		AND HUMAN SERVICES				FORM	APPROVED
	RS FOR MEDICARE	& MEDICAID SERVICES				<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY IPLETED
		34G284	B. WING	_		09/	19/2023
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTR	YVIEW RESIDENTIA	L			359 FIRETOWER ROAD RICHLANDS, NC 28574		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 004	Develop EP Plan, F CFR(s): 483.475(a)	Review and Update Annually)	EC	004			
	§483.475(a), §484. §485.542(a), §485.	84(a), §482.15(a), §483.73(a),					
	Federal, State and preparedness requi develop establish a emergency prepare requirements of this	irements. The [facility] must and maintain a comprehensive edness program that meets the s section. The emergency ram must include, but not be					
	and maintain an en that must be [review	n. The [facility] must develop nergency preparedness plan wed], and updated at least plan must do all of the					
	§485.625(a):] Emer CAH] must comply State, and local em requirements. The develop and mainta emergency prepare	482.15 and CAHs at rgency Plan. The [hospital or with all applicable Federal, ergency preparedness [hospital or CAH] must ain a comprehensive edness program that meets the s section, utilizing an ch.					
	Plan. The LTC facil an emergency prep	s at §483.73(a):] Emergency ity must develop and maintain paredness plan that must be ated at least annually.					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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.

PRINTED: 09/20/2023

		AND HUMAN SERVICES			FORM	09/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G284	B. WING _		09/	19/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTR	YVIEW RESIDENTIAL	L		359 FIRETOWER ROAD RICHLANDS, NC 28574		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
E 004	* [For ESRD Faciliti Plan. The ESRD fa maintain an emerge	age 1 ies at §494.62(a):] Emergency cility must develop and ency preparedness plan that], and updated at least every 2	E OC	04		
	Based on record re failed to ensure the	s not met as evidenced by: eview and interview, the facility e Emergency Preparedness ewed and updated every two is:				
	revealed the date o	of the facility's EP plan of their plan was 10/21/19. ealed there was not an updated home.				
E 037	Director (RM) state in 2023.		E 03	37		
	§441.184(d)(1), §46 §483.73(d)(1), §483 §485.68(d)(1), §483	16.54(d)(1), §418.113(d)(1), 60.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 35.542(d)(1), §485.625(d)(1), 85.920(d)(1), §486.360(d)(1),				
	Hospitals at §482.1 at §484.102, REHs under §485.727, OF RHC/FQHCs at §49					

