PRINTED: 05/16/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED		
		34G086	B. WING		0.0	05/44/2025	
	PROVIDER OR SUPPLIER N HEIGHTS GROUP HOM	E	7	STREET ADDRESS, CITY, STATE, ZIP CODE 748 SHARON DR. STATESVILLE, NC 28677		5/14/2025	
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E 037	CFR(s): 483.475(d)(1) §403.748(d)(1), §416 §441.184(d)(1), §460 §483.73(d)(1), §485.4 §485.68(d)(1), §485.5 §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 empolicies and procedure staff, individuals providarrangement, and voluexpected roles. (ii) Provide emergency least every 2 years. (iii) Maintain document preparedness training (iv) Demonstrate staff procedures. (v) If the emergency procedures are significated must conduct training procedures. *[For Hospices at §418 hospice must do all of (i) Initial training in empolicies and procedure hospice employees, at services under arrangers) bected roles.	.54(d)(1), §418.113(d)(1), .84(d)(1), §482.15(d)(1), .875(d)(1), §484.102(d)(1), .542(d)(1), §485.625(d)(1), .920(d)(1), §486.360(d)(1), .920(d)(1), .	E 037	The Qualified Professional and Safety Chairperson will update Emergency Preparedness Plat Qualified Professional will train staff on the plan. The Regiona Administrator will monitor the Emergency Preparedness Platevery 6 months to ensure it rerupdated and staff are trained. Program Manager and Safety Chairperson will organize and complete a tabletop exercise. Safety Chairperson will monito ensure tabletop exercises are completed at least on an annual basis. In the future, the Region Administrator will ensure tablet exercises are completed on an annual basis. The Qualified Professional will ensure the Emergency Preparedness Plar updated and staff are trained or current plan and training condutannually.	The ratio	7/13/25	

IDD Regional Administrator 5/20/25

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	(ii) Demonstrate staff procedures. (iii) Provide emergence least every 2 years. (iv) Periodically review emergency preparedre employees (including special emphasis place procedures necessary others. (v) Maintain document preparedness training (vi) If the emergency procedures are significant must conduct training procedures. *[For PRTFs at §441.1 program. The PRTF medical for the initial training in empolicies and procedures staff, individuals provide arrangement, and volue expected roles. (ii) After initial training, preparedness training (iii) Demonstrate staff procedures. (iv) Maintain document preparedness training. (v) If the emergency procedures are significations.	ey preparedness training at a vand rehearse its less plan with hospice nonemployee staff), with led on carrying out the vato protect patients and leation of all emergency coreparedness policies and leantly updated, the hospice on the updated policies and ling services under ling servic	E 037		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		JITIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		34G086 B. WING				05/14/2025	
	ROVIDER OR SUPPLIER HEIGHTS GROUP HOM	E		STREET ADDRESS, CITY, STATE, ZIP COI 748 SHARON DR. STATESVILLE, NC 28677	THE R. P. LEWIS CO., LANSING, MICH.	3011-112023	
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E 037	staff, individuals provarrangement, contract volunteers, consister (ii) Provide emergence least every 2 years. (iii) Demonstrate staff procedures, including what to do, where to case of an emergence (iv) Maintain docume (v) If the emergency procedures are signiff must conduct training procedures. *[For LTC Facilities and Program. The LTC fat following: (i) Initial training in erpolicies and procedures taff, individuals provarrangement, and vo expected role. (ii) Provide emergence least annually. (iii) Maintain docume preparedness training (iv) Demonstrate staff procedures. *[For CORFs at §485 CORF must do all of (i) Provide initial train preparedness policies and existing staff, individuals and existing staff, individuals procedures.	res to all new and existing iding on-site services under ctors, participants, and it with their expected roles. Expreparedness training at a f knowledge of emergency informing participants of go, and whom to contact in your intation of all training. In preparedness policies and idicantly updated, the PACE go on the updated policies and idicantly must do all of the integency preparedness res to all new and existing iding services under lunteers, consistent with their expreparedness training at intation of all emergency go, if knowledge of emergency 1.68(d):](1) Training. The the following: ing in emergency in emergency is and procedures to all new ividuals providing services and volunteers, consistent	E 03				

