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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EPP) was reviewed and/or updated at least biennially. The finding is: Review on 2/18/26 of the facility's EPP revealed that the facility's EPP was last updated 1/8/24. Interview on 2/19/26 with the qualified intellectual disabilities professional (QIDP) confirmed that the facility does not have an updated EPP.	E 004		
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		

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staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

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E 037	Continued From page 3 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training	E 037		

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E 037	Continued From page 4 Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

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E 037	Continued From page 5 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide and maintain documentation of annual staff training on the Emergency Preparedness Plan (EPP). The finding is: A review of the facility's EPP on 2/18/26 revealed	E 037		

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E 037	Continued From page 6 no documentation of the annual staff training. Interview on 2/19/26 with the qualified intellectual disabilities professional (QIDP) confirmed that the facility did not conduct an updated EPP training.	E 037		
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 observations and interviews, the governing body and management failed to exercise general policy and operating direction over the facility as evidence by damage and safety hazards observed in the group home. The finding is: Observations throughout the 2/18/26 - 2/19/26 survey revealed a broken book shelf, broken chair, and torn seat cushions on the back patio. Further observations revealed broken blinds, chirping smoke detector, torn seat cushions and arm rest in clients' bedrooms. Continued observations revealed tears on seat cushions in the livingroom. Interview with staff and the qualified intellectual disabilities professional (QIDP) on 2/19/26 revealed no knowledge of the damaged furniture on the back patio or torn blinds, tears on seating cushions throughout the home. Further interview with the facility administrator revealed the home will be receiving new furniture within the coming weeks.	W 104		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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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 consisting of needed interventions and services as identified in the person-centered plan (PCP) for 1 of 5 audited clients (#3). The finding is:

Observations on 2/18/26 from 4:00 PM - 6:00 PM revealed client #3 to spend 90 of 120 minutes sitting at the dining room table or pacing around the house unengaged followed by his 1:1 staff. Continued observations for the remaining 30 minutes revealed client #3 to participate in the dinner meal and return to his room.

Further observations on 2/19/26 from 6:30 AM - 9:15 AM revealed client #3 to spend 145 of 165 minutes in his room unengaged or asleep supervised by his 1:1 staff. Subsequent observations for the remaining 20 minutes revealed client #3 to participate in the breakfast meal, and return to his room. At no time during observations was client #3 prompt to engage in formal or informal activities.

Review of the record for client #3 on 2/19/26 revealed a PCP dated 12/9/25 with three formal

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W 249	Continued From page 8 training programs. Further review of the training objectives for client #3 included the following: wipe mouth during meals, tolerate toothbrushing, and hold money. Interview with 1:1 staff on 2/19/26 revealed client #3 participates in activities more at the day program than at the group home. Further interview with 1:1 staff revealed client #3 prefers to lay down in his room most of the time while at the group home. Interview with the qualified intellectual disabilities professional (QIDP) on 2/19/26 revealed client #3's PCP and program goals are current. Further interview with the QIDP revealed client #3 should be offered opportunities to participate in informal and formal programming throughout the day.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all drugs were administered without error for 2 of 5 audited clients (#1 and #4). The findings are: A. The facility failed to assure drugs were administered without error for client #1. For example: Observations in the group home on 2/19/26 at 7:23 AM revealed client #1 to enter the medication room. Further observations revealed staff B to retrieve client #1's medication bin from	W 369		

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the closet, scan the medications then have client #1 to punch each pill from the blister pack into the med cup. Continued observations revealed staff B to hand client #1 the medication cup, with medications mixed with applesauce. Subsequent observations revealed client #1 to swallow the medications followed by a cup of water mixed with polyethylene glycol 3350 powder. Additional observations revealed staff B to place two drops of Ear Wax removal into client's eyes. When surveyor request to see the prescription bottle, staff B recognized that the drops are to be administered in the client's ears and not eyes. Staff B then called the on call nurse for further directives.

Review of record for client #1 on 2/19/26 revealed a physician's order dated 2/19/26 to include the medication earwax removal drops 6.5%, install 5 drops in both ears twice daily for 5 days every month for excessive ear wax.

Interview with the facility nurse 2/19/25 revealed client #1's physician order is current. Further interview with the facility nurse revealed client #1's drops should have been administered as prescribed.

