

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026
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NAME OF PROVIDER OR SUPPLIER DAL-WAN HEIGHTS GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 748 SHARON DR. , STATESVILLE, North Carolina, 28677
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W0249	<p>PROGRAM IMPLEMENTATION</p> <p>CFR(s): 483.440(d)(1)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record reviews and interview, the facility failed to ensure that the active treatment programs for 2 of 4 sampled clients (#1, #2) were implemented. The findings are:</p> <p>A. Observations in the group home on 5/19/26 revealed client #1 to enter the medication room with staff C at 7:44 AM. Further observation revealed that staff C punched all 12 of client #1's medications into a cup and gave the cup to client #1 to swallow the medications. Continued observation revealed that staff C did not prompt client #1 to punch the medications into the cup or to identify one of her medications and what that medication is prescribed to treat.</p> <p>Record review on 5/19/26 revealed a person-centered plan (PCP) for client #1 dated 10/10/25 with a training objective that states, "By January 27, 2027, client #1 will maintain specific med pass skills with a gestural prompt 90% of the time for two consecutive review periods." Further record review revealed that this goal includes 3 tasks which are to punch the medications out of the bubble packs, to state the name of one medication (Zyrtec) and to state the purpose for taking the Zyrtec.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) and the home manager (HM) on 5/19/26 confirmed that client #1's medication goal is current and that staff C should have implemented the medication administration goal during the morning medication administration.</p>	W0249		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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W0249	Continued from page 1 B. Observations in the group home on 5/18/26 and 5/19/26 revealed client #2 to interact with toys, spend time on the patio with staff and housemates, eat dinner and breakfast, and engage in basic self care. Further observation revealed a communication book with client #2's name on it sitting on a table in the dining area of the home. Continued observation revealed that at no time during the observation period did staff use the communication book to interact with client #2 nor assist client #2 to make choices using the communication book. Record review on 5/19/26 revealed a PCP for client #2 dated 1/6/26 with a training objective that states, "By June 18, 2026, client #2 will make a choice in food or leisure activities using her Communication Picture Book with ONE verbal prompt at 75% frequency." Interview with the QIDP and the HM on 5/19/26 confirmed that client #2's communication goal is current and that home staff should have implemented the goal at all relevant opportunities.	W0249		
W0340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is NOT MET as evidenced by: Based on observations, record review and interviews, the facility failed to ensure clients received training with respect to the identity and purpose of their prescribed medications. This affected 3 of 3 clients observed during medication administration (#1, #4, #6). The findings are: A. Observations during the medication administration in the group home on 5/19/26 revealed client #1 to enter the medication room with staff C at 7:44 AM. Further observation revealed staff C to administer 12 prescribed medications to client #1 and to check client #1's blood pressure. Continued observation revealed that staff C did not inform client #1 of the identity of her medications nor the purpose for which client #1 is prescribed each medication. Review of records on 5/19/26 revealed a person-centered plan (PCP) for client #1 dated	W0340		

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W0340	<p>Continued from page 2</p> <p>10/10/25 with a training objective that states, "Client #1 does not know her medications or the reasons for taking them, but it is trained with each medication pass." The plan includes a formal training goal for client #1 to state one of her medications and the purpose for which it is prescribed.</p> <p>Interview with the facility nurse confirmed that client #1 should have received training with respect to the identity and purpose of her prescribed medications.</p> <p>B. Observations during the medication administration in the group home on 5/19/26 revealed client #4 to enter the medication room with staff C at 7:22 AM. Further observation revealed staff C to administer 9 prescribed medications to client #4 and to check client #4's blood pressure. Continued observation revealed that staff C did not inform client #4 of the identity of her medications nor the purpose for which client #4 is prescribed each medication.</p> <p>Interview with the facility nurse confirmed that client #4 should have received training with respect to the identity and purpose of her prescribed medications.</p> <p>C. Observations during the medication administration in the group home on 5/19/26 revealed client #6 to enter the medication room with staff C at 8:00 AM. Further observation revealed staff C to administer 9 prescribed medications to client #6 and to check client #6's blood pressure. Continued observation revealed that staff C did not inform client #6 of the identity of her medications nor the purpose for which client #6 is prescribed each medication.</p> <p>Interview with the facility nurse confirmed that client #6 should have received training with respect to the identity and purpose of her prescribed medications.</p>	W0340		
W0368	<p>DRUG ADMINISTRATION</p> <p>CFR(s): 483.460(k)(1)</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record review and interviews, the facility failed to ensure that all drugs are administered in compliance with the physician's orders. The findings are:</p> <p>A. Observations in the group home on 5/19/26 revealed staff C to enter the medication room with</p>	W0368		

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W0368	Continued from page 3 client #4 at 7:22 AM. Further observation revealed staff C to administer Chlorhexidine gluconate mouthwash to client #4 from a bottle bearing a prescription label for client #1. Review of records on 5/19/26 revealed physician orders for client #1 and client #4 which indicate that both clients are prescribed the same mouthwash for daily use. Interview with the facility nurse confirmed that clients #1's and #4's physician orders are current and that it was an error to administer client #1's prescribed mouthwash to client #4. B. Observations in the group home on 5/19/26 revealed staff C to enter the medication room with client #6 at 8:00 AM. Further observation revealed staff C to administer a hair, skin and nail gummy to client #6 with her other prescribed medications. Review of records on 5/19/26 revealed physician orders for client #6 which indicate that the hair, skin and nail gummy should be administered on Monday, Wednesday, and Friday. 5/19/26 was a Tuesday. Interview with the facility nurse confirmed that client #6's physician orders are current and that it was an error to administer client #6's prescribed hair, skin and nail gummy on a Tuesday.	W0368		
W0382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to keep all drugs and biologicals locked except when being prepared for administration. The finding is: Observations in the group home on 5/19/26 revealed staff C to enter the medication room with client #4 at 7:22 AM. Further observation revealed staff C to prepare all 8 of client #4's medications, placing all pills in a small paper cup and the mouthwash in a small plastic cup. Continued observation revealed staff C to check client #4's blood pressure, then to leave the medication room with the medications still out on the counter, to retrieve a phone so that she could call nursing. While staff C was out of the	W0382		

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W0382	Continued from page 4 medication room for approximately 1 minute, surveyor and client #4 remained in the medication room. Interview with the facility nurse on 5/19/26 confirmed that staff are trained to keep medications locked at all times except when being prepared for administration.	W0382		