		AND HUMAN SERVICES			Ο		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mult A. Buildi		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G236	B. WING			04/2	25/2023
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE PIN	E VALLEY HOME				519 ROBERT E LEE DRIVE /ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 036	EP Training and Te CFR(s): 483.475(d)		E 03	36			
	§441.184(d), §460. §483.475(d), §484. §485.542(d), §485.	54(d), §418.113(d), 84(d), §482.15(d), §483.73(d), 102(d), §485.68(d), 625(d), §485.727(d), 360(d), §491.12(d),					
	Hospice at §418.11 at §460.84, Hospita §484.102, CORFs CAHs at §486.625, 485.727, CMHCs a §486.360, and RHC Training and testing and maintain an en training and testing emergency plan se section, risk assess this section, policie (b) of this section, a paragraph (c) of thi testing program mu least every 2 years *[For LTC facilities and testing. The L maintain an emergency and testing program emergency plan se section, risk assess this section, nolicies (b) of this section, a paragraph (c) of this section, risk assess this section, policie (b) of this section, a paragraph (c) of this	403.748, ASCs at §416.54, 3, PRTFs at §441.184, PACE als at §482.15, HHAs at at §485.68, REHs at §485.542, "Organizations" under t §485.920, OPOs at C/FHQs at §491.12:] (d) g. The [facility] must develop hergency preparedness program that is based on the t forth in paragraph (a) of this sment at paragraph (a)(1) of s and procedures at paragraph and the communication plan at s section. The training and ust be reviewed and updated at at §483.73(d):] (d) Training TC facility must develop and ency preparedness training n that is based on the t forth in paragraph (a) of this sment at paragraph (a) of this sment at paragraph (a)(1) of s and procedures at paragraph and the communication plan at s section. The training and ust be reviewed and updated at					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 04/26/2023

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.

		AND HUMAN SERVICES				FORM	04/26/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G236	B. WING			04/:	25/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE PIN	E VALLEY HOME				519 ROBERT E LEE DRIVE VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 036	*[For ICF/IIDs at §4 testing. The ICF/IID an emergency prep program that is bas forth in paragraph (assessment at para policies and proced section, and the col paragraph (c) of this testing program mul- least every 2 years. requirements for ev §483.470(i). *[For ESRD Facilitie testing, and orientat develop and maintat preparedness trainit orientation program emergency plan set section, risk assess this section, policies (b) of this section, at paragraph (c) of this and orientation program emergency Plan set section, risk assess this section, policies (b) of this section, at paragraph (c) of this and orientation program emergency Prepare failed to ensure all so on the EP plan. The Review on 4/24/23 documentation rever received training or Interview on 4/25/25	83.475(d):] Training and o must develop and maintain paredness training and testing ed on the emergency plan set a) of this section, risk agraph (a)(1) of this section, lures at paragraph (b) of this mmunication plan at s section. The training and ust be reviewed and updated at . The ICF/IID must meet the vacuation drills and training at es at §494.62(d):] Training, tion. The dialysis facility must ain an emergency ing, testing and patient o that is based on the t forth in paragraph (a) of this sment at paragraph (a)(1) of s and procedures at paragraph and the communication plan at s section. The training, testing gram must be evaluated and years. s not met as evidenced by: v and review of the facility's edness (EP) plan, the facility staff were adequately trained	E	036			