If continuation sheet Page 2 of 21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED NAME OF PROVIDER OR SUPPLIER B. WING 09/19/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 359 FIRETOWER ROAD RICHLANDS, NC 28574 359 FIRETOWER ROAD RICHLANDS, NC 28574			AND HUMAN SERVICES					FORM	09/20/2023 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COUNTRYVIEW RESIDENTIAL (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) COX E 037 Continued From page 2 (i) Initial training in emergency preparedness policies and procedures to all new and existing statif, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. E 037 *[For Hospices at §418.113(d):] (1) Training. The hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (iii) Provide emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (iii) Provide emergency preparedness training at least every 2 years.	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	ì í				(X3) DATE	E SURVEY
339 FIRETOWER ROAD RICHLANDS, NC 28574 (YM) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED EY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTING ATTON SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COME E 037 Continued From page 2 (1) 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. E 037 E 037 (ii) Provide emergency preparedness training at least every 2 years. E 037 E 037 "For Hospice as \$418.113(d):] (1) Training. The hospice must do all of the following: (1) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services and procedures. "For Hospice as \$418.113(d):] (1) Training. The hospice must do all of the following: (1) Initial training in emergency preparedness policies and procedures to all new and existing procedures. "For Hospice as \$418.thowledge of emergency procedures. "For Hospice as \$418.th3(d):] (1) Training. The hospice must do all of the following: (1) Initial training in emergency preparedness policies and procedures to all new and existing procedures. Hit Heir expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Demonstrate staff knowledge of emergency procedures. (iii) Demonstrate staff knowledge of emergency procedures. (iii) Drovide emergency preparedness training at least every 2 years. <td></td> <td></td> <td>34G284</td> <td>B. WING</td> <td>;</td> <td></td> <td>_</td> <td>09/[,]</td> <td>19/2023</td>			34G284	B. WING	;		_	09/ [,]	19/2023
RICHLANDS, NC 28574 Image: Trag SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) ID PREFIX (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTIVE ACTOR SHOULD BE (EACH ORDECTIVE ACTOR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Cont Construction E 037 Continued From page 2 (i) 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. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures. (i) Initial training on the updated policies and procedures. (i) Initial training on the updated policies and procedures. (ii) Initial training on the updated policies and procedures. (iii) Initial training on the updated policies and procedures. (iii) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (iii) Demonstrate staff knowledge of emergency procedures. (iii) Demonstrate staff knowledge of emergency procedures. (iii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years.	NAME OF P	PROVIDER OR SUPPLIER					TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Converting DEFICIENCY E 037 Continued From page 2 (i) 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. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures. (v) If the emergency preparedness policies and procedures. (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (iii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iii) Provide emergency preparedness training at least every 2 years.	COUNTR	YVIEW RESIDENTIAI	-						
 (i) 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. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. 	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIV CROSS-REFERENCEI	E ACTION SHOULD D TO THE APPROPF	BE	(X5) COMPLETION DATE
 emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and 	E 037	 (i) Initial training in epolicies and proced staff, individuals proarrangement, and vexpected roles. (ii) Provide emergel least every 2 years. (iii) Maintain docum preparedness trainit (iv) Demonstrate star procedures. (v) If the emergency procedures are sign must conduct trainin procedures. *[For Hospices at § hospice must do all (i) Initial training in epolicies and proced hospice employees services under arraexpected roles. (ii) Demonstrate star procedures. *[For Hospices at § hospice must do all (i) Initial training in epolicies and proced hospice employees services under arraexpected roles. (ii) Demonstrate star procedures. (iii) Provide emerger least every 2 years. (iv) Periodically reviemergency prepare employees (includir special emphasis procedures necess others. (v) Maintain docum preparedness trainit (vi) If the emergency prepare procedures are sign procedures are	emergency preparedness lures to all new and existing oviding services under volunteers, consistent with their ncy preparedness training at nentation of all emergency ing. aff knowledge of emergency y preparedness policies and hificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The of the following: emergency preparedness lures to all new and existing a, and individuals providing ungement, consistent with their aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice ng nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency ing. cy preparedness policies and hificantly updated, the hospice	E		7			

Facility ID: 944710

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		AND HUMAN SERVICES				FORM	09/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G284	B. WING	i		09/ [,]	19/2023
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTR	YVIEW RESIDENTIAL	-			359 FIRETOWER ROAD RICHLANDS, NC 28574		
(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
E 037	Continued From pa procedures.	ge 3	E(037			
	program. The PRTF (i) Initial training in e policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) After initial training preparedness traini (iii) Demonstrate sta procedures. (iv) Maintain docum preparedness traini (v) If the emergency procedures are sign must conduct training procedures. *[For PACE at §460 organization must d (i) Initial training in e policies and proced staff, individuals pro- arrangement, contra- volunteers, consiste (ii) Provide emergen least every 2 years. (iii) Demonstrate sta procedures, including what to do, where to case of an emergen (iv) Maintain docum (v) If the emergence procedures are sign	aff knowledge of emergency nentation of all emergency ng. y preparedness policies and hificantly updated, the PRTF ng on the updated policies and 0.84(d):] (1) The PACE do all of the following: emergency preparedness lures to all new and existing poviding on-site services under actors, participants, and ent with their expected roles. ncy preparedness training at aff knowledge of emergency ng informing participants of o go, and whom to contact in					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G284	B. WING	i		09/	19/2023
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTR	RYVIEW RESIDENTIAL	L			359 FIRETOWER ROAD RICHLANDS, NC 28574		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 037	Continued From pa	ige 4	E	037	7		
	Program. The LTC following: (i) Initial training in e policies and proced staff, individuals pro arrangement, and v expected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate sta procedures. *[For CORFs at §48 CORF must do all c (i) Provide initial trai preparedness polici and existing staff, ir under arrangement with their expected (ii) Provide emerger least every 2 years. (iii) Maintain docum (iv) Demonstrate sta procedures. All new and assigned speci the CORF's emerger their first workday. include instruction in alarm systems and equipment. (v) If the emergen procedures are sign	taff knowledge of emergency 85.68(d):](1) Training. The of the following: nining in emergency ties and procedures to all new ndividuals providing services t, and volunteers, consistent roles.					

