STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X) PROVIDERSUPPLERUIAL IDENTIFICATION NUMBER (X) DATE SUPPLEY BUILDING (X)			AND HUMAN SERVICES				ORM APPROVED NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CTY, STATE, ZP CODE 100 ERWIN AVENUE ERWIN AVENUE HOME STREET ADDRESS, CTY, STATE, ZP CODE 100 ERWIN AVENUE PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES IN FULL REGULATORY OR LSCIDENTFYING INFORMATION) IP REFIX TAG PROVIDERS PLAY OF CORRECTION (EACH DEFICIENCIES IN FULL REGULATORY OR LSCIDENTFYING INFORMATION) IP REFIX TAG PROVIDERS PLAY OF CORRECTION (EACH DEFICIENCY MUST BE FRANCED BY FULL REGULATORY OR LSCIDENTFYING INFORMATION) IP REFIX TAG PROVIDERS PLAY OF CORRECTION (EACH DEFICIENCE) IN FULL REGULATORY OR LSCIDENTFYING INFORMATION) IP REFIX TAG PROVIDERS PLAY OF CORRECTION (EACH DEFICIENCE) IN FULL REGULATORY OR LSCIDENTFYING INFORMATION) IP REFIX TAG PROVIDERS PLAY OF CORRECTION (EACH DEFICIENCE) IN FULL REGULATORY OR LSCIDENTFYING INFORMATION) IP REFIX TAG PROVIDERS PLAY OF CORRECTION (EACH DEFICIENCE) IN FULL REGULATORY OR LSCIDENTFYING INFORMATION) IP REFIX TAG PROVIDERS PLAY OF CORRECTION (EACH DEFICIENCE) IN THE ADDRESS CTY, STATE, ZP CODE COMMENTION (EACH DEFICIENCE) IN FULL REGULATORY OR LSCIDENTFYING INFORMATION) IP REFIX TAG IP REFIX (EACH DEFICIENCE) IN THE ADDRESS (EACH DEFICIENCE) IN THE ADDRESS CTY, STATE, ZP CODE COMMENTIAL (EACH DEFICIENCE) IN THE ADDRESS (EACH DEFICIENCE)	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '			3) DATE SURVEY
INAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ERWIN AVENUE HOME 100 ERWIN AVENUE ERWIN, NC 28339 IVALID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) IP PREFIX TAG EACH DEFICIENCIES (EACH DEFICIENCIES) IP E 039 EP Tasting Requirements CFR(s): 483.475(d)(2), \$416.54(d)(2), \$418.113(d)(2), \$441.184(d)(2), \$445.542(d)(2), \$445.12(d)(2), \$445.727(d)(2), \$455.542(d)(2), \$445.12(d)(2), \$455.68(d)(2), \$445.542(d)(2), \$445.12(d)(2), \$455.68(d)(2), \$445.542(d)(2), \$445.12(d)(2), \$456.58(d)(2), \$445.542, OPO, "Organizations" under \$445.727, CMHCos at \$446.590, CMFE at \$494.62 (1) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based functional exercise every 2 years; or (B) If the flacility] experiences an actual natural or man-made emergency that requires activation of the emergency that nequires activation of the emergency that flacility] is exempt from engaging in its next requires activation of the emergency that flocility] (I) Conduct an additional exercise at least every 2 years; or (C) (A) When a community-based functional exercise every 2 years; or (C) (D) Conduct an additional exercise at least every 2 years; opposite the year the full-scale or functional exercise following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise do individual, facility-based functional exercise do individual, facility-based functional exercise of or individual, facility-based functional exercise of individual, facility-based functional exercise of individual, facility-based functional exercise; or (B) A mock dissert of individual, facility-based functional exercise; or (B) A mock dissert of indi, or			34G043	B. WING _			04/09/2024
ERWIN, NC 28338 (%1) ID PREFIX TAG SUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) RESULTIONY ON LSC DEMTIFYING INFORMATION) IP PREFIX PRECX PRECX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCION SHOULD BE CROSS-REFERENCION DEFINIENCY) 0(99) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCION DEFINIENCY) E 039 E 039 E 039 F 105 S416.54(0)(2), S443.1134(0)(2), S445.542(0)(2), S445.123(0)(2), S445.542(0)(2), S445.123(0)(2), S445.542(0)(2), S445.123(0)(2), S445.542(0)(2), S445.123(0)(2), S445.542(0)(2), S445.123(0)(2), S445.542, OPO, "Organizations" under S445.542, OPO, "Organizations" under S445, S42, OPO, "Organizations" under S445, S42, OPO, "Organizations" under S446, S44,	NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	
Préčix TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIS (DENTIFYING INFORMATION) PRÉFX TAG (EACH CORRENCE ACTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 039 EP Testing Requirements CFR(s): 483.475(d)(2), \$416.54(d)(2), \$448.131(d)(2), \$441.184(d)(2), \$483.475(d)(2), \$484.102(d)(2), \$485.68(d)(2), \$485.542(d)(2), \$485.52(d)(2), \$485.68(d)(2), \$485.542(d)(2), \$484.102(d)(2), \$485.542, OPO, "Organizations" under \$485.727, CMHCs at \$485.920, RHCs/FQHCs at \$481.12, 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 at facility-based functional exercise every 2 years; or (a) 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 requires activation of the emergency plan, the [facility] based functional exercise following: (i) Conduct a additional exercise at least every 2 years; opposite the year the full-scale or 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 following: (A) Second full-scale exercise that is community-based or individual, facility-based functional exercise following: (A) Second full-scale exercise that is community-based or individual, facility-based functional exercise following: (A) Second full-scale exercise that is community-based or individual, facility-based fu	ERWIN A	VENUE HOME					
 CFR(s): 483.475(d)(2) \$416.54(d)(2), \$418.113(d)(2), \$441.184(d)(2), \$440.84(d)(2), \$445.33.73(d)(2), \$446.34(d)(2), \$484.52(d)(2), \$485.373(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(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 \$445.727, CMHCs at \$495.542, OPO, "Organizations" under \$445.727, CMHCs 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 every and the following is exercise every 2 years; or (B) If the [facility] prepriences an actual natural or man-made emergency plan, the [facility] is exempt from engaging in its next requires activation of the emergency plan, the [facility] is exempt from engaging in the next required community-based or individual, facility-based functional evercise for the actual event. (ii) Conduct an additional evercise at least every 2 years, or sposite the year the full-scale or functional evercise following the onset of the actual event. (iii) Conduct an ender paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second functional evercise that is community-based or individual, facility-based functional evercise to the full-scale or functional evercise following the onset of the actual event. (ii) Conduct an additional evercise that is community-based or individual, facility-based functional evercise the full-scale or functional evercise following: (A) A second full-scale evercise that is community-based or individual, facility-based functional evercise; or (B) A mock disaster drill; or 	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE	COMPLÉTION
 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 	E 039	CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §482 §485.542(d)(2), §48 §485.542(d)(2), §48 *[For ASCs at §416 at §485.542, OPO, §485.727, CMHCs §491.12, and ESRE (2) Testing. The [faction of the second	(2) 3.113(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). .54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]: cility] must conduct exercises	E 03	39		
(C) A tabletop exercise of workshop that is led by		 must do all of the for (i) Participate in a for community-based er (A) When a commaccessible, conducted exercise every 2 yet (B) If the [facilitiend for man-maccessible] (Community-based of functional exercise actual event. (ii) Conduct an add years, opposite the functional exercise this section is condinate to the former of (A) A second full-second full-second functional exercise; (B) A mock disaster 	billowing: ull-scale exercise that is every 2 years; or unity-based exercise is not t a facility-based functional ars; or y] experiences an actual de emergency that requires hergency plan, the [facility] is jing 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: cale exercise that is or individual, facility-based or				

