PRINTED: 10/25/2023 FORMAPPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HOME A. BUILDING B. WING STREET ADDRESS, C 2723 BOBWHITE CIE WINGATE, NC 28:	DITY, STATE, ZIP CODE	10/24/2023
MEADOWVIEW HOME 2723 BOBWHITE CIR		10,24,2020
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
\$416.54(d)(2), \$418.113(d)(2), \$441.184(d)(2), \$460.84(d)(2), \$482.15(d)(2), \$483.73(d)(2), \$483.475(d)(2), \$484.102(d)(2), \$485.542(d)(2), \$485.525(d)(2), \$485.727(d)(2), \$485.542(d)(2), \$485.625(d)(2), \$485.727(d)(2), \$485.920(d)(2), \$491.12(d)(2), \$494.62(d)(2). *[For ASCs at \$416.54, CORFs at \$485.68, REHs at \$485.542, OPO, "Organizations" under \$485.727, CMHCs at \$485.920, RHCs/FQHCs at \$491.12, and ESRD Facilities at \$494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is	R - Mental Health NOV 7 2020 & Cert. Section	

BORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kevin Clark Statewide ICF Director

11/2/2023

(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.

	ATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			ESURVEY IPLETED		
		34G117	B. WING		10	/24/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2723 BOBWHITE CIRCLE WINGATE, NC 28174		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	a narrated, clinically-rescenario, and a set of directed messages, or designed to challenge (iii) Analyze the [facility maintain documentation exercises, and emerge [facility's] emergency provides the second for the	es a group discussion using elevant emergency problem statements, prepared questions an emergency plan. y's] response to and on of all drills, tabletop ency events, and revise the plan, as needed. 113(d):] the state provide care in the proper must conduct mergency plan at least must do the following: scale exercise that is y 2 years; or a based exercise is not individual facility based exercise a natural or that requires activation of the hospital is exempt from quired full scale exercise following the avevent. It is exercise every 2 years, all-scale or functional ph (d)(2)(i) of this section include, but is not limited exercise that is accility based functional	E 03	This page is intentionally left blank		

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		34G117	B. WING				10/24/2023
	ROVIDER OR SUPPLIER			272	REET ADDRESS, CITY, STATE, ZIP CODE 23 BOBWHITE CIRCLE NGATE, NC 28174		10/24/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E .TE	(X5) COMPLETION DATE
	Continued From page a narrated, clinically-rescenario, and a set of particle directed messages, or designed to challenge: Testing for hospices the directly. The hospice in to test the emergency phospice must do the form of the form o	elevant emergency problem statements, prepared questions an emergency plan. Interpretation of the problem of the provide inpatient care must conduct exercises plan twice per year. The pollowing: Interpretation of the problem of th	E	039			DATE
h	ospice's emergency pla	an, as needed.					

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ı	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB	NO. 0938-0	139
ı	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY	
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I			240447					
NAME OF PROVIDER OR SUPPLIER		B. WING		1	0/24/2023			
l		NO VIDEN ON SOFFEIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
l	MEADOV	VVIEW HOME			2723 BOBWHITE CIRCLE			
ŀ				1	WINGATE, NC 28174			
ı	(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			_
	TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD F	3F	(X5) COMPLETIC	ON
			THE I'VI CITIVITATION)	TAG	CROSS-REFERENCED TO THE APPROPRI	ATE	DATE	211
_					DEFICIENCY)			
	E 039	Continued From page 3	3					
				E 039	1		1	
		*[For PRFTs at §441.18 §482.15(d), CAHs at §4	195 COE(4)					
		(2) Testing The IDDTE	165.625(d):]		This page is intentionally left blank			
conduct exercises to		conduct evercises to to	PRTF, Hospital, CAH] must					
		twice per year. The IDE	RTF, Hospital, CAH] must					
		do the following:	(TF, Hospital, CAH) must					
			ual full-scale exercise that					
		is community-based; or	-					
		(A) When a community-						
	-	accessible, conduct an	annual individual					
		facility-based functional	exercise: or					- 1
		(B) If the [PRTF, Hospit	al, CAH] experiences an					-
	(6	actual natural or man-m	ade emergency that			1		- 1
		requires activation of the	e emergency plan, the					-
		[facility] is exempt from	engaging in its next					-
	- 1	required full-scale comm	unity based or individual	1 1		1		- 1
	- 1	facility-based functional	exercise following the			- 1		
		onset of the emergency	event.			1		1
		Conduct an [additional] a	annual exercise or and that					-
		may include, but is not li	mited to the following:					
	1.	(A) A second full-scale	exercise that is					
		community-based or indi functional exercise; or	vidual, a facility-based			1		
		(B) A mock disa	ster drill; or se or workshop that is					ı
	- 1	ed by a facilitator and in	se or workshop that is					1
		discussion, using a narra	ted clinically relevant					1
	6	emergency scenario, and	a set of problem					1
	s	statements, directed mes	sames of problem			- 1		1
	C	questions designed to cha	allenge an emergency			1		1
	p	olan.	3- an emergency					1
) A	analyze the [facility's] res	ponse to and maintain					
	d	locumentation of all drills	, tabletop exercises					
	а	ind emergency events an	d revise the [facility's]					
	e	mergency plan, as need	ed.					
	*[For PACE at §460.84(d):]					

NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HOME (X4) ID SUMMARY STATEME PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	gency plan at least		STREET ADDRESS, CITY, STATE, ZIP CODE 2723 BOBWHITE CIRCLE WINGATE, NC 28174 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X3) DATE SURVEY COMPLETED 10/24/2023 E
MEADOWVIEW HOME (X4) ID SUMMARY STATEME PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	MENT OF DEFICIENCIES ST BE PRECEDED BY FULL ENTIFYING INFORMATION) anization must conduct gency plan at least	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5)
MEADOWVIEW HOME (X4) ID SUMMARY STATEME PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	ET BE PRECEDED BY FULL ENTIFYING INFORMATION) anization must conduct gency plan at least	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5)
PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	ET BE PRECEDED BY FULL ENTIFYING INFORMATION) anization must conduct gency plan at least	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	- CMPLETION
E 030 Continue 1 =	gency plan at least	E 039	9	
E 039 Continued From page 4 (2) Testing. The PACE organexercises to test the emergannually. The PACE organifollowing: (i) Participate in an annual is community-based; or (A) When a community-base accessible, conduct an annual facility-based functional executes (B) If the PACE experiences man-made emergency that the emergency plan, the PA engaging in its next required based or individual, facility-bexercise following the onset event. Conduct an additional exercise under paragraph (disconducted that may include the following: (A) A second full-scale exercise under paragraph (disconducted that may include the following: (A) A second full-scale exercise under paragraph (disconducted that may include functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or wo a facilitator and includes a grusing a narrated, clinically-rescenario, and a set of problet directed messages, or preparadesigned to challenge an emediate to challenge an emediate to challenge and emergency events and resemergency plan, as needed. *[For LTC Facilities at §483.73 (2) The [LTC facility] must conditions and the conditions as a set of problem and emergency plan, as needed.	full-scale exercise that sed exercise is not hual individual, ercise; or es an actual natural or t requires activation of ACE is exempt from d full-scale community based functional t of the emergency cise every 2 years ale or functional d)(2)(i) of this section de, but is not limited to rcise that is hal, a facility based orkshop that is led by roup discussion, elevant emergency em statements, ared questions hergency plan. se to and maintain hibletop exercises, evise the PACE's		This page is intentionally left blank	

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) I	(X3) DATE SURVEY COMPLETED	
		34G117	B. WING				
NAMEOF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	10/24/2023	
MEADOV	WVIEW HOME			2723 BOBWHITE CIRCLE WINGATE, NC 28174	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE	
(t	test the emergency plaincluding unannounce emergency procedure ICF/IID] must do the form of the community-based; of the community-based in community-based; of the community-based functional (B) If the [LTC facility] is actual natural or manner requires activation of the LTC facility is exempt for the community-based or an individual, facility-based following the onset of the community-based or an functional exercise; or (B) A mock disaster drill (C) A tabletop exercise a facilitator includes a gonerated, clinically-relevand a set of problem states a facilitator includes a gonerated, clinically-relevand a set of problem states a facilitator includes a gonerated, clinically-relevand a set of problem states a facilitator includes a gonerated, clinically-relevand a set of problem states a facilitator includes a gonerated, clinically-relevand a set of problem states a facilitator includes a gonerated, clinically-relevand a set of problem states a facilitator includes a gonerated challenge an emergency (i) Analyze the [LTC emergency plain for its facility of the community of the com	an at least twice per year, d staff drills using the s. The [LTC facility, billowing: nual full-scale exercise that in based exercise is not annual individual, at exercise. Facility experiences an made emergency that the emergency plan, the rom engaging its next in munity-based or diffunctional exercise that imited to the following: exercise that is individual, facility based or converted to the following: exercise that is individual, facility based or converted to the following: exercise that is individual, facility based or converted to the following: exercise that is individual, facility based or converted facility] facility's individual, facility's indiv	E	This page is intenti			

