PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
		34G236	B. WING	i	04	/25/2023
	PROVIDER OR SUPPLIER E VALLEY HOME			STREET ADDRESS, CITY, STATE, ZIP CO 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		12012020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
	§483.475(d), §484.1 §485.542(d), §485.6 §485.920(d), §486.3 §494.62(d). *[For RNCHIs at §40 Hospice at §418.113 at §460.84, Hospital §484.102, CORFs at §486.625, '485.727, CMHCs at §486.360, and RHC. Training and testing and maintain an emetraining and testing pemergency plan set section, risk assess this section, policies (b) of this section, ar paragraph (c) of this testing program must least every 2 years. *[For LTC facilities at and testing. The LTC facilities at and testing. The LTC	54(d), §418.113(d), 34(d), §482.15(d), §483.73(d), 102(d), §485.68(d), 525(d), §485.727(d), 360(d), §491.12(d), 03.748, ASCs at §416.54, 3, PRTFs at §441.184, PACE s at §482.15, HHAs at t §485.68, REHs at §485.542, 'Organizations" under §485.920, OPOs at /FHQs at §491.12:] (d) The [facility] must develop ergency preparedness program that is based on the forth in paragraph (a) of this ment at paragraph (a) (1) of and procedures at paragraph and the communication plan at section. The training and at be reviewed and updated at t §483.73(d):] (d) Training C facility must develop and	ΕO	All DSPs will receive training on the Emer Plan by 6/1/2023, conducted by the Qu Assurance/ Improver (QA/QI) Coordinator also serves as the saf officer. The QA/QI Coordinator will sche yearly training and w follow-up to ensure a DSPs receive the train annually.	uality ment who ety edule vill	
	maintain an emerger and testing program emergency plan set i section, risk assessn this section, policies (b) of this section, an paragraph (c) of this	ncy preparedness training		DHSR - Mei MAY 1 0 Lic. & Cert.	2023	
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		X6) DATE

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.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY MPLETED
		34G236	B. WING_		04	1/25/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		1720/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD 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 (a assessment at parapolicies and proced section, and the corparagraph (c) of this testing program muleast every 2 years. requirements for every experience of the section, and orientate develop and maintain preparedness training orientation program emergency plan set section, risk assessing this section, policies (b) of this section, and paragraph (c) of this and orientation program emergency prepared failed to ensure all sign the EP plan. The Review on 4/24/23 of documentation reveal received training on Interview on 4/25/23 Disabilities Profession	83.475(d):] Training and must develop and maintain aredness training and testing ed on the emergency plan set a) of this section, risk graph (a)(1) of this section, ures at paragraph (b) of this numinication plan at a section. The training and st be reviewed and updated at The ICF/IID must meet the acuation drills and training at a set §494.62(d):] Training, ion. The dialysis facility must in an emergency ng, testing and patient that is based on the forth in paragraph (a) of this ment at paragraph (a) of this ment at paragraph (a) (1) of and procedures at paragraph and the communication plan at section. The training, testing ram must be evaluated and ears. not met as evidenced by: and review of the facility's dness (EP) plan, the facility taff were adequately trained	E 03	6		

//. Boilebille	S	COMPLETED
34G236 B. WING		04/25/2023
THE PINE VALLEY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412 PROVIDER'S PLAN OF CORRECTION	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
E 036 Continued From page 2 for training on the EP plan. E 039 EP Testing Requirements CFR(s): 483.475(d)(2) \$416.54(d)(2), \$418.113(d)(2), \$441.184(d)(2), \$460.84(d)(2), \$482.15(d)(2), \$483.73(d)(2), \$483.475(d)(2), \$485.625(d)(2), \$485.727(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		of for sure y to nitial

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		34G236	B. WING		0.4	1/25/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		78072020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 039	a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (iii) Analyze the [faci 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 ficommunity based e (A) When a community based e (A) When a community based e (B) If the hospice exemples and emergency planengaging in its next community-based endicition onset of the emergency (ii) Conduct an addition opposite the year the exercise under paratic conducted, that me to the following: (A) A second full-scenario	or 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. ility's] response to and ation of all drills, tabletop rgency events, and revise the ty plan, as needed. 18.113(d):] bices that provide care in the end hospice must conduct the emergency plan at least ice must do the following: ull-scale exercise that is exercise is not an individual facility based exercise is not an individual facility based exercise or individual exercise or individual exercise or individual exercise or individual exercise following the ency event. Itional exercise every 2 years, the full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited	EOS	39		

