STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G166	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015	The Safety Chairperson will in-service the Direct Support Supervisor on Emergency Food Supplies. The clinical team will monitor through environmental assessments bi-weekly for a period of 30 days and then on a routine basis. In the future, the Direct Support Supervisor will ensure adequate emergency food supplies are always in the home.	10/13/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
IDD Regional Administrator 8/25/25		

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.

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E 015	Continued From page 1 hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the provision of subsistence needs for clients and staff, regardless of whether they evacuate or shelter in place, including but not limited to, food and water, as required by Emergency Preparedness Plan (EPP) regulations for Yadkin II facility. The finding is: Observations on 8/12/25 - 8/13/25 included the group home's designated pantry area containing the EPP subsistence supplies revealed the following; 1 small clear bin with a few can goods of fruit and vegetables, sweetner, etc. Continued observations revealed another small clear empty bin labeled for emergency supplies placed next to another bin. Further observations revealed 7 bottles of 101.4 FL gallons of water placed on the pantry shelf. Interview with the home manager (HM) on 8/12/25 revealed that an assigned personnel is scheduled to shop for additional supplies to fill the empty bin. Continued interview with the HM	E 015		10/13/2025

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E 015	Continued From page 2 revealed she wasn't sure when the shopping will be completed. Interview with the qualified intellectual developmental professional (QIDP) on 8/13/25 confirmed that the emergency provisions present in the home were insufficient to meet the subsistence needs of clients and staff in the event of an emergency.	E 015		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the	E 039	The QIDP and Safety Chairperson will update the Emergency Preparedness Plan. The QIDP will train all staff on the plan. The Regional Administrator will monitor the Emergency Preparedness Plan every 6 months to ensure it remains updated and staff are trained. The Program Manager and Safety Chairperson will organize and complete a tabletop exercise. The Safety Chairperson will monitor to ensure tabletop exercises are completed at least on an annual basis. The QIDP will ensure the Emergency Preparedness Plan is updated and staff are trained on the current plan and training conducted annually.	10/13/25

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E 039	Continued From page 3 actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (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 individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.	E 039		10/13/2025

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E 039	Continued From page 4 (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (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 a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a	E 039		10/13/2025

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E 039	Continued From page 5 facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group	E 039		10/13/2025

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E 039	Continued From page 6 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (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 individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion,	E 039		10/13/2025

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E 039	Continued From page 7 using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to	E 039		10/13/2025

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E 039	Continued From page 8 challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		10/13/2025

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E 039	Continued From page 9 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (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 an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		10/13/2025

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E 039	Continued From page 10 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interviews, the	E 039		10/13/2025

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E 039	Continued From page 11 facility failed to conduct exercises to test the emergency preparedness plan (EPP) annually which effects 6 of 6 clients in Yadkin II facility (#1, #2, #3, #4, #5 and #6). The finding is: Review of facility documentation in Yadkin II facility on 8/13/25 revealed an EPP dated 3/4/24. Continued review of the facility's EPP did not reveal evidence of a full-scale facility based, mock drill, or a tabletop exercise to test the facility's EPP. Interview with the qualified intellectual disabilities professional (QIDP) on 8/13/25 revealed that evidence of a full-scale community facility based exercises, tabletop or mock drill exercises were not available during the survey. Continued interview with the QIDP verified that the facility tabletop, mock drill, and/or full-scale exercises for Yadkin II were not completed as required.	E 039		
W 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure clients have a right to personal privacy for 1 sampled client (#10) during personal care in Yadkin III facility. The finding is: Morning observations on 8/13/25 at 7:05 AM revealed client #10 to sit in the bathroom toileting with the door remaining open. Observations did not reveal staff to assist the client with privacy in the bathroom for a total of 10 minutes.	W 129	The Habilitation Specialist will in-service support staff on client #10 OSG #2 Privacy Program located in Therap. The QIDP will in-service support staff to respect the privacy of all clients during toileting and personal care. The clinical team will monitor through interaction assessments completed twice a week for a period of 30 days and then on a routine basis. In the future, the clinical team will ensure training and assessments are completed on a routine basis and as needed to ensure the rights and personal privacy of all clients are met.	10/13/25