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/10/2024

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	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G043	B. WING	i		04/	09/2024
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
ERWIN A	VENUE HOME				100 ERWIN AVENUE ERWIN, NC 28339		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	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 [fac maintain documents exercises, and eme [facility's] emergend *[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 plan engaging in its next community-based function onset of the emerged (ii) Conduct an add opposite the year the exercise under para- is conducted, that n to the following: (A) A second full-sec community-based of exercise; or (B) A mock disaste (C) A tabletop exer	udes a group discussion using y-relevant emergency of problem statements, , or prepared questions ige an emergency plan. Sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not t an individual facility based every 2 years; or xperiences a natural or ncy that requires activation of n, the hospital is exempt from crequired full scale exercise or individual onal exercise following the ency event. ditional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	EC	039			

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G043	B. WING			04/(09/2024
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ERWIN A	AVENUE HOME				00 ERWIN AVENUE RWIN, NC 28339		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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	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 (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functi (B) If the hospice ex- man-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an ador 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 emerge (iii) Analyze the hor- maintain document exercises, and emerge	y-relevant emergency of problem statements, or prepared questions age an emergency plan. bices that provide inpatient hospice must conduct e emergency plan twice per must do the following: n annual full-scale exercise that d; or unity-based exercise is not at an annual individual ional exercise; or xperiences a natural or ency that requires activation of n, the hospice is exempt from t required full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or rcise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to	EC)39			

