STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G117	A. BUILDING _____ B. WING _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW HOME	**2723 BOBWHITE CIRCLE WINGATE, NC 28174**

(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
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide nursing services in accordance with the needs of 1 of 6 clients (#1) relative to a timely response to medical concerns with a change in client health status. The finding is: Review of record for client #1 on 12/1/21 revealed a nursing note completed 10/25/21 by the facility nurse. Review of the nursing note dated 10/25/21 revealed client #1 was taken to the emergency room (ER) on 10/22/21 due to not eating and drinking and transported by ambulance. Continued review of the 10/25/21 nursing note revealed client #1 was seen in the ER on 10/22/21 with a diagnosis of dehydration and a rapid test was done with a positive result for COVID-19. Additional review revealed client #1 was discharged back to the home in stable condition. Review of internal policy revealed a COVID residential plan with specifics about infection control. Review of internal protocol within the infection control policy revealed all clients should be tested within (2) days of a positive test. Continued review of the infection control policy revealed if a resident of a residential facility has suspected or confirmed COVID-19 infection, the residential facility staff will notify the health care provider and their supervisor to implement infection control protocols. Interview with the facility nurse on 12/1/21 confirmed that client #1 was sent to the ER on	W 331		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 331	Continued From page 1 10/22/21 due to not eating and drinking and she arranged for client #1 to go out to ER for further evaluation. Continued interview on 12/1/21 with facility nurse confirmed that she was notified on 10/22/21 of client #1's positive COVID-19 test. Subsequent interview with facility nurse on 12/1/21 revealed she did not notify the infection control nurse of the positive COVID-19 test. Additional interview with facility nurse revealed all residents were tested for COVID-19 on 10/25/21 and 10/28/21 with all residents receiving negative results both days. Interview with the facility infection control nurse on 12/1/21 revealed that she was not notified until 10/23/21 of client #1's positive COVID-19 results. Continued interview with facility infection control nurse confirmed that due to a delay in notification, the after COVID residential plan was not followed and the testing of all clients on day 2 after exposure was delayed as well as the monitoring of infection control practices in the home. Subsequent interview with the facility infection control nurse on 12/1/21 confirmed that all clients were tested on 10/25/21.	W 331		
W 340	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 observation, record review and interview, the facility failed to ensure appropriate health and hygiene methods were implemented	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEADOWVIEW HOME	2723 BOBWHITE CIRCLE WINGATE, NC 28174

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W 340	Continued From page 2	W 340		

relative to the use of appropriate personal protective equipment (PPE). The finding is:

Observation in the group home on 12/1/21 at 9:38 AM revealed staff A to open the front door for the surveyor to enter the group home. Observation of staff A revealed the staff to wear no PPE. Continued observation revealed staff B to enter the living room from the dining room and to also wear no PPE. Further observation in the group home revealed staff C to arrive at 12:13 PM wearing no protective equipment and to put on a face shield covering upon interview with the surveyor. Subsequent observation at 12:36 PM revealed the qualified intellectual disabilities professional (QIDP) to provide staff C with a face mask.

Review of internal documents on 12/1/21 revealed an internal in-service training form dated 8/17/21. Review of the in-service training form revealed a staff training for everyone to be masking in all internal facilities. The in-service further indicated the individuals supported need to mask when out of their bedrooms as much as tolerated.

Interview with the facility nurse on 12/1/21 confirmed that staff are to always wear a face mask while working in the group home due to the current health pandemic. Continued interview with the facility nurse verified that she intermittedly monitored face mask use 2 to 3 days weekly. Interview with the facility service manager on 12/1/21 verified that she had in-serviced staff on 8/17/21 to wear a face mask inside the group home and she was unsure if a formal training had occured since 8/17/21 specific to face mask use.