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		AND HUMAN SERVICES				FORM	09/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G284	B. WING			09/	19/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTR	YVIEW RESIDENTIA	L			59 FIRETOWER ROAD RICHLANDS, NC 28574		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 037	Continued From pa	ige 5	E 0	37			
	The CAH must do a (i) Initial training in a policies and proced reporting and exting and where necessa personnel, and gue cooperation with fir authorities, to all ne individuals providin and volunteers, cor roles. (ii) Provide emerge least every 2 years (iii) Maintain docum (iv) Demonstrate st procedures. (v) If the emergen procedures are sign	emergency preparedness lures, including prompt guishing of fires, protection, ary, evacuation of patients, ests, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, nsistent with their expected ncy preparedness training at					
	CMHC must provid preparedness polic and existing staff, in under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This STANDARD i Based on docume facility failed to ens adequately trained	85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new ndividuals providing services t, and volunteers, consistent roles, and maintain ne training. The CMHC must nowledge of emergency after, the CMHC must provide edness training at least every 2 s not met as evidenced by: nt review and interviews, the ure direct care staff were on the facility's emergency pan. The finding is:					

Facility ID: 944710

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		AND HUMAN SERVICES				FORM	09/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G284	B. WING			09/*	19/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
COUNTR	YVIEW RESIDENTIA	-			59 FIRETOWER ROAD RICHLANDS, NC 28574		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	Continued From pa	ge 6	E ()37			
	(10/21/19) did not ir regarding training o						
W 130	Manager (RM) cont information include of the staff.		W	130			
	The facility must en Therefore, the facili treatment and care This STANDARD is Based on observat	sure the rights of all clients. Ity must ensure privacy during of personal needs. Is not met as evidenced by: tions and interviews, the facility vacy for 1 of 5 audit clients					
	9/18/23 at 6:37pm, on the toilet with the observations reveal walking out of the b remained open. Ac a male client walkin and looking in while there. At 6:39pm, o toilet, pulling up her pants, while the door	ervations in the home on client #3 was observed sitting e door wide open. Further led Staff B walking in and then athroom while the door ditional observations revealed ag by the open bathroom door e Staff B was also standing client #3 stood up from the underwear and then her or remained open. At no time d for client #3's privacy while					
	ever since she has bathroom door rem	on 9/18/23, Staff B revealed worked in the home, the ains open while client #3 is aff B confirmed the bathroom					