Facility ID: 921814

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G043	B. WING			04/0	09/2024
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ERWIN A	VENUE HOME				00 ERWIN AVENUE ERWIN, NC 28339		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	*[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF 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 mar- requires activation of [facility] is exempt for required full-scale of facility-based function onset of the emerge (ii) Conduct an and that may include following: (A) A second full-sc community-based of functional exercise; (B) A mock (C) A tabletop e- led by a facilitator at discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the maintain document	1.184(d), Hospitals at at §485.625(d):] 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 or disaster 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 [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	EC	039			

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G043	B. WING	;		04/0	09/2024
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	VENUE HOME				100 ERWIN AVENUE ERWIN, NC 28339		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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	 (2) Testing. The PA 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 exp man-made emerge the emergency plar engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the exercise under para is conducted that may the following: (A) A second full-sec community-based of functional exercise; (B) A mock disaster (C) A tabletop exer a facilitator and inclusing a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the PA maintain documenta exercises, and emer PACE's emergency 	CE organization must conduct e emergency plan at least E organization must do the annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or periences an actual natural or ncy that requires activation of n, the PACE is exempt from t required full-scale community , facility-based functional he onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited to cale exercise that is or individual, a facility based for er drill; or rcise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, , or prepared questions age an emergency plan. ACE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed.	EC	039			

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G043 B. WING 04/09/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **100 ERWIN AVENUE ERWIN AVENUE HOME ERWIN, NC 28339** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 039 Continued From page 5 E 039 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. (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

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	34G043					04/09/2024	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ERWIN A	VENUE HOME				00 ERWIN AVENUE ERWIN, NC 28339		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	is community-based (A) When a commu accessible, conduct facility-based functi (B) If the ICF/IID ex man-made emerge the emergency plar engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi may include, but is (A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise 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 eme ICF/IID's emergence *[For HHAs at §484 (d)(2) Testing. The to test the emergen least annually. The (i) Participate in a fu community-based; (A) When a cor accessible, conduct	d; or unity-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 r drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, , or prepared questions ige an emergency plan. [/IID's response to and ation of all drills, tabletop ergency events, and revise the ey plan, as needed. A.102] HHA must conduct exercises hat hHA must do the following: ull-scale exercise that is	EC	039			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G043	B. WING			04/09/2024	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ERWIN A	VENUE HOME				100 ERWIN AVENUE ERWIN, NC 28339		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	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, tha limited to the following (A) A second functional exercise; (B) A mock disa (C) A tabletop end led by a facilitator and discussion, using an emergency scenario statements, directed questions designed plan. (iii) Analyze the HHA documentation of an emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The following: (i) Conduct a paper workshop at least an led by a facilitator and discussion, using an emergency scenario	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 itional exercise every 2 years, ne 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 s needed.	EC	039			

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G043	B. WING			04/	09/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ERWIN A	VENUE HOME				100 ERWIN AVENUE ERWIN, NC 28339		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	plan. If the OPO ex man-made emergent 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 followir (i) Conduct a paper least annually. A tak discussion led by a clinically-relevant er of problem stateme prepared questions emergency plan. (ii) Analyze the RNH maintain documents and emergency even emergency plan, as This STANDARD is Based on record re failed to conduct a f emergency prepare is: Review on 4/8/24 or revealed, it had bee Occupational/Physic (OT/PTA) and last r revealed staff had r	 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. D's response to and maintain Il 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 	E	039			

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G043	B. WING			04/	09/2024
NAME OF F	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ERWIN A	VENUE HOME				00 ERWIN AVENUE RWIN, NC 28339		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	Continued From pa 2024.	ge 9	E 0)39			
		with the home manager ot participate in a full-scale					
W 331	was responsible for and did not know a required.		W 3	331			
	The facility must pro- services in accorda This STANDARD is Based on record re failed to monitor an reason for an uninter	ovide clients with nursing ance with their needs. s not met as evidenced by: eview and interviews, nursing d evaluate the underline ended significant weight loss hts (#3). The finding is:					
	#3 revealed the folk On March, 2023 weig On April, 2023 weig On May, 2023 weig On June, 2023 weig On July, 2023 weig On August, 2023 weig On August, 2023 weig On August, 2023 weig On September, 202 On October, 2023 w On November, 202 On January, 2024 weig On March, 2024 weig Client #3's total and	ht was 146.8 lbs. ght was 146.8 lbs. ht was 145 lbs. eight was 144.6 lbs. 23 weight was 143.6 lbs. weight was 143.6 lbs. 3 weight was 145.4 lbs. weight was 136.4 lbs. weight was 139.4 lbs. eight was 134.2 lbs. hual weight loss was 22.4 lbs.					
	Review on 4/9/24 o	f the Nutritional Evaluations					

