STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G278	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER: AVENT FERRY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE: 904 AVENT FERRY ROAD , HOLLY SPRINGS, North Carolina, 27540	

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W0102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met. This CONDITION is NOT MET as evidenced by: The facility failed to ensure all applicable provisions of Federal, State and local laws and regulations pertaining to staff training in emergency procedures, specifically Cardiopulmonary Resuscitation (CPR) and First Aid; medication administration; alternatives to restrictive interventions; and seclusion, physical restraint and isolation time-out (W107). The cumulative effect of these systematic practices resulted in the facility's failure to ensure safety to clients and follow state law, which requires staff to obtain certified training in CPR/First Aid, medication administration, alternatives to restrictive interventions and seclusion, physical restraint, seclusion and isolation time out.	W0102		
W0318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is NOT MET as evidenced by: The facility failed to provide nursing services related to training staff in medication administration (W340); training in appropriate health and hygiene methods (W341); providing comprehensive dental services annually or as needed (W352) and administering drugs without error (W369). The cumulative effect of these systematic practices resulted in the facility's failure to provide statutory mandated services in healthcare.	W0318		

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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W0107	COMPLIANCE W FEDERAL, STATE & LOCAL LAWS CFR(s): 483.410(b) The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to health. This STANDARD is NOT MET as evidenced by: The facility failed to ensure all applicable provisions of Federal, State and local laws and regulations pertaining to staff training in emergency procedures, specifically Cardiopulmonary Resuscitation (CPR) and First Aid; medication administration; alternatives to restrictive interventions; and seclusion, physical restraint and isolation time-out (W107). A. Record reviews on 5/12/26 revealed home manager (HM), staff A and staff B failed to have CPR/First Aid certification as required. Record reviews on 5/12/26 for HM, staff A and staff B revealed: HM, was initially hired on 10/2/23. No record of CPR/First Aid training was available. Staff A, Direct Support Professional (DSP), was initially hired on 9/26/25. No record of CPR/First Aid training was available. Staff B, DSP, was initially hired on 9/30/25. No record of CPR/First Aid training was available. Interview on 5/12/26 with the qualified intellectual disabilities professional (QIDP) revealed that no documentation could be located to show staff in the home had received CPR certification outside of the facility or prior to beginning their employment. When asked what staff were trained to do in the case of a life-threatening emergency or choking, staff are directed to call the emergency medical services (EMS). State Rule at 10A NCAC 27G .0202 Personnel Requirements required at least one staff, per shift, had the training and current certification from a course, similar to the American Heart Association on CPR and First Aid. B. Record reviews on 5/12/26 revealed HM, staff A and staff B failed to have medication administration training as required. Record reviews revealed: HM was initially hired on 10/2/23. No record of medication administration training could be located.	W0107		

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W0107	Continued from page 2 Staff A, DSP, was initially hired on 9/26/25. No record of medication administration training could be located. Staff B, DSP, was initially hired on 9/30/25. No record of medication administration training could be located. Interview on 5/12/26 with the QIDP revealed that no documentation could be located to show that staff in the home received medication administration training. The QIDP confirmed that all staff administer medications. Interview on 5/12/26 with the nurse revealed she started working at the facility on 4/13/26 and had not done any observations in the home yet. State Rule at 10A NCAC 27G .0209(C)(3): Medication Administration: Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. C. Record reviews on 5/12/26 revealed HM and staff A failed to have alternatives to restrictive interventions training or training for seclusion, physical restraint and isolation time out. HM, was initially hired on 10/2/23. No record of alternatives to restrictive interventions training or training for seclusion, physical restraint and isolation time out could be located. Staff A, DSP, was initially hired on 9/26/25. No record of alternatives to restrictive interventions training or training for seclusion, physical restraint and isolation time out could be located. Interview on 5/12/26 with the QIDP revealed that only one staff had current training on alternatives to restrictive interventions and seclusion, physical restraint and isolation time out training that she received from a previous employer, and no documentation could be located to show that any other staff had received training. The QIDP revealed that the home had not used restrictive interventions in some time. However, all 6 clients residing in the home have behavior plans and some behavior support plans include Exclusionary Time Out. State Rule at 10A NCAC 27E .0107 Training on Alternatives to Restrictive Intervention: Facilities shall implement policies and practices that	W0107		