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ND PLAN (OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO (X3) DATES	. 0938-0
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IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/2	4/2023
IEADOW	VIEW HOME			2723 BOBWHITE CIRCLE		
(X4) ID	2111111			WINGATE, NC 28174		
PREFIX	(CACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CO	00505	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULDE	(X5) COMPLETIO DATE
E 039	Continued From page 6	3				
1	is community-based; or		E 03	9		
1	(A) When a community	-hased eversion is not				
	accessible, conduct an	annual individual		This page is intentionally le	eft blank	
	racility-based functiona	ll exercise: or				
	(B) If the ICF/IID experi	ences an actual natural ar				
1	man-made emergency	that requires activation as				
1	are emergency plan, th	e ICF/IID is exempt from				
- 1	crigaging in its next req	uired full-scale				
	community-based or inc	dividual, facility-based				
0	functional exercise follo emergency event.	wing the onset of the				
	(ii) Conduct an additiona	d appual				
r	may include, but is not lin	mited to the following				
(A) A second full-scale e	exercise that is				
0	community-based or an i	ndividual facility-based				
"	uncuonal exercise; or		1 1			
(E	B) A mock disaster drill;	or	1			
(0	C) A tabletop exercise of	r workshop that is led by				
a	racilitator and includes	a group discussion				
l us	sing a narrated, clinical	V-relevant emergency				
30	certailo, and a set of pro	oblem statements				
de	rected messages, or pr	epared questions				
Giii	esigned to challenge an	emergency plan.				
ma	i) Analyze the ICF/IID's aintain documentation of	response to and				
ex	ercises, and emergency	all drills, tabletop				
IC	F/IID's emergency plan	, as needed.				
*[F	or HHAs at §484.102]					
(d)	(2) Testing. The HHA m	ust conduct eversions				
100	iest the emergency plan	n at				
lea	st annually. The HHA m	ust do the following:				
(1) 1	articipate in a full-scale	exercise that is	1			
con	nmunity-based; or	1				
	(A) When a community	/-based exercise is not				
acc	essible, conduct an ann	nual individual				- 1
£	IIIV-Dacad function I				I I	
facil or.	ity-based functional exe	rcise every 2 years;				- 1

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G117	B. WING_		10/24/2023
	PROVIDER OR SUPPLIER WVIEW HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2723 BOBWHITE CIRCLE WINGATE, NC 28174	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION
E 039	(C) If the HHA experie man-made emerg activation of the exempt from engal full-scale communifacility based function the onset of the ereceived with the onset of the exercise under paragrisis conducted, that limited to the following (A) A second full-community-based or an functional exercise; or (B) A mock disaste (C) A tabletop exelled by a facilitator and discussion, using a nare emergency scenario, a statements, directed minimal questions designed to oplan. (iii) Analyze the HHA's documentation of all driemergency events, and emergency plan, as need to the following: (i) Conduct a paper-base (i) Conduct a paper-base (ii) Conduct a paper-base (iii) Conduct a paper-base (iii) Conduct a paper-base (iii) Conduct a paper-base (iii) Conduct a paper-base (iiii) Conduct a paper-base (iiii) Conduct a paper-base (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	ences an actual natural or ency that requires mergency plan, the HHA is ging in its next required ity-based or individual, tional exercise following mergency event. Inal exercise every 2 years, full-scale or functional aph (d)(2)(i) of this section may include, but is not it is scale exercise that is in individual, facility-based er drill; or reise or workshop that is includes a group trated, clinically-relevant and a set of problem dessages, or prepared challenge an emergency response to and maintain and the revise the HHA's eded. On must conduct exercises and drevise the HHA's eded. On must conduct exercises or ally. A tabletop exercise is includes a group rated, clinically relevant and a set of problem as a group rated, clinically relevant and a set of problem	EO	This page is intentionally left blank	