PRINTED: 05/16/2025

OMB NO. 0938-0391

FORM APPROVED

PRINTED: 05/16/2025 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 34G086 B. WING

NAME OF I	ME OF PROVIDER OR SUPPLIER			05/14/2025	
	N HEIGHTS GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 748 SHARON DR.	
				STATESVILLE, NC 28677	
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E 037	Continued From page 3 (ii) Provide emergency preparedness least every 2 years. (iii) Maintain documentation of the trait (iv) Demonstrate staff knowledge of exprocedures. All new personnel must be and assigned specific responsibilities the CORF's emergency plan within 2 their first workday. The training progratinclude instruction in the location and alarm systems and signals and firefight equipment. (v) If the emergency preparedness procedures are significantly updated, formust conduct training on the updated procedures. *[For CAHs at §485.625(d):] (1) Training The CAH must do all of the following: (i) Initial training in emergency prepared policies and procedures, including program and extinguishing of fires, proand where necessary, evacuation of personnel, and guests, fire prevention, cooperation with firefighting and disast authorities, to all new and existing staff individuals providing services under an and volunteers, consistent with their exposes the extension of the train (iv) Demonstrate staff knowledge of emprocedures. (v) If the emergency preparedness procedures are significantly updated, the must conduct training on the updated procedures.	ning. mergency e oriented regarding weeks of m must use of nting olicies and the CORF policies and ong program. edness mpt otection, attients, and ter f, rangement, epected raining at onergency olicies and one CAH	E 03		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/16/2025 **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 34G086 B. WING 05/14/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 748 SHARON DR. DAL-WAN HEIGHTS GROUP HOME STATESVILLE, NC 28677 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 037 Continued From page 4 E 037 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide and maintain documentation of annual staff training on the Emergency Preparedness Plan (EPP). The finding is: Review of facility documentation on 5/14/25 revealed an EPP dated 2/24/25. Continued review of the 2/2025 EPP did not reveal evidence of an annual staff in-service training. Interview with the qualified intellectual disabilities professional (QIDP) on 5/14/25 verified that evidence of the facility EPP in-service training could not be located during the survey. Continued interview with the QIDP verified that the EPP in-service training should be completed and documented annually and updates are completed as needed. E 039 **EP Testing Requirements** E 039 7/13/25 CFR(s): 483.475(d)(2) E 039

§416.54(d)(2), §418.113(d)(2), §441.184(d)(2),

§460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).