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W0107	Continued from page 3 emphasize the use of alternatives to restrictive interventions; and 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint and Isolation Time-Out: Seclusion, physical restraint and isolation may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. The cumulative effect of this systemic practice resulted in the facility's failure to provide statutorily mandated personnel training on CPR and First Aid, medication administration training and alternatives to restrictive interventions and seclusion, physical restraint and isolation time out to ensure knowledge and skills to administer care without causing injury.	W0107		
W0129	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 observation and interview, the facility failed to ensure personal privacy for 1 of 5 audit clients (#5). The finding is: During evening observations on 5/11/26 in the home, at 4:50pm, client #4 walked into client #5's room and grabbed the key resting above client #5's door. Further observations revealed that client #4 then proceeded to use it to open his door, wake him up, and tell him to go to the kitchen to make Kool-Aid. Record Review on 5/12/26 of client #4's Behavior Support Plan (BSP) dated 7/22/25 revealed that client #4 exhibits severe disruptive behavior, including making loud noises that bother his peers and entering peers' bedrooms. Interview on 5/12/26 with the qualified intellectual disabilities professional (QIDP) revealed that staff should have intervened and stopped client #4 from entering client #5's room unannounced.	W0129		
W0210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the	W0210		

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W0210	Continued from page 4 preliminary evaluation conducted prior to admission. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to obtain an audiological evaluation, vision assessment, speech and language evaluation (SLE), physical therapy evaluation (PT) or occupational therapy evaluation (OT) for 1 of 1 newly admitted audit clients (#4). The finding is: Review on 5/11/26 of client #4's record revealed the client was admitted to the facility on 6/18/25. Further record review on 5/11/26 revealed client #4 had not received an audiological evaluation, vision assessment, SLE, PT evaluation or OT evaluation. Interview on 5/12/26 with the qualified intellectual disabilities professional confirmed client #4 had not received an audiological evaluation, vision assessment, SLE, PT evaluation or OT evaluation since admission.	W0210		
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 interviews, the facility failed to continuously implement the Individual Support Plans (ISP). This affected 2 of 5 audit clients (#3 and #4). The finding is: During evening observations on 5/11/26 in the home, client #5 entered at 3:20pm and was not seen again until 4:50pm, after another client went to get him. Staff never checked on client #5 for over an hour and a half. Record review on 5/12/26 of client #5's ISP dated 2/10/26 revealed that staff should ask client #5 how he is, how he is doing, and what he may need help with. Staff should support client rights and choices for leisure activities.	W0249		

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W0249	Continued from page 5 Interview on 5/12/26 with the qualified intellectual disabilities professional (QIDP) revealed that staff should have checked on client #5 at least once an hour.	W0249		
W0252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is NOT MET as evidenced by: The facility failed to ensure data relative to accomplishment of the criteria specified in the individual support plan (ISP) objectives were documented in measurable terms. The affected 2 of 5 audit clients (#4 and #5). The findings are: A. Review on 5/11/26 of client #4's behavior support plan (BSP) dated 7/23/25 revealed client #4 is prescribed Hydroxyzine for insomnia. Further record review on 5/12/26 revealed no evidence of sleep data in client #4's record. Interview on 5/12/26 with the qualified intellectual disabilities professional (QIDP) revealed that the facility does not record sleep data for client #4. The QIDP also confirmed that the facility would be unable to determine the medications effectiveness without sleep data. B. Review on 5/11/26 of client #5's BSP dated 11/4/25 revealed that client #5 is prescribed Trazodone for insomnia. Interview on 5/12/26 with the QIDP revealed that the facility does not record sleep data for client #5. The QIDP also confirmed that the facility would be unable to determine the medication's effectiveness without sleep data.	W0252		
W0262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage 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:	W0262		

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W0262	Continued from page 6 Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 2 of 5 audit clients (#4 and #5) was reviewed and monitored by the human rights committee (HRC). The findings are: A. Record review on 5/11/26 of client #4's behavior support plan (BSP) dated 7/22/25 revealed target behaviors for severe disruptive behaviors, depressive/psychotic symptoms, threats and/or attempts of self-harm and failure to make responsible choices. The BSP listed the use of the medications Duloxetine, Prazosin, Risperidone, Guanfacine and Hydroxyzine. The BSP also listed the use of exclusionary time out and restricted access to knives and objects that could be used for hanging himself. Further review on 5/11/26 of client #4's BSP revealed no HRC consent could be located. Interview on 5/12/26 with the qualified intellectual disabilities professional (QIDP) revealed no HRC consent for client #4 had been obtained. B. Record review on 5/11/26 of client #5's BSP dated 11/4/25 revealed target behaviors for severe disruptive behaviors, aggression, and failure to make responsible choices. The BSP listed the use of the medications Depakote, Guanfacine, Geodon, and Trazodone. Further review on 5/11/26 of client #5's BSP revealed that no HRC consent could be located. Interview on 5/12/26 with the QIDP revealed that no HRC consent for client #4 had been obtained.	W0262		
W0263	PROGRAM MONITORING & CHANGE 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 record review and interviews, the facility failed to ensure restrictive programs were only conducted with written informed consent of a legal guardian. This affected 1 of 5 audit clients (#4). The finding is:	W0263		