B. The facility failed to assure drugs were administered without error for client #4. For example:

Observations in the group home on 2/19/26 from 6:30 AM - 9:15 AM did not reveal client #4 to receive his morning medications. When surveyor asked if client #4 receives morning medications, staff B responded yes, however the med keys were accidentally locked in the med room. Further observations at 9:15 AM revealed a staff

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W 369	Continued From page 10 member to enter the home and unlock the med room. Review of record for client #4 on 2/19/26 revealed a physician's order dated 2/19/26 to include several medications to be administered at 8:00 AM. Interview with the facility nurse 2/19/25 revealed client #4's physician order is current. Further interview with the facility nurse revealed client #4's medications should have been administered as prescribed.	W 369		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve food in a form consistent with the developmental level of 4 of 5 audited clients (#1, #3, #4 and #5) in the facility. The findings are: A. The facility failed to provide client #1 with prescribed diet. For example: Observations in the group home on 2/18/26 at 5:30 PM revealed client #1 to participate in the dinner meal which consisted of lasagna, green beans and slice bread. Further observations revealed client #1 to consume the dinner meal in whole consistency. Continued observations at 5:45 PM revealed client #1 to receive a second serving of lasagna and consume the entire portion.	W 474		

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Review of client #1's record on 2/19/26 revealed a Person-Centered Plan (PCP) dated 3/14/25. Review of the PCP revealed a nutritional assessment dated 8/13/25 for client #1 to be prescribed a weight loss 1800 calorie, heart healthy, high fiber, whole consistency diet, no seconds, and encourage fluids.

Interview with the facility nurse and Qualified Intellectual Disabilities Professional (QIDP) on 2/19/26 confirmed client #1's prescribed diet. Continued interview with the facility nurse and QIDP confirmed specially modified diets should be followed as prescribed.

B. The facility failed to provide client #3 with prescribed diet. For example:

Observations in the group home on 2/18/26 at 5:30 PM revealed client #3 to participate in the dinner meal which consisted of lasagna, green beans and slice bread served in whole consistency. Further observations revealed client #3 to consume the entire meal and stuff a whole slice of bread into his mouth. At no time during the dinner meal was staff observed to provide the client with a ground consistency diet. Additionally, during observations client #3 did not have any difficulty with consuming the dinner meal.

Review of client #3's record on 2/19/ 26 revealed a PCP dated 7/17/25. Review of the PCP revealed a nutritional assessment dated 3/27/24 for client #3 to be prescribed a weight gain 2000+ calories, ground consistency, double portions of meats all meals, 4 oz pudding, yogurt, applesauce with lunch and dinner.

Interview with the facility nurse and QIDP on

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2/19/26 confirmed client #3's prescribed diet. Continued interview with the facility nurse and QIDP confirmed specially modified diets should be followed as prescribed.

C. The facility failed to provide client #4 with prescribed diet. For example:

Observations in the group home on 2/18/26 at 5:30 PM revealed client #4 to participate in the dinner meal which consisted of lasagna, green beans and slice bread served in whole consistency. Further observations revealed client #4 to consume the entire meal and stuff a whole slice of bread into his mouth. At no time during the dinner meal was staff observed to provide the client with a ground consistency diet. Additionally, during observations client #4 did not have any difficulty with consuming the dinner meal.

Review of client #4's record on 2/19/26 revealed a Person-Centered Plan (PCP) dated 7/17/25. Review of the PCP revealed a nutritional assessment dated 3/27/24 for client #4 to be prescribed a weight gain 2000+ calories, ground consistency, double portions of meats all meals, 4 oz pudding, yogurt, applesauce with lunch and dinner.

Interview with the facility nurse and QIDP on 2/19/26 confirmed client #4's prescribed diet. Continued interview with the facility nurse and QIDP confirmed specially modified diets should be followed as prescribed.

D. The facility failed to provide client #5 with prescribed diet. For example:

Observations in the group home on 2/19/26 at

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FORSYTH GROUP HOME #1	216 LINVILLE SPRINGS ROAD KERNERSVILLE, NC 27284

(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
W 474	Continued From page 13 8:10 AM revealed client #5 to participate in the breakfast meal which consisted of oatmeal and bacon. Further observations at 8:25 AM revealed client #5 to grab a handful of bacon cut into pieces, place it in his plate and consume in it's entirety. Additionally, during observations client #5 did not have any difficulty with consuming the dinner meal. Review of client #5's record on 2/19/26 revealed a PCP dated 12/15/25. Review of the PCP revealed a nutritional assessment dated 1/21/26 for client #5 to be prescribed a regular 2000 calorie, double meats pureed consistency. May have seconds of fruits and vegetables, no peanut butter, and Ensure BID between meals. Interview with the facility nurse and QIDP on 2/19/26 confirmed client #5's prescribed diet. Continued interview with the facility nurse and QIDP confirmed specially modified diets should be followed as prescribed.	W 474		