

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G273	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3301 BARKSDALE ROAD , FAYETTEVILLE, North Carolina, 28301	
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E0013	<p>Development of EP Policies and Procedures</p> <p>CFR(s): 483.475(b)</p> <p>§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(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 at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least</p>	E0013		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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E0013	<p>Continued from page 1 every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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 at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on document review and interview, the facility failed to ensure the Emergency Preparedness Plan (EPP) included policies and procedures to address an epidemic/pandemic event. The finding is:</p> <p>Review on 3/23/26 of the facility's EPP (last reviewed on 10/16/25) did not include policies and procedures to address an epidemic or pandemic event at the facility.</p> <p>Interview on 3/24/26 with the Qualified Professional Supervisor (QPS) confirmed the EPP did not include information regarding an epidemic or pandemic. The QPS confirmed the EPP should include policies and procedures in the event of an epidemic or pandemic.</p>	E0013		
W0229	<p>INDIVIDUAL PROGRAM PLAN</p> <p>CFR(s): 483.440(c)(4)(i)</p> <p>The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure objectives included in the Individual Program Plan (IPP) for 2 of 4 audit clients (#4 and #6) were written in terms of a single behavioral outcome. The findings are:</p> <p>A. Review on 3/23/26 of client #4's IPP dated 11/1/25 identified objectives for the client to correctly name a \$1, \$5, \$10, \$20 dollar bill and all coins with 100% accuracy for 3 consecutive months and an objective to</p>	W0229		

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W0229	Continued from page 2 correctly separate white clothes from colored clothes, sheets/towels/wash clothes/pillowcases with 50% accuracy for 3 consecutive months. B. Review on 3/23/26 of client #6's IPP dated 4/1/25 revealed an objective to correctly name a \$1, \$5, \$10, \$20 dollar bill and all coins with 100% accuracy for 3 consecutive months. Additional review of each client's IPP indicated the objectives were not written in with a single behavioral outcome. Interview on 3/24/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objectives did not identify a single behavioral outcome.	W0229		
W0249	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 review and interview, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of food preparation. This affected 1 of 4 audit clients (#4). The finding is: During morning observations in the home on 3/24/26 from 6:01am - 7:10am, client #4 placed plates on the table and retrieved two items from the refrigerator. During this time, the client also stood in the kitchen with gloves on while Staff B completed various cooking tasks such as preparing a pot of grits and scrambled eggs on the stove. Although client #4 asked the staff more than once if he needed any help, the client was not prompted or encouraged to assist with any cooking tasks. Interview on 3/24/26 with Staff B revealed client #4 can assist with stirring, getting items from the refrigerator, putting food in the oven or cooking food on the stove.	W0249		

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W0249	<p>Continued from page 3</p> <p>Review on 3/24/26 of client #4's Annual Comprehensive Functional Assessment (signed 12/27/23) revealed he requires assistance to set the table, prepare a cold breakfast, prepare a sandwich for lunch, operate manual can opener, measure items for cooking, use the stove/microwave, and prepare items requiring mixing and cooking.</p> <p>Interview on 3/24/26 with the Home Manager indicated client #4 can assist with kitchen tasks such as washing potatoes, making Kool-Aid, stirring in pots, and operating the stove and other small appliances.</p>	W0249		
W0288	<p>MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>CFR(s): 483.450(b)(3)</p> <p>Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure techniques to address inappropriate behaviors were included in a formal active treatment plan. This affected 2 of 4 audit clients (#3 and #6). The findings are:</p> <p>A. During observations throughout the survey in the home on 3/23 - 3/24/26, various clothing items belonging to client #3 were noted in office area of the home. Staff E was noted to sort through the items to retrieve clothes for client #3 to wear.</p> <p>Interview on 3/23/26 with Staff E revealed client #3's mother does not want her clothes kept in the client's bedroom due to her tendency to change her clothes repeatedly throughout the day.</p> <p>Review on 3/24/26 of client #3's Behavior Support Plan (BSP) signed 5/16/25 revealed an objective to demonstrate no more than 5 episodes of her target behaviors per month for 6 consecutive months. Additional review of the BSP included target behaviors of noncompliance and aggression. The plan did not include a technique of removing client #3's clothes from her bedroom to address her inappropriate behaviors.</p> <p>Interview on 3/24/26 with the Qualified Professional Supervisor (QPS) confirmed client #3 likes to change her clothes several times a day; however, there is no</p>	W0288		