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		AND HUMAN SERVICES				FORM	09/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G284	B. WING			09/ [,]	19/2023
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTR	YVIEW RESIDENTIAI	L			59 FIRETOWER ROAD ICHLANDS, NC 28574		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 130	Continued From pa door should be close toilet. Review on 9/19/23 Behavior Inventory she has partial inder bathroom door for p During an interview staff stated the bath while client #3 is us interview revealed of staff been told to lea while a client is usin STAFF TRAINING CFR(s): 483.430(e) For employees who must focus on skills toward clients' heal This STANDARD is Based on observat failed to ensure star reporting medical c audit clients (#6). T During observations 9/18 - 19/23, client is hurt". There where yelling how her gum the staff working in her gums. During an interview technician on secon	age 7 sed while client #3 is using the of client #3's Adaptive (ABI) dated 11/1/22 revealed ependence with closing the privacy. on 9/19/23, the management nroom door should be closed sing the toilet. Further under no circumstances have ave the bathroom door open ng the toilet. PROGRAM)(2) o work with clients, training s and competencies directed th needs. s not met as evidenced by: tions and interviews, the facility ff were sufficiently trained in oncerns. This affected 1 of 5	W 1				
	contact the nurse s	ne said "No".					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DA) <u>. 0938-039</u> TE SURVEY MPLETED
		34G284	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	09	/19/2023
	PROVIDER OR SUPPLIER	L	3	59 FIRETOWER ROAD RICHLANDS, NC 28574		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
W 192 W 247	staff revealed staff client #6 when she her gums where hu revealed staff have medical concerns of INDIVIDUAL PROC CFR(s): 483.440(c) The individual prog opportunities for cli self-management. This STANDARD in Based on observa	y on 9/19/23, management should have followed up with was complaining about how urting. Further interview been trained to follow up on of the clients in the home. GRAM PLAN)(6)(vi) rram plan must include ent choice and s not met as evidenced by: tions, record review and	W 192 W 247			
	clients (#4) was prochoice. The finding During morning ob 9/19/23 at 6:39am, seat and began was Staff C put out her #4 and telling him t around and sat bac 6:41am, client #4 a and Staff C told him Client #4 sat back of leave the group at at the chair where of sat back down in the	servations in the home on client #4 stood up from his lking away from the group. arm at the waist level of client o "Stop". Client #4 then turned ck down in his chair. At gain stood up from his chair n "Stop" and "No, [Client #4]". down. Client again tried to 6:42am, Staff C pointed back client #4 was sitting. Client #4 he chair and crossed his legs.				
	8/25/22 did not indi allowed freedom of environment.	of client #4's record dated cate that client #4 was not movement within his own on 9/19/23, management				