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W0263	Continued from page 7 Record review on 5/11/26 of client #4's behavior support plan (BSP) dated 7/22/25 revealed target behaviors for severe disruptive behaviors, depressive/psychotic symptoms, threats and/or attempts of self-harm and failure to make responsible choices. The BSP listed the use of the medications Duloxetine, Prazosin, Risperidone, Guanfacine and Hydroxyzine. The BSP also listed the use of exclusionary time out and restricted access to knives or anything client #4 could use to hang himself. Further review on 5/11/26 of client #4's BSP revealed no guardian consent could be located. Interview on 5/12/26 with the qualified intellectual disabilities professional (QIDP) revealed no guardian consent for client #4 had been obtained.	W0263		
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 and interviews, the facility failed to ensure staff were sufficiently trained in medication administration. This affected 2 of 5 audit clients (#2 and #3). The finding is: Observations on 5/11/26 during the medication pass from 3:52pm to 3:55pm, staff D was observed administering medications to client #2 and client #3. At no time did staff D open the medication administration record (MAR) to ensure the correct medications were being administered. Interview on 5/12/26 with the facility nurse revealed that staff should always compare the medications being given to the MAR during medication pass.	W0340		
W0341	NURSING SERVICES CFR(s): 483.460(c)(5)(ii) 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 control	W0341		

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W0341	Continued from page 8 of communicable diseases and infections, including the instruction of other personnel imethods of infection control. This STANDARD is NOT MET as evidenced by: Based on observation and interviews, the facility failed to ensure staff were sufficiently trained in health and hygiene methods. This potentially affected all clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: During observations on 5/11/26 of medication administration at 3:52pm and 3:55pm, client #2 and client #3 were observed taking medication. At no time were clients instructed to wash or sanitize their hands. Further observations on 5/11/26 of meal prep from 4:00pm through 5:10pm, client #4 was observed assisting staff with meal prep. Client #4 touched raw chicken various times and was never prompted during meal prep to wash his hands. At 4:34pm, client #4 was observed breaking off a piece of a rice krispy treat and putting it into client #3's mouth. At 5:05pm, client #1 went into the kitchen to obtain silverware, plates and cups to set the table for dinner and was never prompted to wash his hands. At 5:10pm, the clients go to the dining room to sit down for dinner and were not prompted to wash or sanitize their hands. During observations on 5/12/26 of medication administration at 7:10am and 7:15am, client #3 and client #1 were observed taking medication. At no time were clients instructed to wash or sanitize their hands. Interview on 5/12/26 with the facility nurse revealed she just started working at the facility on 4/13/26 and was unsure what staff were trained on regarding health and hygiene methods. The nurse also confirmed she had not done any observations in the home yet. The nurse confirmed that staff and clients should be washing their hands before medication administration and while preparing meals.	W0341		
W0352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is NOT MET as evidenced by:	W0352		

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W0352	Continued from page 9 Based on the record review and interview, the facility failed to ensure a comprehensive dental examination was performed at least annually. This affected 1 of 5 audit clients (#2). The finding is: Record review on 5/12/26 of client #2, Individual Support Plan (ISP) dated 11/17/26 revealed a dental appointment on 11/16/24, client #2 received no treatment, even with sedation medication. Further review of client #2's dental evaluation dated 1/29/25 revealed no treatment due to client #2 being uncooperative, and no X-rays were taken. Interview on 5/12/26 with the Qualified Intellectual Disabilities Professional revealed that client #2 should have been scheduled for another dental appointment.	W0352		
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 3 of 5 audit clients (#1, #2 and #3). The findings are: A. During observations of medication administration in the home on 5/11/26 at 3:52pm, staff D administered Diazepam 5mg to client #2. Review on 5/12/26 of client #2's physician's orders dated 11/17/25 revealed an order for Diazepam 5mg, take 1 tablet by mouth twice daily at 8am, and 8pm. Interview on 5/12/26 with the facility nurse revealed she could not find an updated order for client #2 to have received Diazepam 5mg at 3:52pm. B. During observations of medication administration on 5/12/26 at 7:10am, the home manager (HM) administered Chlorhexidine 7.5ml on a mouth swab to client #3. Review on 5/12/26 of client #3's physician's orders dated 11/17/25 revealed an order for Antiseptic Mouth Rinse, wipe gum line after brushing teeth for two minutes daily at 8pm.	W0369		

