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 _____	10/25/2022

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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: The facility failed to ensure the privacy of 2 of 6 audit clients during care of personal needs as evidenced by observations and interviews. The findings are: A. During observations in the home on 10/24/22 at 4:36pm revealed client #4 to enter the bathroom, with Staff B following behind her. Staff B closed the bathroom door; however, there was a large hole observed around the door knob and anyone standing in the hallway could see through the hole and see client #4 sitting on the toilet. Further observations in the home on 10/25/22 at 7:21sm revalued client #4 sitting on the toilet in the bathroom. Although the door was closed, client #4 was observed through the hole around the door knob. B. During observations in the home on 10/24/22 at 4:57pm revealed client #2 to enter the bathroom. Although client #2 closed the bathroom door, there was a large hole observed around the door knob and anyone standing in the hallway could see through the hole and see client #2 sitting on the toilet. Interview on 10/25/22 with Staff D revealed it is a privacy issue for any of the clients to use this particular bathroom since they can be observed sitting on the toilet through the hole in the door. Interview on 10/25/22 with the home manager	W 130		

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

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W 130	Continued From page 1 (HM) confirmed that using the bathroom with the hole around the doorknob was not providing the clients privacy. The HM revealed that the door has been broken for months, and they have been waiting for the door to be replaced.	W 130		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to assure a continuous active treatment program was provided to support the achievement of the objectives identified in the person centered plans for 1 of 3 sample clients (#3) The finding is: Afternoon observations in the group home on 10/23/22 from 4:00 PM to 4:30 PM revealed clients #3, #4, and #6 to sit in the living room area with the television on. Continued observation revealed client #3 to sit on the recliner with his headphones and tablet in hand. Further observations at 4:30 PM to 5:00 PM revealed clients #1, #2, #4, and #5 and #6 to participate in leisure activities. Subsequent observations revealed client #3 to walk around the house, sit in the recliner, get back up and continued pacing	W 249		

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W 249	Continued From page 2 rapidly around the house. Additional observations at 5:00 PM revealed all clients to sit and participate in dinner. At 5:15 PM client #3 to grab a can of Pepsi from on top of the microwave, drink it, stand in the common area then to begin pacing around the house. At no point during observation was client #3 prompt or offered to participate in any activities. Morning observations on 10/24/22 from 6:30 AM -7:15 AM revealed client #3 to sit on the recliner in the living room, pace around the house with headphones and tablet in hand and participate in medication administration. Continued observations at 7:15 AM revealed client #3 to participate in breakfast meal, put his cereal bowl in the sink then pace rapidly around the house with headphones on his ears and tablet in hand. Further observations revealed client #3 to then go outside and wait for the school bus. At no time during observation was client #3 prompt to participate in an activity. Review of the record for client #3 on 10/24/22 revealed a person-centered plan (PCP) dated 10/12/22. Review of the PCP revealed the following program goals: bath, brush teeth, participate in an activity, make his bed and meal prep. Interview with the qualified intellectual disabilities professional (QIDP) on 10/23/22 and home manager (HM) on 10/23/22 verified that all of client #3's program goals are current. Further interview with the HM verified that staff should follow all program goals for client #3 as written.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)	W 263		

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W 263	Continued From page 3 The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: The specially constituted committee, designated as the human rights committee (HRC) failed to assure written consent was obtained from 4 of 6 clients' (#1, #4, #5 and #6) legal guardians regarding all knives being kept in a locked box in the kitchen as evidenced by observations, interview and record verification. The finding is: Observations in the group home during the 10/24-25/22 survey revealed the group home knives are kept in a locked box in the kitchen on top of the refrigerator. Continued observation also revealed facility staff to use a key to open the locked box and obtain a knife to prepare a dish for dinner. Review of the record for client #2 revealed a person-centered plan (PCP) dated 10/11/22. Continued review revealed a behavior support plan (BSP) for client #6 dated 3/28/22 which indicates the following target behaviors: physical and verbal aggression, property destruction and self-injurious behaviors (SIBs). Further review revealed consents for locked knives dated Review of the record for client #3 revealed a PCP dated 10/12/22. Continued review revealed a BSP dated 4/11/22 which indicates the following target behaviors: physical aggression, verbal aggression and SIB. Further review revealed consents for locked knives in Subsequent review of client documentation did	W 263		

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W 263	Continued From page 4 not reveal client #1, #4, #5 and #6 consents were obtained from the clients' guardians to assure informed consent was provided for the knives being kept in a locked box for restricted use. Interview with the home manager (HM) revealed the locked knives are a part of client #6's behavior programming due to targeted behaviors. Continued interview with the HM and Residential Director (RM) verified that the restriction effects all clients and consents should be signed annually by the legal guardian.	W 263		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or	W 508		

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W 508	Continued From page 5 other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section;	W 508		

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W 508	Continued From page 6 (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and	W 508		

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W 508	Continued From page 7 considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure proof of COVID-19 vaccinations was documented for all employees. The finding is: Review on 10/24/22 and 10/25/22 of the facility's list of employees revealed where each staff on the list was vaccinated and/or had an exemption on file. Further review revealed no proof of COVID-19 vaccines cards and exemptions were available for review. Review on 10/24/22 of the facility's COVID-19 vaccination policy dated 2/17/22 revealed all staff must produce proof of vaccination or have an approved exemption on file. Interview on 10/25/22 with the home manager (HM) revealed all staff working in the home had been vaccinated, but confirmed no proof was	W 508		

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W 508	Continued From page 8 provided.	W 508		