STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G085	A. BUILDING _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKDALE GROUP HOME	436 MOCKSVILLE HWY STATESVILLE, NC 28625

(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 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 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	E 039	E 039 The Qualified Professional and Safety Chairperson will update the Emergency Preparedness Plan. The Qualified Professional will train all staff on the plan. The Qualified Professional and Safety Chairperson will complete a mock drill/tabletop exercise as part of the training for The Emergency Preparedness Plan. The Administrator will monitor the Emergency Preparedness Plan every 6 months to ensure it remains updated, staff are trained, and mock drills/tabletop exercise are completed. The Qualified Professional will ensure the Emergency Preparedness Plan is updated, staff are trained on the current plan, and training conducted annually including mock drills or tabletop exercises.	11/7/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	IDD Regional Administrator 9/23/25	

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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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.
(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

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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 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.

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E 039	Continued From page 3 *[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 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):]	E 039		

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E 039	Continued From page 4 (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, 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	E 039		

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E 039	Continued From page 5 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 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	E 039		

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E 039	Continued From page 6 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. *[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.	E 039		

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E 039	Continued From page 7 (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. *[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	E 039		

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E 039	Continued From page 8 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 interview, the facility failed to conduct exercises to test the emergency preparedness plan (EPP) annually which effects 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: Review of facility documentation on 9/9/25 revealed an EPP dated 3/7/24. 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.	E 039		

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E 039	Continued From page 9 Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/10/25 revealed the evidence of a full-scale community facility based exercise, 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 were not completed as required.	E 039		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure the interior and exterior of the facility was sanitary and orderly affecting 6 of 6 clients (#1, #2, #3, #4, #5, and #6). The finding is: Observations around the exterior of the facility during the recertification survey from 9/9/25-9/10/25 revealed numerous cobwebs and small chunks of dirt around the perimeter of the home and doors. Continued observations revealed a large patio table and chair set extremely rusted and peeling apart. Subsequent observations inside of the facility revealed the facing of three kitchen cabinet drawers to be missing. Continued observation revealed a hole in the living room ceiling with several spots of water damage causing particles to peel. Interview with the Home Manager (HM) on 9/9/25	W 104	W 104 The business manager will in-service the maintenance coordinator on completing work orders in a timely manner. The clinical team will complete environmental assessments 2x a week for a period of 30 days and then on a routine basis to ensure all work orders are completed. In the future, the maintenance coordinator will ensure all work orders are completed.	11/7/25

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W 104	Continued From page 10 revealed that several work orders were requested for the kitchen cabinets and the water damage on the ceiling. Continued interview with the HM stated that no one came to the home to repair the cabinets or ceiling. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/10/25 revealed that she was aware of the facing of the kitchen drawers missing and the condition of the water damage areas in the ceiling and the patio furniture. Continued interview with the QIDP revealed that work orders were completed and that the provider has been approved for the work to be done, but it had not been completed at this time.	W 104		
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 6 clients (#1) received the needed interventions as identified in his positive behavior support plan (PBSP) relative to prevention and proactive measures. The finding is: Observations throughout the recertification survey from 9/9/25-9/10/25 revealed client #1 to urinate on the floor three times in the home. Continued observations revealed client #1 to urinate one time on the floor while standing in front of his bedroom and two times in the living room in front of the other residents. Further observations revealed staff to mop after seeing the puddles of urine on the floor; there were no prompts	W 193		

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W 193	Continued From page 11 throughout the survey for client #1 to go to the bathroom. Review of client #1's clinical record on 9/9/25 revealed a PBSP dated 8/1/25. Continued review of the PBSP revealed target behaviors of compulsive behaviors, self injurious behaviors (SIB), pica, inappropriate toileting, and safe travel. Further review of the PBSP revealed strategies for handling client #1's appropriate toileting as written, staff will routinely prompt client #1 to the bathroom, including after meals and prior to bed or as directed through guidelines; reinforce client #1 when he uses the bathroom appropriately. Interview on 9/10/25 with the Qualified Intellectual Disabilities Professional (QIDP) verified client #1's positive behavior support plan is current and staff should follow as written.	W 193	W 193 The behavior analyst will in-service all staff on client #1's BSP. The clinical team will monitor through interaction assessments 2x a week for a period of 30 days and then on a routine basis to ensure the BSP is followed as written. In the future, the behavior analyst will ensure all staff are trained on BSPs of People Supported.	11/7/25
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment program	W 249		

