PRINTED: 04/11/2025 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MEEK ROAD GROUP HOME  B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 138 MEEK ROAD GASTONIA, NC 28056	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  138 MEEK ROAD  138 MEEK ROAD	34G107	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	FIX (EACH DEF	
E 039 EP Testing Requirements CFR(s): 483.475(d)(2) \$416.54(d)(2), \$418.113(d)(2), \$441.184(d)(2), \$460.84(d)(2), \$482.15(d)(2), \$483.373(d)(2), \$483.475(d)(2), \$484.102(d)(2), \$485.68(d)(2), \$485.542(d)(2), \$485.68(d)(2), \$485.542(d)(2), \$485.68(d)(2), \$485.542(d)(2), \$485.68(d)(2), \$485.542(d)(2), \$485.68(d)(2), \$485.542(d)(2), \$485.68(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542, OPO, "Organizations" under \$485.727, CMHCs at \$485.920, RHCs/FCHCs at \$491.12, and ESRD Facilities at \$494.62(c) \$489.12, and ESRD Facilities at \$494.62(c) \$489.12, and ESRD Facilities at \$494.62(c) \$489.12, and Edra 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 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)(j) of this section is conducted, that may include, but is not limited to the following:  (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or  (B) A mock disaster drill; or  (C) A tabletop exercise or workshop that is led by	CFR(s): 483.  §416.54(d)(2 §460.84(d)(2 §483.475(d)( §485.542(d)( §485.920(d)( *[For ASCs a at §485.542, §485.727, CN §491.12, and  (2) Testing. T to test the en must do all of  (i) Participate community-b (A) When a accessible, of exercise even (B) If the natural or ma activation of the exempt from community-b functional exe actual event. (ii) Conduct at years, oppose functional exe this section is not limited to (A) A second community-b functional exe (B) A mock d (C) A tabletop	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
		34G107	B. WING _		04	/09/2025
	PROVIDER OR SUPPLIER  DAD GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP O 138 MEEK ROAD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
E 039	a narrated, clinically scenario, and a set directed messages designed to challen (iii) Analyze the [fac maintain document exercises, and emergacility's] emergency *[For Hospices at 4 (2) Testing for hospices to test the annually. The hospice in a facommunity based of (A) When a community based of (A) When a community based of (B) If the hospice of man-made emergency plar engaging in its next community-based of facility-based functionset of the emergency plar engaging in its next community-based of facility-based functionset of the emergency plar exercise under parais conducted, that in to the following:  (A) A second full-scommunity-based of exercise; or  (B) A mock disaster (C) A tabletop exercise	udes a group discussion using y-relevant emergency of problem statements, or prepared questions ge an emergency plan. Sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed.  18.113(d):] Dices that provide care in the ency plan at least poice must conduct the emergency plan at least poice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not that an individual facility based every 2 years; or experiences a natural or experiences a natural or exercise or individual onal exercise following the exercise or individual onal exercise following the ency event. Sitional exercise every 2 years, the full-scale or functional exercise or individual onal exercise or individual onal exercise or functional exercise every 2 years, the full-scale or functional exercise that is or a facility based functional or	E 03	9		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG	` ,	TE SURVEY MPLETED	
		34G107	B. WING		04	/09/2025
	PROVIDER OR SUPPLIER  OAD GROUP HOME			STREET ADDRESS, CITY, STAT 138 MEEK ROAD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
E 039	a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The hexercises to test the year. The hospice (i) Participate in an is community-based (A) When a community-based (A) When a community-based functi (B) If the hospice exam-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-scommunity-based of exercise; or (B) A mock disasted (C) A tabletop exertifacilitator that including narrated, clinically-rand a set of problem messages, or preparately and a set of problem messages, or preparately and an emergical in analyze the hosmaintain document	of problem statements, or prepared questions ge an emergency plan.  ices that provide inpatient hospice must conduct elemergency plan twice per must do the following: annual full-scale exercise that d; or unity-based exercise is not an annual individual onal exercise; or experiences a natural or noty that requires activation of a the hospice is exempt from a required full-scale community sed functional exercise of the emergency event. Ititional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or cise or workshop led by a des a group discussion using a relevant emergency scenario, in statements, directed ared questions designed to gency plan.  spice's response to and ation of all drills, tabletop ergency events and revise the	EO	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	, ,	TE SURVEY MPLETED	
		34G107	B. WING _		04	/09/2025
NAME OF PROVIDER OR SUPPLIER  MEEK ROAD GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP 138 MEEK ROAD GASTONIA, NC 28056	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 039	*[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF conduct exercises at twice per year. The do the following: (i) Participate in an is community-based (A) When a community-based function (B) If the [PRTF, Ho actual natural or marequires activation (facility-based functionset of the emerging (ii) Conduct an and that may include following: (A) A second full-scommunity-based of functional exercises (B) A mock (C) A tabletop of led by a facilitator ad discussion, using a emergency scenari statements, directed questions designed plan.  (iii) Analyze the maintain document	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan annual full-scale exercise that d; or unity-based exercise is not annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event.  I [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based or individual, a facility-based or includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared I to challenge an emergency effacility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	E 03	9		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	COMPLETED		
		34G107	B. WING		04/09/2025		
NAME OF PROVIDER OR SUPPLIER  MEEK ROAD GROUP HOME				1	STREET ADDRESS, CITY, STATE, ZIP CODE  38 MEEK ROAD  GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	(2) Testing. The PA exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a community-based function (B) If the PACE expman-made emerge the emergency plar engaging in its next based or individual, exercise following the exercise under parais conducted that must be following: (ii) Conduct an years opposite the exercise under parais conducted that must be following: (A) A second full-secommunity-based of functional exercise; (B) A mock disasted (C) A tabletop exert a facilitator and inclusing a narrated, clusing a	CE organization must conduct a emergency plan at least a corganization must do the annual full-scale exercise that d; or unity-based exercise is not an annual individual, onal exercise; or periences an actual natural or ney that requires activation of a the PACE is exempt from a required full-scale community facility-based functional the onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section has include, but is not limited to cale exercise that is or individual, a facility based or ear drill; or recise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. CE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed.  at §483.73(d):]		039			
		must conduct exercises to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G107	B. WING			04/09/2025	
NAME OF PROVIDER OR SUPPLIER  MEEK ROAD GROUP HOME			138	REET ADDRESS, CITY, STATE, ZIP CODE  MEEK ROAD  STONIA, NC 28056			
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E 039	including unannour emergency proced ICF/IID] must do the (i) Participate in aris community-base (A) When a community-based (A) When a community-based funct (B) If the [LTC facility-based functional natural or morequires activation LTC facility is exemorequired a full-scale individual, facility-based functional the community-based (ii) Conduct an additional exercises (B) A mock disasted (C) A tabletop exemolated a facilitator include narrated, clinically-and a set of problemessages, or preponallenge an emergiant maintain document of the community facility and maintain document of the community facility and maintain document of the community facility fac	y plan at least twice per year, need staff drills using the ures. The [LTC facility, ne following: In annual full-scale exercise that d; or unity-based exercise is not an annual individual, ional exercise. Ity] facility experiences an an-made emergency that of the emergency plan, the npt from engaging its next exercise of the emergency event. In annual exercise of the emergency event. In an individual, facility based in an individual in an individual in a relevant emergency scenario, in statements, directed ared questions designed to gency plan.  The facility facility's response to mentation of all drills, tabletop ergency events, and revise the individual in an individual in an individual individual in an individual individual in an individual indi	E	039			