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W0288	Continued from page 4 formal objective to address this behavior or the removal of her clothes from her bedroom. B. Observations in the home throughout the survey on 3/23 - 3/24/26, revealed no paper products (i.e paper towels, toilet paper) in a hall bathroom of the home. Clients were prompted to the bathroom to wash their hands and then retrieved paper towels from kitchen counter afterwards or a staff handed each client a paper towel as the hand washing task was complete. Interview on 3/24/26 with Staff B revealed client #6 will go in bathroom and take all of the paper products and throw them away or take them to his room. The staff noted this was the reason they limit the amount of paper products in the bathroom. Review on 3/24/26 of client #6's BSP (signed 5/16/25) revealed an objective to address noncompliance and aggression. The plan did not include a technique of removing paper products form the bathroom to address client #6's inappropriate behaviors. Interview on 3/24/26 with the QPS confirmed the paper products should not be removed from the bathroom to address client #6's inappropriate behaviors and is not included in his BSP.	W0288		
W0340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is NOT MET as evidenced by: Based on observations, record/document reviews and interviews, the facility failed to ensure staff were sufficiently trained on the proper use of lates gloves, application of topical medications and securing personal medications. This affected 1 of 4 audit clients (#6). The findings are: A. During dinner observations in the home on 3/23/26 at 5:00pm, staff wore latex gloves while assisting clients with serving themselves food items and pouring their drinks. Additional observations of medication administration on 3/24/26, Staff D wore latex gloves while handling keys, using a pen and assisting clients to punch their medications from pill cards.	W0340		

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W0340	<p>Continued from page 5</p> <p>Interview on 3/24/26 with Staff D revealed she had been trained to wear gloves when applying creams or topicals, not throughout medication administration.</p> <p>Review on 3/24/26 of the facility's Policy on Use of Latex Gloves (posted in the dining room of the home) revised 7/20/25 revealed, "Wear gloves when touching blood, body fluids, secretions, excretions or mucous membranes." Additional review of the policy did not indicate latex gloves should be worn in the manner previously described.</p> <p>Interview on 3/24/26 with the Qualified Professional Supervisor (QPS) confirmed staff should be wearing gloves as indicated in the policy.</p> <p>B. During observations in the home on 3/23/26 at 4:24pm, client #6 was given Diclofenac gel 1% by Staff A. While standing in the dining room, next to the medication cart and the staff, client #6 quickly applied the cream below his right knee, to his lower leg (on top of his sock) and across his sneaker. He then quickly returned to the table to manipulate his tablet.</p> <p>Immediate interview with Staff A indicated the client has been applying the cream to his knee for an injury he sustained. Additional interview indicated the cream should applied to the client's knee.</p> <p>Review on 3/24/26 of the facility's Medication Administration Observation sheet noted, "Staff administers medications in proper place...Staff gives full attention to task..."</p> <p>Interview on 3/24/26 with the QPS confirmed client #6's topical cream should have been monitored by staff to ensure it was applied to his knee correctly.</p> <p>C. Upon arrival to the home on 3/24/26 at 6:01am, a pill cup was noted on a table in the dining area of the home. The cup contained various pills which were unsecured and accessible to anyone in the home from 6:01am - 7:38am.</p> <p>Interview on 3/24/26 with Staff A (Med Tech) revealed the pills belonged to Staff B who was also working in the home at the time. Staff A stated, "He knows better."</p> <p>Interview on 3/24/26 with Staff B confirmed the pills belonged to him. He indicated he had forgotten they were on the table.</p>	W0340		

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W0340	Continued from page 6 Interview on 3/24/26 with the QPS revealed the facility does not have a specific policy for securing personal medications, however, staff should ensure their personal medications are not accessible to other staff and clients in the home.	W0340		
W0369	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 review and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 3 clients (#4) observed receiving medications. The finding is: During observations of medication administration in the home on 3/23/26 at 12:05pm, client #4 received Refresh ointment to his left eye. Review on 3/24/26 of client #4's physician's orders (signed 3/3/26) revealed an order for Refresh P.M. ointment, apply into each eye at bedtime at 8pm. Interview on 3/24/26 with Staff E indicated client #4 receives Refresh eye ointment at 8pm. Interview on 3/24/36 with the Qualified Professional Supervisor confirmed client #4's Refresh eye ointment should not have been administered at lunch time but at 8pm as indicated on his physician's orders.	W0369		
W0383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is NOT MET as evidenced by: Based on observations, document review and interviews, the facility failed to ensure only authorized persons have access to keys to the medication closet/cart. The finding is: During observations in the home on 3/23/26, the keys to	W0383		

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W0383	<p>Continued from page 7 the medication closet/cart were noted hanging from a tack on the wall in the dining area. Additional observations revealed staff retrieved the keys to unlock the medication closet/cart and obtain medications to be dispensed.</p> <p>During observations in the home on 3/24/26 at 7:45am, Staff D finishes dispensing medications and immediately hung the keys from a tack on a wall in the dining area.</p> <p>Interview on 3/24/26 with Staff D revealed keys to the medication cart should be kept by the person passing medications "at all times".</p> <p>Review of the facility's Medication Administration Observation sheet noted, "Medication closet keys are on staff administrating medication".</p> <p>Interview on 3/24/26 with the Qualified Professional Supervisor confirmed the keys to the medication closet/cart should be kept on the medication technician while in the home.</p>	W0383		