DEPARIMENT OF HEALTH	AND HUMAN SERVICES			FORM APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	2) MULTIPLE CONSTRUCTION (X3) DA CO	
	34G117	B. WING _		10/25/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MEADOWVIEW HOME			2723 BOBWHITE CIRCLE WINGATE, NC 28174	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION
W 130 PROTECTION OF CFR(s): 483.420(a)		W 13	30	
 Therefore, the facilit treatment and care This STANDARD i The facility failed to audit clients during evidenced by obset findings are: A. During observatiat 4:36pm revealed bathroom, with Stare B closed the bathroa a large hole observation anyone standing in the hole and see cl Further observation 7:21sm revalued cl the bathroom. Alth client #4 was observatient at 4:57pm revealed bathroom. Althoug bathroom door, the around the door knoh hallway could see t #2 sitting on the toi 	hsure the rights of all clients. ity must ensure privacy during of personal needs. s not met as evidenced by: o ensure the privacy of 2 of 6 care of personal needs as rvations and interviews. The ions in the home on 10/24/22 d client #4 to enter the ff B following behind her. Staff bom door; however, there was ved around the door knob and the hallway could see through ient #4 sitting on the toilet. hs in the home on 10/25/22 at ient #4 sitting on the toilet in hough the door was closed, rved through the hole around ions in the home on 10/24/22 d client #2 to enter the the client #2 closed the re was a large hole observed ob and anyone standing in the hrough the hole and see client let. 22 with Staff D revealed it is a			
privacy issue for an particular bathroom sitting on the toilet	ny of the clients to use this n since they can be observed through the hole in the door.			
	22 with the home manager		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.

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		AND HUMAN SERVICES				FORM	11/05/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G117	B. WING			10/2	25/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	VVIEW HOME				723 BOBWHITE CIRCLE VINGATE, NC 28174		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 130 W 249	(HM) confirmed that hole around the door clients privacy. The has been broken fo waiting for the door	t using the bathroom with the orknob was not providing the e HM revealed that the door or months, and they have been to be replaced. MENTATION	W 1 W 2				
	As soon as the inter formulated a client's each client must rea treatment program interventions and se and frequency to su	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program					
	Based on observat reviews, the facility active treatment pro the achievement of	s not met as evidenced by: tion, interviews, and record failed to assure a continuous ogram was provided to support the objectives identified in the ans for 1 of 3 sample clients					
	10/23/22 from 4:00 clients #3, #4, and # with the television of revealed client #3 to headphones and ta observations at 4:30 clients #1, #2, #4, a leisure activities. Su revealed client #3 to	ions in the group home on PM to 4:30 PM revealed #6 to sit in the living room area on. Continued observation to sit on the recliner with his blet in hand. Further 0 PM to 5:00 PM revealed and #5 and #6 to participate in ubsequent observations to walk around the house, sit in the up and continued pacing					

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM	11/05/2022 APPROVED 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	E SURVEY PLETED	
	34G117	B. WING			10/2	25/2022
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOWVIEW HOME				723 BOBWHITE CIRCLE VINGATE, NC 28174		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
at 5:00 PM revealed a participate in dinner. A a can of Pepsi from or drink it, stand in the co pacing around the hou observation was client participate in any activ Morning observations -7:15 AM revealed client in the living room, pace headphones and table medication administrat observations at 7:15 A participate in breakfass in the sink then pace r with headphones on h Further observations r outside and wait for th during observation was participate in an activity Review of the record f revealed a person-cer 10/12/22. Review of th following program goa participate in an activity prep. Interview with the qual professional (QIDP) o manager (HM) on 10/2 client #3's program goa interview with the HM	use. Additional observations all clients to sit and At 5:15 PM client #3 to grab in top of the microwave, ommon area then to begin use. At no point during t #3 prompt or offered to vities. on 10/24/22 from 6:30 AM ent #3 to sit on the recliner ce around the house with et in hand and participate in ation. Continued AM revealed client #3 to st meal, put his cereal bowl rapidly around the house his ears and tablet in hand. revealed client #3 to then go be school bus. At no time as client #3 prompt to ty. for client #3 on 10/24/22 ntered plan (PCP) dated he PCP revealed the als: bath, brush teeth, ty, make his bed and meal lified intellectual disabilities in 10/23/22 and home 23/22 verified that all of bals are current. Further verified that staff should als for client #3 as written. RING & CHANGE	W 2 W 2				

