DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				FOR	MAPPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> 0938-0391</u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED	
		34G086	B. WING			05/14/2025		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
	HEIGHTS GROUP HOM	E		7	748 SHARON DR.			
DALMAN		_		5	STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	EP Training Program CFR(s): 483.475(d)(1 §403.748(d)(1), §416 §441.184(d)(1), §460 §483.73(d)(1), §483.4 §485.68(d)(1), §485.3 §485.727(d)(1), §485.3 §491.12(d)(1). *[For RNCHIs at §403 Hospitals at §482.15, at §484.102, REHs at under §485.727, OPC RHC/FQHCs at §491 (1) Training program the following: (i) Initial training in em policies and procedur staff, individuals provi arrangement, and vol expected roles. (ii) Provide emergenc least every 2 years. (iii) Maintain documer preparedness training (iv) Demonstrate staff procedures. (v) If the emergency p procedures are signifi) .54(d)(1), §418.113(d)(1), .84(d)(1), §482.15(d)(1), .84(d)(1), §482.15(d)(1), .75(d)(1), §484.102(d)(1), .542(d)(1), §485.625(d)(1), .920(d)(1), §486.360(d)(1), .920(d)(1), §486.360(d)(1), .920(d)(1), §486.360(d)(1), .920(d)(1), §486.360(d)(1), .12:] . The [facility] must do all of nergency preparedness es to all new and existing ding services under unteers, consistent with their y preparedness training at ntation of all emergency	TAG		CROSS-REFERENCED TO THE APPROF DEFICIENCY)			
	hospice must do all o (i) Initial training in en policies and procedur hospice employees, a	8.113(d):] (1) Training. The f the following: nergency preparedness es to all new and existing and individuals providing gement, consistent with their						

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

TITLE

(X6) DATE

PRINTED: 05/16/2025

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.

DEPARTMENT OF HEALTH AND F CENTERS FOR MEDICARE & MEI					FORM	: 05/16/2025 APPROVED . 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE S COMPL	
	34G086	B. WING		_	05/1	4/2025
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
DAL-WAN HEIGHTS GROUP HOME			48 SHARON DR. STATESVILLE, NC 286	77		
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
expected roles. (ii) After initial training, pr preparedness training ev (iii) Demonstrate staff kno procedures. (iv) Maintain documentati preparedness training. (v) If the emergency prep procedures are significant	areparedness training at and rehearse its s plan with hospice hemployee staff), with on carrying out the protect patients and on of all emergency paredness policies and atly updated, the hospice the updated policies and add of the following: gency preparedness to all new and existing g services under eers, consistent with their rovide emergency ery 2 years. owledge of emergency ion of all emergency paredness policies and atly updated, the PRTF the updated policies and atly updated, the PRTF the updated policies and atly updated policies and	E 037				

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/16/2025 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE	
		34G086	B. WING _			05/	14/2025
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
DAL-WAN	HEIGHTS GROUP HOMI	Ξ			48 SHARON DR. TATESVILLE, NC 28677		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	staff, individuals provi arrangement, contract volunteers, consistent (ii) Provide emergence least every 2 years. (iii) Demonstrate staff procedures, including what to do, where to ge case of an emergency (iv) Maintain documer (v) If the emergency procedures are signifit must conduct training procedures. *[For LTC Facilities at Program. The LTC fact following: (i) Initial training in empolicies and procedur staff, individuals provi arrangement, and vol expected role. (ii) Provide emergence least annually. (iii) Maintain documer preparedness training (iv) Demonstrate staff procedures. *[For CORFs at §485. CORF must do all of t (i) Provide initial traini preparedness policies and existing staff, individes.	es to all new and existing ding on-site services under tors, participants, and t with their expected roles. y preparedness training at knowledge of emergency informing participants of go, and whom to contact in y. ntation of all training. preparedness policies and cantly updated, the PACE on the updated policies and \$483.73(d):] (1) Training cility must do all of the mergency preparedness es to all new and existing ding services under unteers, consistent with their y preparedness training at ntation of all emergency to fall emergency for the following: in emergency is and procedures to all new ividuals providing services ind volunteers, consistent	EO	37			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	05/16/2025
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		(X3) DATE). 0938-0391 SURVEY LETED
		34G086	B. WING			05/	14/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
DAL-WAN	HEIGHTS GROUP HOM	Ξ		748 SHARON DR. STATESVILLE, NC 286	377		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. All new p and assigned specific the CORF's emergen their first workday. The include instruction in the alarm systems and side equipment. (v) If the emergency procedures are signific must conduct training procedures. *[For CAHs at §485.6 The CAH must do all (i) Initial training in empolicies and procedur reporting and extinguinand where necessary personnel, and guests cooperation with firefin authorities, to all new individuals providing sand volunteers, consision roles. (ii) Provide emergenco least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. (v) If the emergency procedures are signification procedures are signification the signification the signification procedures are signification the signification the signification procedures are signification the signifi	y preparedness training at thation of the training. Knowledge of emergency bersonnel must be oriented responsibilities regarding cy plan within 2 weeks of the location and use of gnals and firefighting preparedness policies and icantly updated, the CORF on the updated policies and 25(d):] (1) Training program. of the following: nergency preparedness res, including prompt ishing of fires, protection, , evacuation of patients, s, fire prevention, and ghting and disaster and existing staff, services under arrangement, stent with their expected by preparedness training at	E 03	57			