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W 129	Continued From page 12 Interview with the qualified intellectual disabilities professional (QIDP) on 8/13/25 revealed staff should have ensured client #10's privacy during toileting. Further interview with the QIDP revealed staff are aware that privacy is an ongoing problem for client #10 during toileting and personal care. Continued interview with the QIDP verified staff have been trained to respect the privacy of all clients during toileting and personal care.	W 129		10/13/2025
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to update the person centered plan (PCP) annually for 8 of 12 sampled clients (#1, #4 and #6) in Yadkin II and clients (#7, #8, #9, #10, and #11) in Yadkin III. The findings are: A. The facility failed to ensure the PCPs for clients in Yadkin II facility (#1, #4, and #6) were updated annually as required. For example: 1. Review on 8/12/25 of client #1's record revealed a PCP dated 6/6/24. Interview on 8/13/25 with the qualified intellectual developmental professional (QIDP) confirmed an updated PCP have not been completed for client #1. 2. Review on 8/12/25 of client #4's record revealed a PCP dated 10/25/23.	W 260	The QIDP will revise and update all PCPs at least annually and as needed based on reviews and interviews. This will be monitored by the administrator by generating and reviewing PCP dates in Therap. In the future, the QIDP will ensure all PCPs are revised and updated at least annually and as needed based on QP reviews and interviews.	10/13/25

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W 260	Continued From page 13 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 signatures should have been completed prior to 7/8/25.	W 260		10/13/2025

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W 260	Continued From page 14 3. Review of the record on 8/13/25 for client #9 revealed a PCP dated 11/1/23. Further review of the record for client #9 did not reveal evidence of a PCP meeting or updated program goals since 11/1/23. Interview with the QIDP on 8/13/25 revealed the 11/2023 PCP for client #9 should have been updated and signed by the legal guardian and treatment team prior to the expiration date. 4. Review of the record on 8/13/25 for client #10 revealed a PCP dated 3/14/24. Further review of the record for client #10 did not reveal evidence of updated program goals or PCP meeting since 3/14/24. Interview with the QIDP on 8/13/25 revealed the 3/2024 PCP for client #10 should have been updated and signed by the legal guardian and treatment team prior to the expiration date. 5. Review of the record on 8/13/25 for client #11 revealed a PCP dated 11/1/23. Further review of the record for client #11 did not reveal evidence of a PCP meeting or updated program goals since 11/1/23. Interview with the QIDP on 8/13/25 revealed the 11/2023 PCP for client #11 should have been updated and signed by the legal guardian and treatment team prior to the expiration date.	W 260		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage	W 262	The Behavior Analyst will re-inservice support staff on client #5 BSP. The administrator will in-service QIDP on reviewing and approving consents with guardian and HRC annually and/or PRN of all people supported including client #1, #2, #3, #4, #5, and #6. The QIDP will	10/13/25

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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.	W 262	This will be monitored by the QIDP completing quarterly QP reviews, and the clinical team completing routine chart reviews. In the future, the QIDP will ensure the support staff are trained on people supported BSP. The QIDP will ensure guardian and HRC review and approve consents annually and PRN.	10/13/2025

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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. D. Review on 8/13/25 of client #4's record revealed a BSP and Medication consents signed by the guardian on 10/25/23. 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 not signed by HRC. 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. Interview on 8/13/25 with the qualified intellectual developmental professional (QIDP) revealed that current human rights consent limitation forms for clients #1, #2, #3, #4, #5 and #6 could not be located during the survey. Continued interview with the QIDP verified HRC limitation consent forms for all clients should be updated and signed by the HRC annually.	W 262		10/13/2025
W 263	PROGRAM MONITORING & CHANGE	W 263	The Behavior Analyst will re-inservice support staff on client #5 BSP.	