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
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PROVIDER OR SUPPLIER				DE	
YVIEW RESIDENTIA	L				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO DATE
Continued From pa	age 9	W 247			
PROGRAM IMPLE	MENTATION	W 249			
formulated a client' each client must re treatment program interventions and s and frequency to su	s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the				
Based on observation interviews, the facilic clients (#2, #3, #4, continuous active the of needed intervent in the Individual Press of program guideling of program guideling for the second se	tions, record reviews and lity failed to ensure 5 of 5 audit #5 and #6) received a reatment program consisting tions and services as identified ogram Plan (IPP) in the areas nes, adaptive equipment,				
5:10pm, Staff A wa dinner. Staff A oper	s in the kitchen preparing ned a kitchen drawer that				
knives are kept in t	he drawer and butcher knives				
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa freedom of movem PROGRAM IMPLE CFR(s): 483.440(d As soon as the inter formulated a client' each client must re treatment program interventions and s and frequency to su objectives identified plan. This STANDARD in Based on observa interviews, the facil clients (#2, #3, #4, continuous active t of needed interven in the Individual Pro of program guidelind dinner, Staff A oper contained butter kr	IDENTIFICATION NUMBER: 34G284 PROVIDER OR SUPPLIER EXPVIEW RESIDENTIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 freedom of movement within his environment. 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 observations, record reviews and interviews, the facility failed to ensure 5 of 5 audit clients (#2, #3, #4, #5 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of program guidelines, adaptive equipment, dining, toileting and handwashing. The findings are: A. During observations in the home on 9/18/23 at 5:10pm, Staff A was in the kitchen preparing dinner. Staff A opened a kitchen drawer that contained butter knives. Immediate interview with Staff A revealed butter knives are kept in the drawer and butcher knives are kept in an unsecured kitchen cabinet on a	A BUILDING 34G284 B. WING CONDER OR SUPPLIER CONDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 freedom of movement within his environment. 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 observations, record reviews and interviews, the facility failed to ensure 5 of 5 audit clients (#2, #3, #4, #5 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of program guidelines, adaptive equipment, dining, toileting and handwashing. The findings are: A. During observations in the home on 9/18/23 at 5:10pm, Staff A was in the kitchen preparing dinner. Staff A opened a kitchen drawer that contained butter knives. Immediate interview with Staff A revealed butter knives are kept in the drawer and butcher knives are kept in an unsecured kitchen cabinet on a	of correction iDENTIFICATION NUMBER: A.BUILDING 34G284 B.WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO SUMMARY STATEMENT OF DEFICIENCIES BRETOWER ROAD (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX PREFIX (EACH DEFICIENCY BUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Continued From page 9 W 247 freedom of movement within his environment. PROGRAM IMPLEMENTATION W 249 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 observations, record reviews and interviews, the facility failed to ensure 5 of 5 audit continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of program guidelines, adaptive equipment, dining, toileting and handwashing. The findings are: A. During observations in the home on 9/18/23 at 5:10pm, Staff A was in the kitchen preparing dinner. Staff A opened a kitchen drawer that contained butter knives. Immediate interview with Staff A revealed butter knives are kept in the drawer and butcher k	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING Corr 34G284 B. WING TREET ADDRESS, CITY, STATE, ZIP CODE 359 FIRETOWER ROAD STREET ADDRESS, CITY, STATE, ZIP CODE SWMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG PROVIDER'S FLAN, C2 8574 Continued From page 9 W 247 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CORRECTIVE ACTION BHOLD BE (CACY DEFICIENCY WIST ADDRESS, CITY, STATE, ZIP CODE PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) W 247 W 249 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. W 249 This STANDARD is not met as evidenced by: Based on observations, record reviews and interventions and services as identified in the Individual Program Plan (IPP) in the areas of program guidelines, adaptive equipment, dining, tolleting and handwashing. The findings are: A. Buring observations in the home on 9/18/23 at 5:10pm, Staff A was in the kitchen preparing dinner. Staff A opened a kitchen drawer that contained butter knives. Immediate interview with Staff A revealed butter knives are kept in an unsecure dkitchen client number

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		AND HUMAN SERVICES				FORM	09/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE	E SURVEY PLETED
		34G284	B. WING	i		09/	19/2023
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
COUNTR	YVIEW RESIDENTIA	-		-	59 FIRETOWER ROAD RICHLANDS, NC 28574		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 249	February 1, 2024 cl fewer challenging b consecutive months identified as aggres disruptive behavior, belong to him, failur choices and attemp Further review of th served a year and a threatening to use a team implemented day program and he a secure area. Afte be cleaned and retu Client #2 can only u supervision. Interview on 9/19/22 are to be kept in a s behavior. Staff F to unsecured kitchen shelf in the pantry. door on and closed Interview on 9/19/22 the BSP states sec where the area is o management acknot cabinet shelf is not B. During observati 9/19/23, at no time wearing a gait belt. 5:10pm, Staff B was to transfer from her at 6:16pm from the	lient #2 will exhibit four or behaviors per month for eleven s. Challenging behaviors are sive behavior, severe , taking things that do not re to make responsible oted AWOL/actual AWOL. The BSP revealed client #2 a half jail sentence after a knife on a police officer. The a restriction of knives at the ome that knives will be kept in r a knife is used, the knife will urned to the secure area. Use knives under direct staff 3 with Staff F revealed knives secure area due to client #2's ok the knives from the cabinet and placed them on a Staff F turned the pantry alarm the door. 3 with management revealed ure area but does not specify r if it is to be locked. However, owledges that a kitchen	W 2	249			