Facility ID: 921730

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	-					FORM	05/16/2025 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		34G086	B. WING		_	05/	14/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
DAL-WAN	HEIGHTS GROUP HOM	Ξ		748 SHARON DR. STATESVILLE, NC 2867	77		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	CMHC must provide i preparedness policies and existing staff, indi- under arrangement, a with their expected ro documentation of the demonstrate staff knop procedures. Thereaft emergency preparedr years. This STANDARD is r Based on record revi- failed to provide and r annual staff training o Preparedness Plan (E Review of facility docu- revealed an EPP date review of the 2/2025 fl of an annual staff in-se Interview with the qua professional (QIDP) o evidence of the facility could not be located of interview with the QID in-service training sho documented annually as needed. EP Testing Requireme CFR(s): 483.475(d)(2), §418.1 §460.84(d)(2), §448.1	6.920(d):] (1) Training. The nitial training in emergency is and procedures to all new ividuals providing services and volunteers, consistent les, and maintain training. The CMHC must owledge of emergency ter, the CMHC must provide ness training at least every 2 not met as evidenced by: ew and interview, the facility maintain documentation of on the Emergency EPP). The finding is: umentation on 5/14/25 ed 2/24/25. Continued EPP did not reveal evidence service training. Alified intellectual disabilities on 5/14/25 verified that y EPP in-service training during the survey. Continued DP verified that the EPP build be completed and and updates are completed ents	E 037				

Facility ID: 921730

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/16/2025 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		34G086	B. WING		_	05/	14/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
		-		748 SHARON DR.			
DAL-WAN	HEIGHTS GROUP HOME	=		STATESVILLE, NC 2867	77		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From page	• 5	E 03	39			
	at §485.542, OPO, "C §485.727, CMHCs at §491.12, and ESRD F (2) Testing. The [facili to test the emergency must do all of the follo (i) Participate in a full- community-based eve (A) When a communi accessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the emer exempt from engaging community-based or i functional exercise fol actual event. (ii) Conduct an addition years, opposite the year functional exercise un this section is conduct not limited to the follow (A) A second full-scale community-based or i functional exercise; on	§485.920, RHCs/FQHCs at Facilities at §494.62]: ity] must conduct exercises y plan annually. The [facility] owing: -scale exercise that is ery 2 years; or ity-based exercise is not a facility-based functional s; or experiences an actual emergency that requires rgency plan, the [facility] is g in its next required individual, facility-based llowing the onset of the onal exercise at least every 2 ear the full-scale or oder paragraph (d)(2)(i) of ted, that may include, but is wing: e exercise that is individual, facility-based r					
		e or workshop that is led by les a group discussion using relevant emergency f problem statements, r prepared questions a an emergency plan.					