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		AND HUMAN SERVICES				FORM	04/26/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		34G236	B. WING			04/2	25/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE PINE	E VALLEY HOME				519 ROBERT E LEE DRIVE VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 036	• • • • • • • • • • • • • • • • • • •	-	E 0)36			
E 039	for training on the E EP Testing Require CFR(s): 483.475(d)	ments	E 0	39			
	§460.84(d)(2), §482 §483.475(d)(2), §48 §485.542(d)(2), §48	8.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.68(d)(2), 35.625(d)(2), §485.727(d)(2), 91.12(d)(2), §494.62(d)(2).					
	at §485.542, OPO, §485.727, CMHCs a	54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]:					
		cility] must conduct exercises acy plan annually. The [facility] bllowing:					
	community-based e (A) When a commu accessible, conduct exercise every 2 yea (B) If the [facility natural or man-mad activation of the em exempt from engag community-based o functional exercise actual event. (ii) Conduct an addi years, opposite the functional exercise this section is condu not limited to the fol (A) A second full-sc	unity-based exercise is not t a facility-based functional ears; or y] experiences an actual de emergency that requires hergency plan, the [facility] is ging in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing:					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/26/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G236	B. WING			04/25/2023	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE PINI	E VALLEY HOME				1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	functional exercise; (B) A mock disaster (C) A tabletop exerce a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (iii) Analyze the [fac maintain documents exercises, and eme [facility's] emergence *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based e (A) When a commu- accessible, conduct functional exercise (B) If the hospice ex- man-made emergent the emergency plane engaging in its next community-based functions onset of the emergent (ii) Conduct an add opposite the year the exercise under para- is conducted, that in to the following: (A) A second full-so	or drill; or drill; or dise or workshop that is led by udes a group discussion using -relevant emergency of problem statements, or prepared questions ge an emergency plan. ility's] response to and ation of all drills, tabletop rgency events, and revise the y plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least ice must do the following: ull-scale exercise that is very 2 years; or nity based exercise is not an individual facility based every 2 years; or correspondences a natural or ney that requires activation of the hospital is exempt from required full scale xercise or individual onal exercise every 2 years, e full-scale or functional or any include, but is not limited	EC	039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/26/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G236	B. WING			04/:	25/2023
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE PIN	E VALLEY HOME				1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	 (B) A mock disaste (C) A tabletop exer a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (3) Testing for hosp care directly. The h exercises to test the year. The hospice of (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based function (B) If the hospice ex- man-made emerged the emergency plan engaging in its next based or facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-sec community-based or exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerged (iii) Analyze the hose maintain documental 	r drill; or cise or workshop that is led by udes a group discussion using y-relevant emergency of problem statements, or prepared questions ge an emergency plan. ices that provide inpatient tospice must conduct e emergency plan twice per must do the following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual onal exercise; or xperiences a natural or ncy that requires activation of a, the hospice is exempt from required full-scale community sed functional exercise of the emergency event. litional annual exercise that not limited to the following: cale exercise that is or a facility based functional r drill; or cise or workshop led by a des a group discussion using a elevant emergency scenario, n statements, directed ared questions designed to	E)39			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/26/2023 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		34G236	B. WING			04/25/2023		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
THE PIN	E VALLEY HOME				1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
E 039	Continued From pa hospice's emergeno	-	EC)39				
	§482.15(d), CAHs a (2) Testing. The [PF conduct exercises t twice per year. The do the following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the [PRTF, Ho actual natural or marequires activation of [facility] is exempt for required full-scale of facility-based function onset of the emerge (ii) Conduct an and that may includ following: (A) A second full-sc community-based of functional exercise; (B) A mock (C) A tabletop e led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the maintain documents	RTF, Hospital, CAH] must o test the emergency plan e [PRTF, Hospital, CAH] must annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based						

		FORM	04/26/2023 APPROVED 0938-0391
` ´	TPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
B. WING _		04/25/2023	
	STREET ADDRESS, CITY, STATE, ZIP CODE		
	1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		
ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
E 03			
	A. BUILDII B. WING B. WING D PREFIX TAG	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI	OMB NO. (X2) MULTIPLE CONSTRUCTION (X3) DATE COMP A. BUILDING COMP B. WING 04/2 STREET ADDRESS, CITY, STATE, ZIP CODE 04/2 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412 04/2 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

Facility ID: 921588

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/26/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		34G236	B. WING			04/2	25/2023
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE PIN	E VALLEY HOME				I519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	Continued From pa	ge 7	EC)39			
	test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based functii (B) If the [LTC facili actual natural or ma- requires activation of LTC facility is exem requires activation of LTC facility is exem requires activation of LTC facility is exem required a full-scale individual, facility-ba- following the onset (ii) Conduct an add may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the [LT and maintain docum exercises, and emerge [LTC facility] facility *[For ICF/IIDs at §4	 g) must conduct exercises to plan at least twice per year, ced staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise. ty] facility experiences an an-made emergency that of the emergency plan, the pt from engaging its next e community-based or ased functional exercise of the emergency event. titional annual exercise that not limited to the following: cale exercise that is or an individual, facility based or er drill; or cise or workshop that is led by a group discussion, using a relevant emergency scenario, n statements, directed ared questions designed to gency plan. C facility] facility's response to nentation of all drills, tabletop ergency events, and revise the s emergency plan, as needed. 					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/26/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G236	B. WING			04/	25/2023
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE PIN	E VALLEY HOME				1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	to test the emergen The ICF/IID must di (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the ICF/IID ex- man-made emergen the emergency plan engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addit may include, but is (A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exerce a facilitator and incl using a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the ICF maintain document exercises, and emer ICF/IID's emergence *[For HHAs at §484 (d)(2) Testing. The to test the emergen least annually. The (i) Participate in a fu	cy plan at least twice per year. o the following: annual full-scale exercise that d; or inity-based exercise is not t an annual individual, onal exercise; or. periences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from required full-scale or individual, facility-based following the onset of the itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based or drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. //IID's response to and ation of all drills, tabletop ergency events, and revise the ey plan, as needed. .102] HHA must conduct exercises cy plan at HHA must do the following: ull-scale exercise that is	EC	039			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/26/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G236	B. WING	i		04/:	25/2023
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE PIN	E VALLEY HOME				1519 ROBERT ELEE DRIVE WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	accessible, conduct facility-based function or. (B) If the HHA or man-made emer of the emergency p engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi opposite the year the exercise under para is conducted, that limited to the follow (A) A second functional exercise; (B) A mock disa (C) A tabletop et led by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HHL documentation of a emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The following: (i) Conduct a paper workshop at least a	t an annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation lan, the HHA is exempt from required full-scale or individual, facility based following the onset of the tional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section t may include, but is not ing: Ill-scale exercise that is or an individual, facility-based or aster drill; or exercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency A's response to and maintain II drills, tabletop exercises, and and revise the HHA's a needed.	E	039			