Cross Reference E 037

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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DAL-WAN	ROVIDER OR SUPPLIER HEIGHTS GROUP HOM			STREET ADDRESS, CITY, STATE, ZIP CODE 748 SHARON DR. STATESVILLE, NC 28677		00/14/2023	
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	at §485.542, OPO, "C §485.727, CMHCs at §491.12, and ESRD F (2) Testing. The [facilit to test the emergency must do all of the following of the following of the following of the following of the facility] natural or man-made exercise every 2 years (B) If the [facility] natural or man-made exempt from engaging community-based or infunctional exercise following of the following	4, CORFs at §485.68, REHs organizations" under §485.920, RHCs/FQHCs at facilities at §494.62]: [ty] must conduct exercises plan annually. The [facility] wing: scale exercise that is ry 2 years; or ty-based exercise is not facility-based functional si; or experiences an actual emergency that requires gency plan, the [facility] is in its next required adividual, facility-based owing the onset of the mal exercise at least every 2 far the full-scale or der paragraph (d)(2)(i) of ed, that may include, but is ving: exercise that is adividual, facility-based II; or or workshop that is led by se a group discussion using levant emergency problem statements, prepared questions an emergency plan.	EO	39			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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E 039	maintain document exercises, and emergacility's] emergence *[For Hospices at 4 (2) Testing for hospices to test the annually. The hospice in a formulation of the community based of (A) When a community based of (A) When a community based of (B) If the hospice of the emergency planengaging in its next community-based of facility-based functionset of the emerge (ii) Conduct an add opposite the year the exercise under parais conducted, that must be the following: (A) A second full-so community-based of exercise; or (B) A mock disaster (C) A tabletop exercise a facilitator and inclusion an arrated, clinically scenario, and a set directed messages, designed to challenged.	ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] pices that provide care in the e hospice must conduct e emergency plan at least pice must do the following: full-scale exercise that is every 2 years; or entity based exercise is not an individual facility based every 2 years; or experiences a natural or ency that requires activation of an the hospital is exempt from exercise or individual conal exercise following the ency event. Ititional exercise every 2 years, are full-scale or functional egraph (d)(2)(i) of this section may include, but is not limited coale exercise that is a facility based functional	EO	39			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	57 57 57 57 77 77 77 77	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER I HEIGHTS GROUP HO	ME		STREET ADDRESS, CITY, STATE, ZIP COL 748 SHARON DR. STATESVILLE, NC 28677	DE		
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E 039	exercises to test the year. The hospice of (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the hospice examan-made emerger the emergency plan engaging in its next based or facility-based following the onset of (ii) Conduct an add may include, but is in (A) A second full-socommunity-based of exercise; or (B) A mock disasted (C) A tabletop exercise (C	respice must conduct e emergency plan twice per must do the following: annual full-scale exercise that d; or nity-based exercise is not e an annual individual conal exercise; or experiences a natural or ncy that requires activation of ent, the hospice is exempt from required full-scale community sed functional exercise of the emergency event. itional annual exercise that not limited to the following: cale exercise that is er a facility based functional or drill; or cise or workshop led by a eles a group discussion using a elevant emergency scenario, en statements, directed ared questions designed to ency plan. spice's response to and ation of all drills, tabletop rgency events and revise the exy plan, as needed. 1.184(d), Hospitals at	EO	39			

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 34G086 B. WING 05/14/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 748 SHARON DR. DAL-WAN HEIGHTS GROUP HOME STATESVILLE, NC 28677 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 039 Continued From page 8 E 039 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the (i) Participate in an annual full-scale exercise that is community-based; or

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	(A) When a communit accessible, conduct a facility-based function (B) If the PACE experiman-made emergency plan, the emergency plan, the emergency plan, the emergency plan, the engaging in its next rebased or individual, factorise following the event. (ii) Conduct an acceptance of the exercise following the event. (iii) Conduct an acceptance of the exercise under paragrists conducted that may the following: (A) A second full-scal community-based or infunctional exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and includiusing a narrated, clinic scenario, and a set of directed messages, or designed to challenge (iii) Analyze the PACE maintain documentation exercises, and emergency plantal exercises, and emergency plantal exercises at (2) The [LTC facility] model the emergency procedures the emergency procedures the emergency procedures the following must do the following must do the following must do the following including must do the following including must do the following mannounced emergency procedures the following must do the following must do the following mannounced emergency procedures the following must do the following mannounced emergency procedures the following must do the following mannounced emergency procedures the following must do the following mannounced emergency procedures the following mannounced emergency procedures the following must do the following mannounced emergency procedures the following mannounced emergency procedures the full mannounced emergency procedures the following mannounced emergency proce	ty-based exercise is not in annual individual, all exercise; or iences an actual natural or y that requires activation of the PACE is exempt from equired full-scale community cility-based functional onset of the emergency. Iditional exercise every 2 are the full-scale or functional aph (d)(2)(i) of this section include, but is not limited to be exercise that is individual, a facility based will; or e or workshop that is led by es a group discussion, cally-relevant emergency problem statements, prepared questions an emergency plan. It's response to and for of all drills, tabletop ency events and revise the fan, as needed. S483.73(d):] Just conduct exercises to an at least twice per year, distaff drills using the stateff drills using the stateff drills using the stateff drills cale exercise that	EO	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	(A) When a communit accessible, conduct an facility-based function. (B) If the [LTC facility] actual natural or manrequires activation of the LTC facility is exempting required a full-scale of individual, facility-based following the onset of the community-based or an functional exercise; or the community-based or an functional exercise and a set of problem is messages, or prepared the community-based; or problem in the community in the community in the community-based; or the community-based; or the community-based; or the community-based; or the community-based functional (B) If the ICF/IID experience.	y-based exercise is not in annual individual, all exercise. facility experiences an imade emergency that the emergency plan, the from engaging its next formunity-based or experiences and individual exercise that it limited to the following: exercise that is in individual, facility based want emergency scenario, tatements, directed diquestions designed to explan. facility facility's response to exercise that individual, facility is response to exercise that is in individual, facility is response to exercise that is led by group discussion, using a evant emergency scenario, tatements, directed diquestions designed to explan. facility facility's response to exercise that individual, as needed. 475(d)]: O must conduct exercises olan at least twice per year. The following: an all full-scale exercise that inchased exercise is not annual individual,	EC	039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TORE GRONOUT DE THE	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	the emergency plan, the engaging in its next recommunity-based or if functional exercise fol emergency event. (ii) Conduct an addition may include, but is noted (A) A second full-scale community-based or a functional exercise; or (B) A mock disaster drecommunity-based or a facilitator and include using a narrated, clinic scenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/III maintain documentation exercises, and emerged ICF/IID's emergency performed to test the emergency performed in a full-scommunity-based; or (A) When a commaccessible, conduct ar facility-based functions or. (B) If the HHA export man-made emerger.	the ICF/IID is exempt from equired full-scale individual, facility-based lowing the onset of the small annual exercise that it limited to the following: exercise that is in individual, facility-based exercise is not annual individual, facility-based exercise is not annual individual, facility-based individual, facili	E	039			