Facility ID: 921730

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/16/2025 MAPPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G086	B. WING			05/	14/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DAL-WAN	HEIGHTS GROUP HOMI	E			48 SHARON DR. STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	maintain documentati exercises, and emerg [facility's] emergency *[For Hospices at 418 (2) Testing for hospic patient's home. The f exercises to test the e annually. The hospic (i) Participate in a full community based ever (A) When a communit accessible, conduct a functional exercise even (B) If the hospice expi man-made emergence the emergency plan, the engaging in its next re- community-based ever facility-based function onset of the emergence (ii) Conduct an addition opposite the year the exercise under parago is conducted, that mat to the following: (A) A second full-sca community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and include a narrated, clinically-ri- scenario, and a set of directed messages, of designed to challenge	on of all drills, tabletop ency events, and revise the plan, as needed. 5.113(d):] es that provide care in the nospice must conduct emergency plan at least e must do the following: -scale exercise that is ery 2 years; or ty based exercise is not n individual facility based ery 2 years; or eriences a natural or y that requires activation of the hospital is exempt from equired full scale ercise or individual al exercise following the cy event. onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section y include, but is not limited le exercise that is a facility based functional drill; or se or workshop that is led by les a group discussion using elevant emergency problem statements, r prepared questions	E	039			

Facility ID: 921730

If continuation sheet Page 7 of 16

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/16/2025 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		34G086	B. WING _			05/	14/2025
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
DAL-WAN	HEIGHTS GROUP HOMI	E			48 SHARON DR. TATESVILLE, NC 28677		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
E 039	year. The hospice ma (i) Participate in an a is community-based; (A) When a community accessible, conduct a facility-based function (B) If the hospice exp man-made emergency the emergency plan, t engaging in its next re based or facility-based following the onset of (ii) Conduct an additi may include, but is no (A) A second full-sca community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercise facilitator that includes narrated, clinically-rel- and a set of problem a messages, or prepare challenge an emergen (iii) Analyze the hosp maintain documentati exercises, and emergen (iii) Analyze the fusp maintain documentati exercises, and emergen (iii) Conduct exercises to the fusp hospice's emergency	spice must conduct emergency plan twice per ust do the following: nnual full-scale exercise that or ty-based exercise is not n annual individual al exercise; or eriences a natural or y that requires activation of the hospice is exempt from equired full-scale community d functional exercise the emergency event. onal annual exercise that t limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ed questions designed to ncy plan. ice's response to and on of all drills, tabletop ency events and revise the plan, as needed.	EO	39			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/16/2025 MAPPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		34G086	B. WING			_	05/	14/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
DAL-WAN	HEIGHTS GROUP HOM	E			48 SHARON DR. STATESVILLE, NC 2867	77		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	 (i) Participate in an a is community-based; (A) When a community accessible, conduct a facility-based function (B) If the [PRTF, Hosp actual natural or manrequires activation of [facility] is exempt from required full-scale correction facility-based function onset of the emergence (ii) Conduct an [a and that may include, following: (A) A second full-scale correction onset of the emergence (ii) Conduct an [a and that may include, following: (A) A second full-scale correction on the emergence (ii) Conduct an [a and that may include, following: (A) A second full-scale correction on the emergence (C) A tabletop exelled by a facilitator and discussion, using a matemergency scenario, statements, directed replan. (iii) Analyze the [immaintain documentati exercises, and emergency *[For PACE at §460.8 (2) Testing. The PACE context and the participation of th	nnual full-scale exercise that or cy-based exercise is not n annual individual, al exercise; or bital, CAH] experiences an made emergency that the emergency plan, the m engaging in its next nmunity based or individual, al exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is ndividual, a facility-based determined to the le exercise that is ndividual, a facility-based determined to the le exercise or workshop that is and includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed. 4(d):] E organization must conduct emergency plan at least organization must do the	E	039				