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Not the American	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		34G236	B. WING		04	/25/2023
	PROVIDER OR SUPPLIER E VALLEY HOME			STREET ADDRESS, CITY, STATE, ZIP CODI 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	(B) A mock disaste (C) A tabletop exer a facilitator and incident a narrated, clinically scenario, and a set directed messages designed to challent (3) Testing for hospicare directly. The hexercises to test the year. The hospice (i) Participate in an is community-based (A) When a community-based function (B) If the hospice expansible, conduct facility-based function (B) If the hospice expansible emergency planengaging in its next based or facility-based or facilitator that including an a set of problem messages, or prepare challenge an emerg (iii) Analyze the hospical facilitation that including the order of the facility	er drill; or roise or workshop that is led by ludes a group discussion using y-relevant emergency of problem statements, or prepared questions ge an emergency plan. Idea that provide inpatient hospice must conduct emergency plan twice per must do the following: annual full-scale exercise that di; or unity-based exercise is not an annual individual onal exercise; or experiences a natural or noty that requires activation of an the hospice is exempt from required full-scale community sed functional exercise of the emergency event. It into a limited to the following: cale exercise that is refacility based functional exercise that is refacility based functional exercise or workshop led by a less a group discussion using a elevant emergency scenario, in statements, directed ared questions designed to	EO	39		

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		34G236	B. WING _		04	/25/2023
	PROVIDER OR SUPPLIER E VALLEY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		, 20, 2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	§482.15(d), CAHs a (2) Testing. The [PR conduct exercises to 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 ma requires activation of [facility] is exempt for required full-scale cof acility-based function onset of the emerge (ii) Conduct an and that may include following: (A) A second full-sc community-based or functional exercise; (B) A mock of (C) A tabletop ex led by a facilitator and	2. plan, as needed. 1.184(d), Hospitals at t §485.625(d):] 3. TF, Hospital, CAH] must to test the emergency plan [PRTF, Hospital, CAH] must annual full-scale exercise that it; or nity-based exercise is not an annual individual, anal exercise; or spital, CAH] experiences an in-made emergency that if the emergency plan, the omengaging in its next annual exercise following the incy event. [additional] annual exercise or exercise that is individual, a facility-based or disaster drill; or exercise or workshop that is	E 039			
	statements, directed questions designed t plan. (iii) Analyze the [maintain documenta	, and a set of problem messages, or prepared to challenge an emergency facility's] response to and tion of all drills, tabletop gency events and revise the				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION	(XS	3) DATE SURVEY COMPLETED
		34G236	B. WING			04/25/2023
	PROVIDER OR SUPPLIER E VALLEY HOME			STREET ADDRESS, CITY, STATE, ZIP 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412	CODE	0 1120/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIAT	
	[facility's] emergence *[For PACE at §460 (2) Testing. The PACE exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the PACE export man-made emerger the emergency plan engaging in its next based or individual, exercise following the event. (ii) Conduct an a years opposite the y exercise under para is conducted that ma the following: (A) A second full-so community-based or functional exercise; (B) A mock disaster (C) A tabletop exerci a facilitator and inclu using a narrated, clir scenario, and a set of directed messages, designed to challeng (iii) Analyze the PAC maintain documenta	As plan, as needed. As (d):] CE organization must conduct be emergency plan at least be organization must do the emergency plan at least be organization must do the emergency plan at least be organization must do the emergency between the context an annual individual, and exercise; or eriences an actual natural or not that requires activation of the PACE is exempt from required full-scale community facility-based functional emergency emergency additional exercise every 2 ear the full-scale or functional graph (d)(2)(i) of this section and include, but is not limited to emergency be or workshop that is led by include a group discussion, inically-relevant emergency of problem statements, or prepared questions are an emergency plan. CE's response to and tion of all drills, tabletop gency events and revise the	EOS	39		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.0000000000000000000000000000000000000	IPLE CONSTRUCTION		TE SURVEY MPLETED
		34G236	B. WING_		04	/25/2023
	PROVIDER OR SUPPLIER E VALLEY HOME			STREET ADDRESS, CITY, STATE, ZIP COL 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		72072020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the [LTC facility actual natural or marequires activation of LTC facility is exemprequired a full-scale individual, facility-based following the onset (ii) Conduct an add may include, but is represented (A) A second full-scale individual, facility-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator includes narrated, clinically-reand a set of problem messages, or preparately cand maintain docume exercises, and emer [LTC facility] facility's *[For ICF/IIDs at §48]	at §483.73(d):]] must conduct exercises to plan at least twice per year, ced staff drills using the tres. The [LTC facility, et following: annual full-scale exercise that d; or nity-based exercise is not an annual individual, and exercise. y] facility experiences an in-made emergency that of the emergency plan, the out from engaging its next community-based or sed functional exercise of the emergency event. In the interior of the exercise that is an individual, facility based or drill; or cise or workshop that is led by a group discussion, using a elevant emergency scenario, in statements, directed a group discussion, using a elevant emergency scenario, in statements, directed a group discussion designed to ency plan. C facility] facility's response to entation of all drills, tabletop agency events, and revise the semergency plan, as needed.	E 03			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION		TE SURVEY MPLETED
		34G236	B. WING_		04	1/25/2023
	PROVIDER OR SUPPLIER E VALLEY HOME			STREET ADDRESS, CITY, STATE, ZIP COD 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412		72072020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 039	The ICF/IID must d (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the ICF/IID ex man-made emergency planengaging in its next community-based of functional exercises emergency event. (ii) Conduct an addinay include, but is a (A) A second full-secommunity-based of functional exercises; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, cliscenario, and a set directed messages, designed to challeng (iii) Analyze the ICF/maintain documenta exercises, and emerical exercises, and emerical exercises and emerical exercises.	cy plan at least twice per year. of the following: annual full-scale exercise that di; or inity-based exercise is not an annual individual, onal exercise; or. periences an actual natural or ncy that requires activation of the ICF/IID is exempt from required full-scale rindividual, facility-based following the onset of the stional annual exercise that not limited to the following: ale exercise that is ran individual, facility-based for drill; or ise or workshop that is led by udes a group discussion, nically-relevant emergency of problem statements, or prepared questions ge an emergency plan. IIID's response to and attion of all drills, tabletop regency events, and revise the or plan, as needed. 102] HHA must conduct exercises by plan at HHA must do the following: II-scale exercise that is	E 03	39		