		AND HUMAN SERVICES				FORM	09/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		34G284	B. WING			09/	19/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
COUNTR	YVIEW RESIDENTIAL	L			59 FIRETOWER ROAD RICHLANDS, NC 28574		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 249	Continued From pa	ige 11	W 2	249			
	Guidelines dated 7/ transfers, provide 1	's Fall Prevention and Safety /29/23 revealed for stand-pivot + minimum assistance and support of a gait belt for all					
		3 at 7:50am with Staff F should wear a gait belt for all					
		3 with management confirmed e used when transferring client					
	- 19/23, clients #2, a hands prior to eatin	servations in the home on 9/18 #4 and #6 did not wash their g dinner or breakfast. At no 2 #4 and #6 given any type of ir hands.					
	Behavior Inventory	of client #2's Adaptive (ABI) dated 11/1/22 revealed with washing his hands prior to					
		of client #4's ABI dated e has partial independence ands prior to meals.					
		of client #6's ABI dated ne is independent with washing neals.					
	clients #2 and #6 ar washing their hands	on 9/19/23, Staff E revealed re totally independent with s. Further interview revealed sistance with washing his					

		AND HUMAN SERVICES				FORM	09/20/2023 APPROVED 0938-0391
STATEMENT			· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	34G284		B. WING	i		09/ [.]	19/2023
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRYVIEW RESIDENTIAL					59 FIRETOWER ROAD RICHLANDS, NC 28574		
(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 249	Continued From pa	ige 12	W 2	249			
	 9/18 - 19/23, clients any napkins at their meals. Further obs a paper towel holde Additional observat his forearm to wipe Review on 9/19/23 11/1/22 revealed he napkin to wipe his r Review on 9/19/23 1/10/22 revealed he with using a napkin meals. Review on 9/19/23 11/1/22 revealed he with using a napkin meals. Review on 9/19/23 11/1/22 revealed sh napkin to wipe her r E. During evening 9/18/23 at 6:37pm, on the toilet. At 6:3 the toilet, pulling up pants. Client #3 ex wiping herself, flush hands. Further obs standing in front of clothes. At no time wipe herself, flush t Review on 9/19/23 11/1/22 revealed sh 	oservations in the home on s #2, #4 and #6 did not have r place settings during their servations revealed there was er located in the kitchen. tions revealed client #4 using this mouth after breakfast. of client #2's ABI dated e is independent with using a mouth during/after meals. of client #4's ABI dated e has partial independence to wipe his mouth during/after of client #6's ABI dated he is independent with using a mouth during/after meals. observations in the home on client #3 was observed sitting 39pm, client #3 stood up from o her underwear and then her stied the bathroom without hing the toilet or washing her servations revealed Staff B client #3 and straightening her e was client #3 prompted to the toilet or wash her hands. of client #3's ABI dated he is totally independent with hing the toilet and washing her					
	During an interview	on 9/19/23, management					

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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 34G284 B. WING 09/19/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **359 FIRETOWER ROAD** COUNTRYVIEW RESIDENTIAL **RICHLANDS, NC 28574** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 249 Continued From page 13 W 249 staff stated client #3 should have wiped herself, flushed the toilet and washed her hands prior to leaving the bathroom. W 262 PROGRAM MONITORING & CHANGE W 262 CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 1 of 5 audit clients (#2) was reviewed and monitored by the human rights committee (HRC). The finding is: Review on 9/18/23 of client #2's Behavior Support Plan (BSP) dated 2/2/23 revealed target behaviors consisting of aggressive behavior, severe disruptive behavior, taking things that do not belong to him, failure to make responsible choices and attempted AWOL/actual AWOL. Further review on 9/18/23 of client #2's BSP revealed no written consent by the HRC. Interview on 9/19/23 with the Regional Director revealed that no written consent has been obtained by HRC. W 263 PROGRAM MONITORING & CHANGE W 263 CFR(s): 483.440(f)(3)(ii) 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:

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 944710

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PRINTED: 09/20/2023 FORM APPROVED