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W 368	Continued From page 14 on 9/10/25 at 7:13 AM revealed the Home Manager (HM) to call client #4 to the medication closet after he had completed his breakfast meal. Continued observation revealed the HM to place the following medications in a small cup: Clonidine, Omega 3 Fish Oil, Pantoprazole, POT Chloride, Propranolol, Carbamazepin, Citalopram, Vitamin D3, Hydrochlorot, PEG3350 Powder, Lorazepam, and Levothyroxine. Further observation revealed client #4 to take the medications together with a cup of water; then exited the room. Review of client #4's clincial record on 9/10/25 revealed a physician's order dated 7/17/25 which indicated that client #4 should take Levothyroxine 50mcg without any other medications and at least 30 minutes before breakfast. Interview with the facility nurse and the Qualified Intellectual Disabilities Professional (QIDP) on 9/10/25 confirmed that the HM should have not provided client #4 with the Levothyroxine medication with his other medications and should have been administered at least 30 minutes before breakfast as prescribed.	W 368	W368 The nurse will in-service all staff on proper medication passes and following all the rights and protocol as directed. The clinical team will monitor through medication assessments 2x a week for a period of 30 days and then on a routine basis to ensure medications are given as directed. In the future, the nurse will ensure all staff are trained on proper medication passes.	11/7/25
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure all appropriate utensils were provided to 4 of 6 clients (#1, #2, #3 and #4). The finding is: Observations during the dinner meal on 9/9/25 at 5:22 PM revealed clients #1, #2, #3 and #4 to	W 475		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G085	A. BUILDING _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKDALE GROUP HOME	436 MOCKSVILLE HWY STATESVILLE, NC 28625

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W 475	Continued From page 15 participate in the dinner meal which consisted of two ground beef tacos, tomatoes, lettuce, salsa, green salad with lite dressing, green beans, milk and water. At no point during the observation did staff offer a full place setting consisting of placemats, napkins, forks and knives during the dinner meal. Observations during the breakfast meal on 9/10/25 at 6:40 AM revealed clients #1, #3, and #4 to participate in the breakfast meal which consisted of oatmeal, two scrambled eggs, blueberries, milk and orange juice. At no point during the observation did staff offer a full place setting consisting of placemats, napkins, forks and knives during the breakfast meal. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/10/25 verified that clients #1, #2, #3 and #4 can use utensils during mealtimes and should have received a full place setting during all meals.	W 475	W 475 The Habilitation Specialist will in-service all staff on the proper utensils for People Supported during meal times. The clinical team will monitor through meal time assessments 2x a week for 30 days and then on a routine basis to ensure all People Supported have the proper utensils. In the future, the Habilitation Specialist will ensure all staff are trained on utensils required for meal times.	11/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G085	A. BUILDING _____ B. WING _____	09/10/2025

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W 249	Continued From page 12 consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of adaptive dining equipment use. This affected 2 of 6 clients (#2 and #6). The findings are: A. The facility failed to provide appropriate adaptive dining equipment to client #2 during mealtimes. For example: Observations during the dinner meal on 9/9/25 revealed client #2 to consume his meal using a regular plate, regular tablespoon and two regular cups. Continued observations revealed staff to provide client #2 a maroon spoon after he ate 95% of his meal. Review of client #2's clinical record on 9/9/25 revealed an IPP dated 5/27/25 with a list of mealtime adaptive equipment to include a small spoon for slow pace eating. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/10/25 confirmed client #2's IPP is current and that staff should have provided client #2 with a small spoon or a maroon spoon during mealtimes as prescribed. B. The facility failed to provide appropriate adaptive dining equipment to client #6 during mealtimes. For example: Observations during the dinner and breakfast meal on 9/9/25-9/10/25 revealed client #6 to consume his meal using a divided dish, maroon spoon, two cups with lids and straws, and a clothing protector. Continued observations revealed client #6 to cough several times during both meals after drinking from the cups with	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G085	A. BUILDING _____ B. WING _____	09/10/2025

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W 249	Continued From page 13 straws. Further observations revealed staff to not remove the cups with straws and replace with two sippy cups for client #6 as prescribed. Review of client #6's clinical record on 9/9/25 revealed an Occupational Therapy (OT) Evaluation dated 7/29/25 revealed staff reported that client #6 has been coughing sometimes when drinking from a cup with straw. Continued review of the OT Evaluation revealed the therapist recommended that client #6's straw be discontinued and replaced with a sippy cup, cup with lid and a free flow hole (such as a travel coffee mug) or a flo-trol cup to limit liquid flow. Further review of client #6's clinical record revealed a Mini-Team Report dated 8/20/25 indicating the team agreed to discontinue client #6's cups with straws and replace with sippy cups. Interview with the QIDP on 9/10/25 confirmed the cups with straws were discontinued and that staff should have provided client #6 with sippy cups during mealtimes as prescribed.	W 249	W249 A&B The habilitation specialist will in-service all staff on the programs of client's 2 and 6. The QP will in-service all staff on the PCP of clients #2 and 6. The behavior analyst will in-service all staff on the BSP of clients #2 and #6. The clinical team will monitor through interaction assessments 1x a week for a period of 30 days and then on a routine basis to ensure PCPs, BSPs, and programs are followed as written. In the future, the clinical team will ensure all staff are trained on the programs, PCPs and BSPs.	11/7/25
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 all medications were administered in accordance with physician's orders for 1 of 6 clients (#4). The finding is: Observations during the medication adminstration	W 368		