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	-	D HUMAN SERVICES				FORM	05/16/2025 APPROVED
STATEMENT C	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY LETED
1		34G086	B. WING			05/	14/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		_		7	48 SHARON DR.		
DAL-WAN	HEIGHTS GROUP HOME	-		s	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	 (A) When a communital accessible, conduct a facility-based function (B) If the PACE experiman-made emergency plan, the emergency plan, the engaging in its next rebased or individual, face exercise following the event. (ii) Conduct an additional exercise following the event. (iii) Conduct an additional exercise under paragelis conducted that may the following: (A) A second full-scal community-based or infunctional exercise; on (B) A mock disaster of (C) A tabletop exercise a facilitator and include using a narrated, clini scenario, and a set of directed messages, or designed to challenge (iii) Analyze the PACE maintain documentati exercises, and emerg PACE's emergency plincluding unannounce emergency procedure ICF/IID] must do the following is the following including unannounce emergency procedure ICF/IID] must do the following is the following is conducted that is the emergency procedure is a facilitator and include using a narrated, clini scenario, and a set of directed messages, or designed to challenge (iii) Analyze the PACE maintain documentati exercises, and emerge is emergency procedure including unannounce is the emergency procedure including unannoun	ty-based exercise is not n annual individual, hal exercise; or iences an actual natural or y that requires activation of the PACE is exempt from equired full-scale community acility-based functional conset of the emergency dditional exercise every 2 ar the full-scale or functional raph (d)(2)(i) of this section y include, but is not limited to le exercise that is individual, a facility based r drill; or se or workshop that is led by les a group discussion, cally-relevant emergency i problem statements, r prepared questions a an emergency plan. E's response to and on of all drills, tabletop ency events and revise the lan, as needed. §483.73(d):] must conduct exercises to an at least twice per year, ed staff drills using the es. The [LTC facility, following: nnual full-scale exercise that	E	039			

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	-	D HUMAN SERVICES				FORM	: 05/16/2025 APPROVED
STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	
		34G086	B. WING			05/ [,]	14/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
DAL-WAN	HEIGHTS GROUP HOM	Ξ		48 SHARON DR. TATESVILLE, NC 286	77		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	accessible, conduct a facility-based function (B) If the [LTC facility] actual natural or man- requires activation of LTC facility is exempt required a full-scale c individual, facility-base following the onset of (ii) Conduct an additi- may include, but is no (A) A second full-sca community-based or a functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-rel- and a set of problem a messages, or prepare challenge an emerger (iii) Analyze the [LTC and maintain docume exercises, and emerger [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/I to test the emergency The ICF/IID must do t (i) Participate in an ar is community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID expe	ty-based exercise is not n annual individual, hal exercise. facility experiences an -made emergency that the emergency plan, the from engaging its next ommunity-based or ed functional exercise the emergency event. onal annual exercise that ot limited to the following: le exercise that is an individual, facility based r drill; or se or workshop that is led by a group discussion, using a evant emergency scenario, statements, directed ed questions designed to ncy plan. facility] facility's response to intation of all drills, tabletop ency events, and revise the emergency plan, as needed. 8.475(d)]: ID must conduct exercises y plan at least twice per year. the following: nual full-scale exercise is not n annual individual,	E 039				

Facility ID: 921730

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CENTER STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	FORM OMB NC (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		СОМР	LETED
		34G086	B. WING			05/	14/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DAL-WAN	HEIGHTS GROUP HOME	≣			748 SHARON DR. STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	engaging in its next re community-based or i functional exercise fol emergency event. (ii) Conduct an addition may include, but is not (A) A second full-scale community-based or a functional exercise; or (B) A mock disaster d (C) A tabletop exercise a facilitator and include using a narrated, clini scenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/II maintain documentatii exercises, and emerg ICF/IID's emergency f *[For HHAs at §484.1 (d)(2) Testing. The HH to test the emergency least annually. The HI (i) Participate in a full- community-based; or (A) When a comma accessible, conduct a facility-based function or. (B) If the HHA ex- or man-made emerge of the emergency plane engaging in its next re community-based or i	he ICF/IID is exempt from equired full-scale ndividual, facility-based lowing the onset of the onal annual exercise that it limited to the following: e exercise that is an individual, facility-based rill; or e or workshop that is led by les a group discussion, cally-relevant emergency problem statements, r prepared questions e an emergency plan. D's response to and on of all drills, tabletop ency events, and revise the olan, as needed. 02] 1A must conduct exercises plan at HA must do the following: escale exercise that is nunity-based exercise is not n annual individual, al exercise every 2 years; experiences an actual natural ncy that requires activation n, the HHA is exempt from	E	039			