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	11/05/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G117	B. WING			10/:	25/2022
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEADO	WVIEW HOME				723 BOBWHITE CIRCLE /INGATE, NC 28174		
(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
W 263	Continued From pa	ige 3	W 2	263			
	are conducted only consent of the clien minor) or legal guar This STANDARD is The specially cons as the human rights assure written cons clients' (#1, #4, #5 a regarding all knives the kitchen as evide interview and record Observations in the 10/24-25/22 survey knives are kept in a top of the refrigerate also revealed facility locked box and obta for dinner. Review of the recor person-centered pla Continued review re plan (BSP) for clien indicates the follow and verbal aggress self-injurious behav revealed consents for Review of the record dated 10/12/22. Con BSP dated 4/11/22 target behaviors: pf aggression and SIB consents for locked	s not met as evidenced by: atituted committee, designated s committee (HRC) failed to sent was obtained from 4 of 6 and #6) legal guardians s being kept in a locked box in enced by observations, d verification. The finding is: e group home during the v revealed the group home a locked box in the kitchen on for. Continued observation ty staff to use a key to open the ain a knife to prepare a dish rd for client #2 revealed a an (PCP) dated 10/11/22. evealed a behavior support an (PCP) dated 10/11/22. evealed a behaviors: physical sion, property destruction and viors (SIBs). Further review for locked knives dated rd for client #3 revealed a PCP ontinued review revealed a which indicates the following hysical aggression, verbal 3. Further review revealed					

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		AND HUMAN SERVICES				FORM	11/05/2022 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G117	B. WING	·		10/2	25/2022
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WVIEW HOME				723 BOBWHITE CIRCLE VINGATE, NC 28174		
(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
W 263	not reveal client #1, obtained from the c informed consent w being kept in a lock Interview with the h the locked knives a behavior programm Continued interview Director (RM) verific all clients and conse annually by the lega COVID-19 Vaccinat CFR(s): 483.430 (f) § 483.430 Condition staffing. (f) Standard: COVII staff. The facility m policies and proced fully vaccinated for this section, staff ar if it has been 2 wee completed a primar COVID-19. The co vaccination series f as the administration the administration c multi-dose vaccine. (1) Regardless of c contact, the policies to the following faci care, treatment, or and/or its clients: (i) Facility employee (ii) Licensed practiti (iii) Students, traine	 #4, #5 and #6 consents were dients' guardians to assure vas provided for the knives ed box for restricted use. ome manager (HM) revealed re a part of client #6's ning due to targeted behaviors. A with the HM and Residential ed that the restriction effects ents should be signed al guardian. tion of Facility Staff (1)-(3)(i)-(x) an of Participation: Facility D-19 Vaccination of facility nust develop and implement lures to ensure that all staff are COVID-19. For purposes of re considered fully vaccinated thes or more since they y vaccination series for mpletion of a primary for COVID-19 is defined here on of a single-dose vaccine, or of all required doses of a clinical responsibility or client s and procedures must apply lity staff, who provide any other services for the facility es; 	W S				