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		AND HUMAN SERVICES				FORM	04/26/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		34G236	B. WING			04/2	25/2023
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE PIN	E VALLEY HOME				1519 ROBERT ELEE DRIVE WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	discussion, using a emergency scenari statements, directe questions designed plan. If the OPO ex man-made emerge the emergency plar engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followin (i) Conduct a paper least annually. A tat discussion led by a clinically-relevant en of problem stateme prepared questions emergency plan. (ii) Analyze the RNH maintain document and emergency eve emergency plan, as This STANDARD is Based on document facility failed to ensi- community-based of their Emergency Pr conducted. The fir Review on 4/24/23 reviewed on 1/9/23	narrated, clinically relevant o, and a set of problem d messages, or prepared to challenge an emergency periences an actual natural or ncy that requires activation of n, the OPO is exempt from required testing exercise of the emergency event. O's response to and maintain II tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: -based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's a needed. s not met as evidenced by: nt review and interviews, the ure full scale or tabletop exercises to test reparedness (EP) plan were	EC	039			

		AND HUMAN SERVICES				FORM	04/26/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE	E SURVEY PLETED
		34G236	B. WING			04/2	25/2023
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE PINI	E VALLEY HOME				519 ROBERT E LEE DRIVE /ILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	Continued From pa	ge 11	EO	39			
W 288	and Qualified Intellet (QIDP) confirmed n exercise or tabletop at the home.		W 2	88			
	behavior must never an active treatment This STANDARD is Based on observat interviews, the facilit to manage inapproprin an active treatment	age inappropriate client er be used as a substitute for program. s not met as evidenced by: tions, record reviews and ity failed to ensure a technique priate behaviors was included ent program. This affected 2 of and #5). The findings are:					
	4:17pm and on 4/25 key to unlock a close home. Closer observed	tions in the home on 4/24/23 at 5/23 at 8:01am, staff utilized a set in a back office of the rvation of the closet revealed a g coloring books, puzzles and					
	D revealed the bag client #5. Additional are locked because	4/25/23 with Staff A and Staff of leisure items belonged to I interview indicated the items e client #5 will try to play with ce and likes to rip all of the pooks.					
	Program Plan (IPP) things that are impo	of client #5's Individual) dated 6/28/22 revealed the ortant to him include, "His d his leisure activities."					

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		AND HUMAN SERVICES				FORM	04/26/2023 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
34G236		34G236	B. WING			04/25/2023		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE PINE VALLEY HOME			1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 288	EVALLEY HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 Additional review of the record did not include an active treatment program to keep his leisure activities locked. Interview on 4/25/23 with the Qualified Intellectual Disabilities Professional (QIDP) indicated a technique of locking away client #5's personal leisure items was not included in a formal active treatment program. B. During 2 of 3 mealtime observations in the home throughout the survey on 4/24 - 4/25/23, staff consistently removed client #4's plate/bowl of food out of her reach as she attempted to pick up food from her dish. The client was frequently prevented from eating and made to wait. Interview on 4/25/23 of client #4's IPP dated 7/26/22 revealed Rate of Eating guidelines dated 7/10/17. The guidelines noted, "Staff will monitor [Client #4] during meals at the group home and at the day program to ensure she maintains a proper rate of eating" Additional review of the record did not include a formal active treatment program for physically removing the client's food from her at meals to slow her rate of eating. Interview on 4/25/23 with the QIDP confirmed a technique of removing client #4's food out of her reach to address eating too fast was not included in a formal active treatment program.		W 2					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		DENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		B. WING _		04	04/25/2023		
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
THE PIN	E VALLEY HOME			1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIOI DATE	
W 368	Continued From page 13 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. This affected 1 of 3 audit clients (#4) observed receiving medications. The finding is: During observations of medication administration in the home on 4/25/23 at 7:45am, client #4 received Neo/Poly/Dex ointment 0.1% in both eyes.		W 36	58			
W 369	orders signed 4/5/2 Neo/Poly/Dex ointr twice a day8:00 Interview on 4/25/2 confirmed client #4 ointment in both ey DRUG ADMINISTF CFR(s): 483.460(k The system for dru that all drugs, inclu self-administered, This STANDARD Based on observa interview, the facili medications were a This affected 1 of 3	23 with the facility's nurse 4 should not have received the /es. RATION	W 36	59			

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		AND HUMAN SERVICES				FORM	04/26/2023 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
34G236		B. WING			04/25/2023		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE PIN	E VALLEY HOME		1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 369	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		W 3				

Facility ID: 921588

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