Facility ID: 921730

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 05/16/2025 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G086	B. WING			05/	/14/2025	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
DAL-WAN HEIGHTS GROUP HOME			748 SHARON DR. STATESVILLE, NC 28677					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 039	emergency event. (ii) Conduct an additic opposite the year the exercise under parage is conducted, that limited to the following (A) A second full- community-based or a functional exercise; of (B) A mock disas (C) A tabletop exe led by a facilitator and discussion, using a na emergency scenario, statements, directed r questions designed to plan. (iii) Analyze the HHA's documentation of all c emergency events, ar emergency plan, as n *[For OPOs at §486.3 (d)(2) Testing. The OF to test the emergency following: (i) Conduct a paper-bay workshop at least ann led by a facilitator and discussion, using a na emergency scenario, statements, directed r questions designed to plan. If the OPO exper- man-made emergency	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the		039	9			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/16/2025 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G086	B. WING			05/	14/2025
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DAL-WAN HEIGHTS GROUP HOME			748 SHARON DR. STATESVILLE, NC 28677				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 039	documentation of all t emergency events, ar OPO's] emergency pl *[RNCHIs at §403.74 (d)(2) Testing. The RI exercises to test the e must do the following (i) Conduct a paper-b least annually. A table discussion led by a fa clinically-relevant emergency plan. (ii) Analyze the RNHC maintain documentati and emergency event emergency plan, as n This STANDARD is r Based on record revi facility failed to condu emergency preparedr is: Review of facility doct revealed an EPP data review of the facility's evidence of a mock d community-based exe EPP. Interview with the qua professional (QIDP) o evidence of a mock d community-based exe prior to the survey. F	s response to and maintain abletop exercises, and and revise the [RNHCI's and an, as needed. [8]: NHCI must conduct emergency plan. The RNHCI : ased, tabletop exercise at etop exercise is a group cilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an CI's response to and on of all tabletop exercises, is, and revise the RNHCI's eeded. not met as evidenced by: ew and interviews, the ct exercises to test the ness plan (EPP). The finding umentation on 5/14/25 ed 2/24/25. Continued EPP did not reveal rill or full-scale ercise to test the facility's alified intellectual disabilities on 5/14/25 revealed that	EO	39			

Facility ID: 921730

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	-	ID HUMAN SERVICES				FORM	05/16/2025 APPROVED		
CENTERS FOR MEDICARE & N STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
34G086		B. WING	_	05/14/2025					
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE				
DAL-WAN	HEIGHTS GROUP HOME	E	748 SHARON DR. STATESVILLE, NC 28677						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
E 039	but not completed. C QIDP verified that sta	ontinued interview with the ff and management should icy preparedness exercises	E 039						
W 368		TION	W 368						
	that all drugs are adm the physician's orders This STANDARD is n Based on observation interview, the facility f medications were adm	not met as evidenced by: n, record review, and failed to ensure all ministered in accordance rs for 1 of 3 audit clients							
	client #5 to participate breakfast meal. Contii AM revealed staff C c room to administer he observation revealed medications in the cup Sulfate 325mg EC, Ju Glycinate 100mg, Om 80mg ER, Risperidon Vitamin B-2 100mg, C	/25 at 6:50 AM revealed e and complete 100% of her nued observation at 7:34 called client #5 to the med er medications. Further staff C to place the following p: Aripiprazole 2mg, Ferrous unel Fe 1/20, Magnesium neprazole 20mg, Propranolol e 0.5mg, Triamt/HCTZ, and Dbservations also revealed er medications with a cup of							
	physician's order date that client #5 should to breakfast for GERD. Interview with the faci	14/25 revealed client #5's ed 4/25/25 which indicated ake Omeprazole before ility nurse on 5/14/25 orders were current and							
	sommed physicial s	oracio wore current anu							

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				FORM	D: 05/16/2025 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
34G086		B. WING		05/14/2025		
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CO	DE		
DAL-WAN HEIGHTS GROUP HO	ME		48 SHARON DR. TATESVILLE, NC 28677			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
that staff C should h Omeprazole medica prescribed.	ave provided client #5's ation before breakfast as	W 368 W 448				
W 448 EVACUATION DRIL CFR(s): 483.470(i)(3 The facility must inverse evacuation drills, ind This STANDARD is Based on record re failed to investigate evacuation drills, ind needed for the evacuation Review on 5/14/25 of drills over the 12 mod conducted that did r (6/24/24 and 3/14/25 two drills conducted evaluation timefram Interview on 5/14/25 disabilities profession drills should have be	that staff C should have provided client #5's Omeprazole medication before breakfast as prescribed.					

Facility ID: 921730

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