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
		34G236	B. WING _		04	/25/2023
	PROVIDER OR SUPPLIER E VALLEY HOME			STREET ADDRESS, CITY, STATE, ZIP COL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 039	accessible, conduct facility-based function. (B) If the HHA or man-made emergor the emergency plengaging in its next community-based of functional exercise emergency event. (ii) Conduct an additional exercise under paralise conducted, that limited to the following (A) A second full community-based of functional exercise; (B) A mock disactional exercise; (B) A mock disaction	an annual individual, conal exercise every 2 years; experiences an actual natural gency that requires activation an, the HHA is exempt from required full-scale r individual, facility based following the onset of the stional exercise every 2 years, e full-scale or functional graph (d)(2)(i) of this section may include, but is not mg: el-scale exercise that is an individual, facility-based or ster drill; or exercise or workshop that is and includes a group marrated, clinically-relevant of, and a set of problem is messages, or prepared to challenge an emergency exercise the HHA's needed. 360] DPO must conduct exercises by plan. The OPO must do the based, tabletop exercise or inually. A tabletop exercise is	E 03			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY MPLETED
		34G236	B. WING _		04/	/25/2023
	PROVIDER OR SUPPLIER E VALLEY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	discussion, using a emergency scenario statements, directed questions designed plan. If the OPO expanded plan. If the OPO expanded plan is the emergency planengaging in its next following the onset of (ii) Analyze the OPO documentation of all emergency events, OPO's] emergency events, OPO's] emergency exercises to test the must do the followin (i) Conduct a paperleast annually. A tab discussion led by a folinically-relevant en of problem statemer prepared questions emergency plan. (ii) Analyze the RNH maintain documenta and emergency even emergency plan, as This STANDARD is Based on documentation for their Emergency Preconducted. The fine Review on 4/24/23 or Review on 4/2	narrated, clinically relevant of, and a set of problem of messages, or prepared to challenge an emergency periences an actual natural or ney that requires activation of the OPO is exempt from required testing exercise of the emergency event. O's response to and maintain abletop exercises, and and revise the [RNHCl's and plan, as needed. 748]: RNHCl must conduct emergency plan. The RNHCl g: based, tabletop exercise at letop exercise is a group facilitator, using a narrated, hergency scenario, and a set of the emessages, or designed to challenge an Cl's response to and tion of all tabletop exercises, and revise the RNHCl's needed. not met as evidenced by: treview and interviews, the refull scale tabletop exercises to test sparedness (EP) plan were ding is: f the facility's EP plan (last did not include a full scale	E 03			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		34G236	B. WING _		04/	25/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	and Qualified Inteller (QIDP) confirmed in exercise or tabletop at the home. MGMT OF INAPPR BEHAVIOR CFR(s): 483.450(b) Techniques to manabehavior must neve an active treatment This STANDARD is Based on observati interviews, the facilit to manage inappropin an active treatme 4 audit clients (#4 at 4.17pm and on 4/25 key to unlock a closhome. Closer obserlarge bag containing other smaller toys. Interview on 4/24 - 4 D revealed the bag of client #5. Additional are locked because everything all at onc pictures out of the because of the program Plan (IPP) things that are imposited.	3 with the Executive Director ectual Disabilities Professional of full scale community-based exercise had been conducted OPRIATE CLIENT (3) age inappropriate client robe used as a substitute for program. Sonot met as evidenced by: ions, record reviews and ty failed to ensure a technique priate behaviors was included int program. This affected 2 of ind #5). The findings are: ons in the home on 4/24/23 at at 8:01am, staff utilized a et in a back office of the vation of the closet revealed a grooloring books, puzzles and allowed to interview indicated the items client #5 will try to play with e and likes to rip all of the	E 039		ed e of	