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		TE SURVEY MPLETED	
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ĺ	NAMEOFP	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/24/2023	
l	MEADOW	VIEW HOME			2723 BOBWHITE CIRCLE			
ŀ					WNGATE, NC 28174			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
		plan. If the OPO expension man-made emergency the emergency plan, the engaging in its next refollowing the onset of the emergency expension of all tale emergency events, and OPO's] emergency plan. *[RNCHIs at §403.748 (d)(2) Testing. The RN exercises to test the emmust do the following: (i) Conduct a paper-balleast annually. A tablet discussion led by a fact clinically-relevant emergof problem statements, prepared questions desemergency plan. (ii) Analyze the RNHCI' maintain documentation and emergency events, emergency plan, as nearly as the facility's emergency at least biennially. The face is the facility's emergency plan (EPF of initial or biennial train therview on 10/23/23 we retained to be initial or biennial train therview on 10/23/23 we retained to be initial or biennial train therview on 10/23/23 we retained to the facility's emental train therview on 10/23/23 we retained to be initial or biennial train therview on 10/23/23 we retained to the facility's emergency plan (EPF of initial or biennial train therview on 10/23/23 we retained to the facility or biennial train therview on 10/23/23 we retained to the facility or biennial train therview on 10/23/23 we retained to the facility or biennial train therview on 10/23/23 we retained to the facility or biennial train the facility of the facility of the facility or biennial train the facility of t	challenge an emergency iences an actual natural or that requires activation of the OPO is exempt from quired testing exercise the emergency event. response to and maintain abletop exercises, and drevise the [RNHCI's and in, as needed.]: HCI must conduct the percent and a set op exercise is a group ilitator, using a narrated, gency scenario, and a set directed messages, or signed to challenge an instructions of all tabletop exercises, and revise the RNHCI's edd. It met as evidenced by: If and interview, the facility are staff were trained on preparedness plan (EPP) finding is: Ithe facility's emergency or exercise in gon the EPP. Ith the Statewide ICF initial training and biennial	E 03	E 039 ICF Director will retrain Resident Manager and Residential Team on updating the Emergency Preparedness Plan at least every years, and/or whenever a change clientele in the group home by 12/1/2023. RM and/or designee will retrain a on the emergency preparedness by 12/1/2023. ICF Director will complete Tablete Exercise with all staff by 12/1/2022 Director will monitor annually by requesting EPP and TTX to be seme directly.	Leader y 2 e in ill staff plan op 3. ICF	10/28/2023	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE	ESURVEY PLETED
		34G117	B. WING		10	/24/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2723 BOBWHITE CIRCLE WINGATE, NC 28174		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	(X5) COMPLETION DATE
	CFR(s): 483.470(g)(2). The facility must furnis and teach clients to us choices about the use hearing and other com and other devices ider interdisciplinary team at This STANDARD is not Based on observation, interview, the facility faculipment was furnish plate guard, gait belt at Evening observation in 5:03 PM revealed client dinner meal. Continued client #4 to be provided equipment for the dinner protector and a deep dobservation revealed the home during survey use of any adaptive equipment for the breakfast meal. Continuction #4 to be provided equipment for the breakfast meal. Continuction #4 to be provided equipment for the breakfast meal. Continuction #4 to be provided equipment for the breakfast meal and device the breakfast meal and device equipment for the breakfast protector and a device observation revealed the home during survey use of any adaptive equipment for any adaptive equipment fo	th, maintain in good repair, se and to make informed of dentures, eyeglasses, munications aids, braces, attified by the as needed by the client. The time that as evidenced by: record review and ailed to ensure adaptive ed for client #4 relative to and rollator. The finding is: If the facility on 10/23/23 at at the facility on 10/23/23 at the facility on the dobservation revealed the following adaptive er meal to include a shirt invided dish. Further that client #4 moved about the air belt, and a rollator. The facility on 10/24/23 at the facility on 10/24	W 43		nat d. ne is ptive	

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) 111 11 =		OMB	VO. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DAT	ESURVEY MPLETED
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	PROVIDER OR SUPPLIER VVIEW HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2723 BOBWHITE CIRCLE WINGATE, NC 28174	10	0/24/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DE	(X5) COMPLETION DATE
Ir we side of the control of the con	nutrition assessment dindicated client #4 uses bib/shirt protector. Furt documentation in the gmenu book in the kitche adaptive equipment for guard and bib/shirt prot of records revealed an evaluation dated 10/19/#4 would benefit from u and staff assistance dur safety and decrease risl Interview on 10/24/23 wwere aware of a deep dictient #4 as well as night incontinence. Continued revealed that if client #4 adaptive equipment that had not received any add adaptive equipment characteries on 10/24/23 with yere aware of client #4 to thirt protector. Further interview	ntered Plan (PCP) dated view of the PCP revealed a lated 9/18/23 which is a plate guard and her review of roup home revealed a latent to have a list of client #4 to include a plate ector. Subsequent review occupational therapy 1/22 which indicated client is eof gait belt, rollator, ring mobility to increase is of falls. With staff C revealed they interview with staff C required additional staff was unaware and litional training regarding inges. The staff E revealed they is a deep dish and terview with staff E do support client #4 on ing on to arm. The staff E revealed they is a deep dish and terview with staff E do support client #4 on ing on to arm. The staff E revealed they is a deep dish and terview with staff E do support client #4 on ing on to arm. The staff E revealed they is a deep dish and terview with staff E do support client #4 on ing on to arm.	W 430			