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W 263	Continued From page 17 CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the legal guardian for 4 sampled clients (#1,#3, #4 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 pantry 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 unlock the refrigerator door, unlock the pantry door or obtain knives when needed. A. Review on 8/13/25 of client #1's record revealed consents for the locks on the refrigerator door, pantry and knives were verbal consented by the guardian on 3/26/24. Continued review revealed updated consents were not available to review. B. Review on 8/13/25 of client #3's record did not reveal consents were signed by the legal guardian relative to the locks on the refrigerator door, pantry and knives. C. Review on 8/13/25 of client #4's record did not reveal consents were not signed by legal	W 263	The administrator will in service the QIDP on reviewing and approving consents with guardian and HRC annually and/or PRN of all people supported including client #1, #2, #3, #4, #5, and #6. The QIDP will review and approve consents with guardian and HRC for client #1, #2, #3, #4, #5, and #6. This will be monitored by the QIDP completing quarterly QP reviews, and the clinical team completing routine chart reviews. In the future, the QIDP will ensure the support staff are trained on people supported BSP. The QIDP will ensure guardian and HRC review and approve consents annually and PRN.	10/13/25

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W 263	Continued From page 18 guardian relative to the locks on the refrigerator door, pantry door and knives. D. Review on 8/13/25 of client #6's record revealed consents for the locks on the refrigerator door, pantry and knives were verbal consented by the guardian on 3/26/24. Continued review revealed updated consents were not available to review. Interview on 8/13/25 with the qualified intellectual developmental professional (QIDP) revealed that current consent limitation forms for clients #1, #3, #4, and #6 could not be located during the survey. Continued interview with the QIDP revealed limitation consent forms for all clients will be updated and signed by the legal guardian annually.	W 263		10/13/2025
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 sampled client (#2) observed during medication administration at Yadkin II facility. The finding is: Observations on 8/13/25 at 7:10 AM revealed client #2 to enter the medication room with staff to take his morning medications. Continued observations revealed client #2 was administered the following medications; Eliquis 5mg, Farxiga 10mg, Furosemide 20mg, Lisinopril 10mg,	W 368	Nursing will re-inservice support staff on med administration protocol, including client #2 medication Metformin which should be taken with food or after eating. This will be monitored by the clinical team completing 2 med pass observations a week for a period of one month and then on routine basis. In the future, the QIDP will ensure support staff follow med administration protocols.	10/13/25

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W 368	Continued From page 19 Metformin 100mg, Metoprolol 50mg, Loratadine 10mg, Tamsulosin 0.4mg, Omeprazole 20mg, Myrbetriq 25mg and POT CL MICRO 20mg. Further observations revealed client #2 to take his medications followed by a cup of water. Review on 8/13/25 of client #2's physician's orders dated 7/15/25 revealed Metformin should be taken with food or after a meal to minimize GI irritation and/or GI bleeding. Interview on 8/13/25 with the facility nurse verified client #2's Metformin medication should have been administered with food or after his breakfast meal as prescribed.	W 368		10/13/2025
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the potential for cross-contamination was prevented relative to 1 audited client (#10) in Yadkin III facility. The finding is: Observations in the group home on 8/13/25 at 7:05AM revealed client #10 to sit in the bathroom while toileting with the door open. Further observations at 7:07 AM revealed client #10 to pull up her pants and leave out of the bathroom without wiping or washing her hands. Continued observations revealed client #10 to lay in her bed. Subsequent observations at 7:50 AM revealed	W 454	Nursing will re-inservice support staff on 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 one month and then on routine basis. In the future, the QIDP will ensure support staff follow med administration protocols.	10/13/25

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W 454	Continued From page 20 staff to call client #10 to the medication room for medication administration. Further observations revealed client #10 to participate in medication administration without washing or sanitizing her hands. Interview with the qualified intellectual disabilities professional (QIDP) on 8/13/25 revealed staff should have monitored client #10 in the bathroom to ensure that she wiped herself and washed her hands. Further interview with the QIDP verified staff have been trained to make sure clients wash their hands after toileting and prior to medication administration.	W 454		10/13/2025