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 THE PINE VALLEY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412				
PREFIX (EACH I	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
active trea activities to Disabilities technique leisure iter treatment. B. During home throstaff consist of food out up food from prevented. Interview of #4's food with fast". Review on 7/26/22 rev 7/10/17. T [Client #4] the day proper rate record did program for from her at Interview of technique of reach to accept to a	review of the there of her reproperties of locking ms was no program. 2 of 3 me ughout the stently reproperties of her properties of her properties of eating more included in physical meals to the reproperties of removidations of the physical active treatments of the	the record did not include an orgam to keep his leisure By with the Qualified Intellectual conal (QIDP) indicated a graway client #5's personal of included in a formal active realtime observations in the e survey on 4/24 - 4/25/23, moved client #4's plate/bowl each as she attempted to pick sh. The client was frequentlying and made to wait. By with Staff D revealed client wed because "she eats too of client #4's IPP dated ate of Eating guidelines dated lines noted, "Staff will monitor eals at the group home and at ensure she maintains a g" Additional review of the dea formal active treatment active treatment lly removing the client's food or slow her rate of eating. By with the QIDP confirmed a nig client #4's food out of her ting too fast was not included eatment program. ATION	W 2				

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
	PROVIDER OR SUPPLIER E VALLEY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) COMPLETION 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. Review on 4/25/23 of client #4's physician's orders signed 4/5/23 revealed an order for Neo/Poly/Dex ointment 0.1%, "apply into right eye twice a day8:00" Interview on 4/25/23 with the facility's nurse confirmed client #4 should not have received the ointment in both eyes. 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 interview, the facility failed to ensure all medications were administered without error. This affected 1 of 3 clients (#4) observed receiving medications. The finding is:		W 368	The DSP who admininst medication incorrectly was receive correction and additional training by 5/4/2023, by the LPN to ensure phsycial orders a followed. The LPN will monitor to ensure addit medication errors do no occur and will be available to answer questions and provide training on how administer specific	will ire ional it ole	

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
	PROVIDER OR SUPPLIER E VALLEY HOME			15	TREET ADDRESS, CITY, STATE, ZIP CODE 519 ROBERT E LEE DRIVE VILMINGTON, NC 28412		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 440	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 administration in the home on 4/25/23 at 7:37am, client #4 received one drop of Sodium Chloride Solution 5% in her left eye. Review on 4/25/23 of client #4's physician's orders signed 4/5/23 revealed an order for Sodium Chloride Solution 5%, "instill 1 drop into right eye twice a day8:00" Interview on 4/25/23 with the facility's nurse confirmed client #4's eye drops should have been administered into her right eye as ordered.		W 44	40 	The DSP who admininstered medication incorrectly will rece correction and additional training 5/4/2023, by the LPN to ensure phsycial orders are followed. The LPN will monitor to ensure additional medication errors do occur and will be available to a questions and provide training how to administer specific medications. The Qualified Professional will instruct DSPs to conduct quarter fire drills on each shift by 5/4/20. The QP will check at least 15 day prior to the end of the quarter to ensure drill have been conducted and will follow-up with DSPs to conduct them if needed.	ne not nswer on	