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(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
E 039	(ii) Analyze the OPO's documentation of all t	s response to and maintain abletop exercises, and nd revise the [RNHCI's and an, as needed.	ΕO	39			
	(d)(2) Testing. The RN exercises to test the emust do the following: (i) Conduct a paper-baleast annually. A table discussion led by a factinically-relevant eme of problem statements prepared questions deemergency plan. (ii) Analyze the RNHC maintain documentation and emergency events emergency plan, as near this STANDARD is not based on record revise facility failed to conduct the conduction of the condu	ased, tabletop exercise at top exercise is a group cilitator, using a narrated, regency scenario, and a set of directed messages, or esigned to challenge an all's response to and on of all tabletop exercises, and revise the RNHCl's esteded.					
	Review of facility docurrevealed an EPP dated review of the facility's E evidence of a mock dri community-based exer EPP.	d 2/24/25. Continued EPP did not reveal					
	professional (QIDP) on evidence of a mock dri community-based exer prior to the survey. Fu	ll or full-scale cise was not completed					

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(VO) MIII TIDI	F COLUMN TO THE	OWB V	OMB NO. 0938-0391	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
34G086		B. WING		05/44/2025			
NAME OF PROVIDER OR SUPPLIER DAL-WAN HEIGHTS GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 748 SHARON DR. STATESVILLE, NC 28677				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E 039	but not completed. C QIDP verified that sta complete all emergen to test the EPP as rec	bleted. Continued interview with the d that staff and management should emergency preparedness exercises PP as required.					
W 368	to test the EPP as required.		W 368	The nurse will in-service all st completing medication passes policy. The clinical team will medication assessment week for a period of 30 days at an aroutine basis to ensure medications are passed appropriately. In the future, the will ensure all staff are trained proper medication passes.	s per nonitor ents 2x a and then	7/13/25	

STATEMENT	OF DEFICIENCIES	The second delivines			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		05/44/2025	
	PROVIDER OR SUPPLIER N HEIGHTS GROUP HOM	E	STREET ADDRESS, CITY, STATE, ZIP CODE 748 SHARON DR. STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ON SHOULD BE COMPLETION DATE	
W 368	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 that staff C should have provided client #5's Omeprazole medication before breakfast as prescribed.		W 368			