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 34G284 B. WING 09/19/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **359 FIRETOWER ROAD** COUNTRYVIEW RESIDENTIAL **RICHLANDS, NC 28574** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 263 Continued From page 14 W 263 Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 5 audit clients (#2). The finding is: Review on 9/18/23 of client #2's Behavior Support Plan (BSP) dated 2/2/23 revealed restrictions for searches of client #2's room and person, restricting access to knives, not having a lock on his bedroom door and installing outside gates that would be secured. Further record review on 9/19/23 of client #2's BSP revealed no written informed consent of a legal guardian. Interview on 9/19/23 with the Regional Director confirmed written informed consent by the guardian should have but has not been obtained for client #2's BSP. COMPREHENSIVE DENTAL DIAGNOSTIC W 352 W 352 SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure each client received comprehensive dental services including periodic examinations at least annually. This affected 1 of 5 audit clients (#2). The finding is: Review on 9/18/23 of client #2's record revealed his last dental examination and cleaning occurred on 7/22/21. No current dental examinations could

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/20/2023

		AND HUMAN SERVICES				FORM	09/20/2023 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	34G284		B. WING			09/19/2023		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
COUNTRYVIEW RESIDENTIAL					59 FIRETOWER ROAD ICHLANDS, NC 28574			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 352	Continued From pa be located.	ge 15	W 3	352				
W 369	revealed she did no to be seen by denta facility nurse confirr a dental/gum exam	RATION	W 3	869				
	that all drugs, includ self-administered, a This STANDARD is Based on observat interview, the facility medications were a This affected 2 of 5	g administration must assure ding those that are are administered without error. s not met as evidenced by: tions, record review and y failed to ensure all administered without error. c clients (#3 and #6) observed ons. The findings are:						
	6:46pm, the medica assisting client #3 w	ons in the home on 9/18//23 at ation technician was observed vith administering her included Metformin ER						
	orders dated 11/19/ Metformin ER 500m	of client #3's physician's /22 reveled an order for ng take 1 tablet by mouth, ening meal and was ordered						
	6:57pm, the medica assisting client #6 w	ons in the home on 9/18/23 at ation technician was observed vith administering her included Latuda 120mg. he medication.						

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		AND HUMAN SERVICES			FORM	09/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G284	B. WING _		09/	19/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRYVIEW RESIDENTIAL				359 FIRETOWER ROAD RICHLANDS, NC 28574		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
W 369	Immediate interview technician revealed order for Latuda 12 5:00pm. The medic when a client refuse document it in the e book and behavior nursing. Review on 9/19/23 orders dated 11/19/ Latuda 120mg take 8:00am. Interview on 9/19/23	ige 16 w with the medication I the electronic MAR had an Omg take 1 tablet by mouth at cation technician revealed es a medication staff has to electronic MAR, comunication log but does not have to notify of client #6's physician's (22 revealed an order for a 1.5 tablets by mouth at 3 with the facility nurse 's medication policy states	W 36	69		
W 440	medications can be hour after schedule nurse also confirme medication outside nurse also revealed change for Latuda t but could not provid the change. The nu refuses a medication EVACUATION DRII CFR(s): 483.470(i)(at least quarterly for This STANDARD is Based on record re failed to ensure fire quarterly for each s Review on 9/18/23 October 2022 - Aug	e given one hour before or one ed medication time. The facility ed that client #3 received the approved time frame. The d that client #6 had an order to be administered at 5:00pm de a physician's order to show arse stated anytime a client on staff should notify nursing. LLS (1) r each shift of personnel. s not met as evidenced by: eview and interview, the facility drills were conducted at least hift. The finding is: of the facility's fire drills for gust 2023 revealed no for June 2023, July 2023,	W 44	40		