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		AND HUMAN SERVICES				FORM	: 11/05/2022 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G117	B. WING			10/	25/2022
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WVIEW HOME				723 BOBWHITE CIRCLE VINGATE, NC 28174		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 508	other services for the under contract or by (2) The policies and do not apply to the fi (i) Staff who exclusi- telemedicine service and who do not have clients and other sta- of this section; and (ii) Staff who provide facility that are perfe- the facility setting and contact with clients paragraph (f)(1) of fi (3) The policies and a minimum, the follor (i) A process for ensi- paragraph (f)(1) of fi staff who have pend- been granted, exem- requirements of this whom COVID-19 va- delayed, as recomm- clinical precautions- received, at a minim- vaccine, or the first vaccine prior to staff treatment, or other its clients; (iii) A process for e- additional precaution transmission and sp who are not fully va- (iv) A process for tra- documenting the Co	he facility and/or its clients, y other arrangement. d procedures of this section following facility staff: ively provide telehealth or es outside of the facility setting ve any direct contact with aff specified in paragraph (f)(1) de support services for the ormed exclusively outside of nd who do not have any direct and other staff specified in this section. d procedures must include, at	W 5	;08			

Facility ID: 922212

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	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		34G117	B. WING _		10	/25/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WVIEW HOME			2723 BOBWHITE CIRCLE WINGATE, NC 28174		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
W 508	(v) A process for tra documenting the C any staff who have as recommended b (vi) A process by w exemption from the requirements based (vii) A process for the documenting inform who have requested has granted, an exe COVID-19 vaccination (viii) A process for e documentation, wh clinical contraindication and which supports exemptions from va and dated by a lice the individual request is acting within their as defined by, and applicable State an ensuring that such (A) All information s authorized COVID- contraindicated for and the recognized contraindications; a (B) A statement by recommending that exempted from the vaccination require recognized clinical (ix) A process for e secure documental staff for whom COV	acking and securely OVID-19 vaccination status of obtained any booster doses by the CDC; hich staff may request an e staff COVID-19 vaccination d on an applicable Federal law; racking and securely nation provided by those staff d, and for whom the facility emption from the staff tion requirements; ensuring that all ich confirms recognized ations to COVID-19 vaccines is staff requests for medical accination, has been signed nsed practitioner, who is not esting the exemption, and who r respective scope of practice in accordance with, all d local laws, and for further documentation contains: specifying which of the 19 vaccines are clinically the staff member to receive clinical reasons for the and the authenticating practitioner t the staff member be facility's COVID-19 ments for staff based on the contraindications; nsuring the tracking and tion of the vaccination must be d, as recommended by the	W 50	08		

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		AND HUMAN SERVICES				FORM	11/05/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G117	B. WING	i		10/	25/2022
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WVIEW HOME				723 BOBWHITE CIRCLE VINGATE, NC 28174		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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)) BE	(X5) COMPLETION DATE
W 508	considerations, incl individuals with acu COVID-19, and ind monoclonal antiboo for COVID-19 treats (x) Contingency pla vaccinated for COV Effective 60 Days A (ii) A process for en- paragraph (f)(1) of vaccinated for COV who have been gra vaccination required staff for whom COV temporarily delayed CDC, due to clinical considerations; This STANDARD is Based on record re failed to ensure pro- was documented for is: Review on 10/24/22 list of employees re the list was vaccinal on file. Further revi COVID-19 vaccines available for review Review on 10/24/22 vaccination policy of must produce proof approved exemptio Interview on 10/25/ (HM) revealed all st	Juding, but not limited to, the illness secondary to ividuals who received dies or convalescent plasma ment; and ans for staff who are not fully /ID-19. After Publication: insuring that all staff specified in this section are fully /ID-19, except for those staff inted exemptions to the ments of this section, or those /ID-19 vaccination must be d, as recommended by the il precautions and s not met as evidenced by: eview and interview, the facility of of COVID-19 vaccinations or all employees. The finding 2 and 10/25/22 of the facility's evealed where each staff on ated and/or had an exemption iew revealed no proof of s cards and exemptions were r. 2 of the facility's COVID-19 lated 2/17/22 revealed all staff f of vaccination or have an	W	508			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY PLETED	
		34G117	B. WING _		10/25/2022		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOV	VVIEW HOME			2723 BOBWHITE CIRCLE WINGATE, NC 28174			
				PROVIDER'S PLAN OF CORRECTION	1	(25)	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX				BE	(X5) COMPLETION DATE	
W 508	Continued From par provided.	ge 8	W 50				

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