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G043	B. WING			04/	09/2024
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ERWIN A	VENUE HOME				00 ERWIN AVENUE ERWIN, NC 28339		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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
W 331	for client #3 on 3/14 158.4 lbs. and she healthy weight loss remained within her lbs. It was noted sh fluctuations and H. prescribed Remero an appetite stimular calorie diet of groun evaluation from 2/8 current weight was weight loss over the stable nutritionally a monitored for trend Review on 4/9/24 o Evaluation for client was within her idea lbs. and had no sign Interview on 4/9/24 Disabilities Profess eats well and had in vocational center th weight loss. The QI not been treated or in the last year, best Interview on 4/9/24 client #3 received a could be used for a did not have calorie revealed the inter-d met to evaluate any continuous weight I Interview on 4/9/24 #3 was not on a her	 4/23 revealed her weight was had already experienced a over the past year, but r total weight range 130-150 he had a history of weight Pylori. Client #3 was on for insomnia but it was also ont. She was on a regular nd consistency. An additional /24 revealed client #3's 136.4 lbs with a healthy e past year. She had been and should have her weights s. f the Annual Nursing t #3 on 2/14/24 revealed she l body weight (IBW) at 136.4 nificant weight change. with the Qualified Intellectual ional (QIDP) revealed client #3 had hospitalized for any illnesses sides a colon exam. with the Nurse confirmed a medication for sleep that an appetite stimulant and she es restrictions. The nurse lisciplinary team (IDT) had not y factors for client #3 	W 3	331			

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		AND HUMAN SERVICES				FORM	04/10/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G043	B. WING	i		04/	09/2024
NAME OF	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
ERWIN A	VENUE HOME				100 ERWIN AVENUE ERWIN, NC 28339		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 331	RD stated he wante RD reviewed her we history of H. Pylori a weighed 132 lbs. bu 160 lbs. The RD sta on his radar and ke determine if other in she continued to tre EVACUATION DRII CFR(s): 483.470(i)(and under varied co This STANDARD is Based on record re failed to conduct fire conditions. This had clients (#1, #2, #3, a Review on 4/8/24 of conducted since Ap following details: First Shift: 4/29/23 at 11:50AM 10/29/23 at 11:38AI Second Shift: 5/30/23 at 8:27PM 8/29/23 at 8:14PM 2/18/14 at 8:38PM Third Shift: 6/28/23 at 3:45AM 9/30/23 at 3:02AM Interview on 4/9/24 disabilities professio created a schedule	ed client #3 to be stable. The eight history, factoring in a and shared in 2015 she ut in Dec., 2022 she weighed ated he wanted to be keep her rep an eye on her weight to nterventions were needed if end down in weight. LLS (1) onditions to- s not met as evidenced by: eview and interview, the facility e drills at varying times and d the potential to effect all #4, #5 and #6). The finding is: f the facility's fire drills oril, 2023 revealed the	W 3		1		

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		TE SURVEY MPLETED
		240040				
	PROVIDER OR SUPPLIER	34G043	B. WING	GTREET ADDRESS, CITY, STATE, ZIP COD	•	/09/2024
			1	00 ERWIN AVENUE ERWIN, NC 28339	_	
(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) COMPLETIO DATE
W 441	Continued From pa she was not aware times per shift.	age 12 that staff did not varying the	W 441			
W 460			W 460			
		eceive a nourishing, including modified and d diets.				
	Based on observa interviews, the faci modified diets were	is not met as evidenced by: tions, record review and lity failed to ensure that e prepared at the correct f 4 audit clients (#2 and #5).				
	4/8/24 at 6:26pm, of consisting of mash puree baked hamb green beans. The g smooth like puddin shape to the veget without any notice staff C and the hom	oservations in the home on client #5 received dinner ed potatoes, puree bread, urger and minced and moist green beans were not blended g and still had detectable able. Client #5 ate the food able difficulty. Staff A, staff B, ne manager were in the dining clients and observed the food				
	from March 2024 r	of client #5's physician's orders evealed she was prescribed a e puree all food diet.				
	disabilities professi the facility had the	with the qualified intellectual ional (QIDP) revealed last year registered dietician (RD) come n staff how to modify diets.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							RINTED: 04/10/2024 FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
34G043		34G043	B. WING			04/09/2024		
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE	-		
ERWIN AVENUE HOME			100 ERWIN AVENUE ERWIN, NC 28339					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 460	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 4	60				

Facility ID: 921814

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