		AND HUMAN SERVICES				FORM	09/20/2023 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G284	B. WING 09/19/2					
NAME OF F	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
COUNTRYVIEW RESIDENTIAL					59 FIRETOWER ROAD RICHLANDS, NC 28574			
(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 440	Continued From pa	ge 17	W 4	140				
W 441	confirmed no fire dr the missing months	LLS	W 4	141				
	Based on review of and interviews, the evacuation drills we times/conditions. Th Review on 9/18/23 evacuation report fo	s not met as evidenced by: f fire drill evacuation reports facility failed to ensure fire ere conducted at varied he finding is: of the facility's fire drill or the time period of October						
	drills were conducte 2nd shift at 7:10pm and 5:46pm; and 3r Interview on 9/19/23	ember 2023 revealed no fire ed in the home on 1st shift; , 7:00pm, 5:45pm, 4:15pm rd shift at 5:00am and 4:30am. 3 with the Regional Director						
W 460	varied times.		W 4	160				
	Each client must re- well-balanced diet in specially-prescribed	ncluding modified and						
	Based on observat interviews, the facili received a nourishin including modified s	s not met as evidenced by: tions, record reviews and ity failed to ensure each client ng, well balanced diet specially prescribed diet as fected 1 of 5 audit clients (#3).						

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		AND HUMAN SERVICES				FORM	09/20/2023 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		34G284	B. WING	B. WING 0					
NAME OF F	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
COUNTRYVIEW RESIDENTIAL					59 FIRETOWER ROAD CICHLANDS, NC 28574				
(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 460	Continued From pa The finding is:	ge 18	W 4	460					
	4:29pm, client #3 w bag of potato chips Further observation	in the home on 9/18/23 at was discovered eating out of a while standing in the pantry. as revealed client #3 o chip which was three inches							
	9/18/23 at 6:18pm, consuming two fish Further observation consumed one slice	rvations in the home on client #3 was observed fillets with two bites each. as revealed client #3 also e of bread in two bites. At no s meal modified modified et.							
	9/19/23 at 7:05am, consuming two roun observations reveal sausage patties wit	oservations in the home on client #3 was observed nd sausage patties. Further led client #3 consumed both h two bites each. At no time sausage patties modified et.							
		of the facility's diet order dated Client #3]All food bite size							
W 478	staff confirmed clien sized.	on 9/19/23, management nt #3's food should be bite (1)(ii)	W 4	178					
	meal.	e a variety of foods at each s not met as evidenced by:							

Facility ID: 944710

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G284	B. WING			09/	19/2023
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTR	YVIEW RESIDENTIAL	-			559 FIRETOWER ROAD RICHLANDS, NC 28574		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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 478	Continued From pa Based on observat	ge 19 ions, document review and	W 4	178			
	interviews, the facili residing in the home foods listed on the r	ity failed to assure clients e were offered the variety of menu. This affected 5 of 5 , #4, #5 and #6). The finding					
	A was observed coo noodles for dinner. indicated fruit cups At no time were the with their meal. Ad	s in the home on 9/18/23 Staff oking fish fillets and egg Further observations where for the clients dessert. clients offered a vegetable ditional observations revealed v of canned vegetables in the					
	9/18/23 revealed st	of the facility's menu book for ir fry shrimp over egg noodles, whole wheat bread, margarine for dinner.					
W 481		-	W 4	181			
	file for 30 days. This STANDARD is Based on observat	ually served must be kept on s not met as evidenced by: ions and interviews, the facility d substitutions were inding is:					
	A was observed coo noodles for dinner.	s in the home on 9/18/23 Staff oking fish fillets and egg Further observations where for the clients dessert.					

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		AND HUMAN SERVICES					FORM	09/20/2023 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	34G284		B. WING	·		09/19/2023			
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE				
COUNTRYVIEW RESIDENTIAL					59 FIRETOWER ROAD RICHLANDS, NC 28574				
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD	BE	(X5) COMPLETION DATE	
W 481	Continued From pa	ige 20	W 4	481					
	9/18/23 revealed st mandarin oranges, and choice of drink During a interview of was no stir fry shrin	of the facility's menu book for ir fry shrimp over egg noodles, whole wheat bread, margarine for dinner. on 9/18/23, Staff A stated there np in the home. Further she was substituting the stir fry							
	shrimp with fish fille								
	revealed the last er	ntry was on 6/21/23.							
	revealed the meal s	r on 9/19/23, management substitution form should have ne dinner meal, which 3.							