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W0369	Continued from page 10 Interview on 5/12/26 with the facility nurse revealed she could not find an updated order for client #3 to have received Chlorhexidine at 7:10am. C. During observations of medication administration on 5/12/26 at 7:15am, the home manager (HM) administered Atorvastatin 10mg to client #1. Review on 5/12/26 of client #1's physician's orders dated 11/17/25 did not list Atorvastatin as medication prescribed. Interview on 5/12/26 with the facility nurse revealed she could not find an updated order for Atorvastatin to be administered to client #1.	W0369		
W0440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is NOT MET as evidenced by: Based on the record review and interview, the facility failed to ensure fire drills were held at least quarterly for each shift. This potentially affected all clients residing in the home (#1, #2, #3, #4, and #5). The finding is: Review on 5/12/26 of the facility's fire drills revealed no third shift drill between Oct. and Dec. 2025. Further review revealed only one drill documentation for the first quarter of 2026: a first-shift drill dated 2/17/26. No other fire drills were available for that quarter. Interview on 5/12/26 with a Qualified Intellectual Disabilities Professional confirmed that the facility was unable to show documentation of fire drills completed for that quarter.	W0440		
W0448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to investigate all problems with evacuation drills. This potentially affected all clients (#1, #2, #3,	W0448		

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W0448	Continued from page 11 #4, and #5). The finding is: Review on 5/12/26 of facility fire drills revealed multiple evacuation times over 3 minutes. Some drills are completed in 6 minutes, 10 minutes, 15 minutes, and 30 minutes. All clients in the home are ambulatory and do not use adaptive equipment to ambulate. Interview on 5/12/26 with QIDP revealed facility policy on fire drills is that they should be completed in 3 minutes or less.	W0448		
E0037	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 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	E0037		

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NAME OF PROVIDER OR SUPPLIER: **AVENT FERRY HOME**		STREET ADDRESS, CITY, STATE, ZIP CODE: **904 AVENT FERRY ROAD , HOLLY SPRINGS, North Carolina, 27540**	

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E0037	Continued from page 12 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. *[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	E0037		

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E0037	Continued from page 13 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 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	E0037		

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E0037	Continued from page 14 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. 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 plan review and interview, the facility failed to develop and maintain an updated, at least annually, Emergency Preparedness Program training and testing program meeting all requirements. On 5/11/26, while reviewing the Emergency Preparedness Program, it was revealed that the facility failed to provide an Emergency Preparedness	E0037		

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E0037	Continued from page 15 Program that staff are annually trained on. Interview on 5/12/26 with the Qualified Intellectual Disabilities Professional revealed that staff should have been trained on the Emergency Preparedness Program.	E0037		
E0039	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 a	E0039		

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E0039	Continued from page 16 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 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	E0039		

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E0039	Continued from page 17 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. *[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	E0039		

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E0039	Continued from page 18 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):] (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	E0039		

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E0039	Continued from page 19 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 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.	E0039		

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E0039	Continued from page 20 (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. *[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:	E0039		

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E0039	Continued from page 21 (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. *[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	E0039		

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E0039	Continued from page 22 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 plan review and interview, the facility failed to develop and maintain, at least annually, an updated Emergency Preparedness Program training and testing program, including unannounced staff drills using the emergency procedures. Review on 5/11/26 of the Emergency Preparedness Plan revealed no documentation of training and testing of the program. Interview on 5/12/26 with the qualified intellectual disabilities professional (QIDP) revealed that they have no Emergency Preparedness Plan annual training.	E0039		
W0460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is NOT MET as evidenced by: Based on observations, record review, and interview, the facility failed to provide specially prescribed diets for 1 of 5 audit clients (#3). The finding is:	W0460		

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NAME OF PROVIDER OR SUPPLIER: **AVENT FERRY HOME**		STREET ADDRESS, CITY, STATE, ZIP CODE: **904 AVENT FERRY ROAD , HOLLY SPRINGS, North Carolina, 27540**	

(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
W0460	Continued from page 23 During evening observations on 5/11/26, at 5:04pm, client #3 received a whole regular chunky chicken, tortilla wrap, rice, and beans. Record review on 5/12/26 of client #3's Individual Support Plan (ISP) revealed that client #3 follows a regular, finely chopped diet. Interview on 5/12/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that client #3's food should have been finely chopped.	W0460		