCY)		5