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E 039	is community-based (A) When a community-based functional emergency plarengaging in its next community-based of functional exercise emergency event. (ii) Conduct an add may include, but is (A) A second full-socommunity-based of functional exercise; (B) A mock disasted (C) A tabletop exerca facilitator and inclusing a narrated, clusing a narrated	d; or unity-based exercise is not that an annual individual, onal exercise; or reperiences an actual natural or ney that requires activation of any, the ICF/IID is exempt from a required full-scale or individual, facility-based following the onset of the ditional annual exercise that not limited to the following: alle exercise that is or an individual, facility-based or and ditional annual exercise that is or an individual, facility-based or a drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. [IIID's response to and action of all drills, tabletop ergency events, and revise the ry plan, as needed.  1.102] HHA must conduct exercises cy plan at HHA must do the following: ull-scale exercise that is	E 03	9		

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E 039	(B) If the HHA or man-made emerof the emergency pengaging in its next community-based of functional exercise emergency event.  (ii) Conduct an add opposite the year the exercise under parties conducted, that limited to the follow (A) A second functional exercise (B) A mock disa (C) A tabletop of led by a facilitator addiscussion, using a emergency scenaristatements, directed questions designed plan.  (iii) Analyze the HH documentation of a emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The to test the emerger following:  (i) Conduct a paper workshop at least as led by a facilitator addiscussion, using a emergency scenarior discussion, using a emergency scenarior discussion.	experiences an actual natural regency that requires activation lan, the HHA is exempt from a required full-scale or individual, facility based following the onset of the ditional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ing: all-scale exercise that is or an individual, facility-based or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency.  A's response to and maintain II drills, tabletop exercises, and and revise the HHA's is needed.	E 03			

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E 039	questions designed plan. If the OPO ex man-made emerge the emergency plan engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the following (i) Conduct a paper least annually. A talk discussion led by a clinically-relevant e of problem statement of problem statement of problem statement and emergency plan. (ii) Analyze the RNI maintain document and emergency plan, as This STANDARD in Based on record refailed to conduct bit Emergency Prepart finding is:  Review of the facility table top exercise or review revealed no full-scale community mock drill exercise.	I to challenge an emergency periences an actual natural or ncy that requires activation of n, the OPO is exempt from a required testing exercise of the emergency event. O's response to and maintain II tabletop exercises, and and revise the [RNHCI's and plan, as needed.  748]: RNHCI must conduct e emergency plan. The RNHCI ng: 1-based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's ents, and interview, the facility ennial testing of the facility's edness Plan (EPP). The	E 03	9		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED	
		34G107	B. WING _		04	/09/2025
NAME OF PROVIDER OR SUPPLIER  MEEK ROAD GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CO 138 MEEK ROAD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	confirmed the facilir additional full-scale exercise or mock d	ty has not conducted an community/facility-based	E 0:			
	developmental leve This STANDARD i Based on observati interview, the facilit served in a form co	ed in a form consistent with the el of the client. s not met as evidenced by: tions, record review and y failed to ensure food was				
	PM revealed the dir pancakes, scramble bacon, strawberries observation revealed pancakes and sause by staff. Further observations	group home on 4/8/25 at 5:00 nner meal to include ed eggs, sausage, turkey s, water and juice. Continued ed client #1 to be served whole sage cut into bite-size pieces servations revealed client #1 onsume the dinner meal				
	AM revealed the br turkey bacon, bake and coffee. Continu #1 to serve himself	group home on 4/9/25 at 7:45 eakfast meal to include cereal, d omelet, toast, water, juice led observation revealed client the breakfast meal in whole e and consume the breakfast //.				
	nutritional assessment inc grams sodium diet,	s record on 4/9/25 revealed a tent dated 7/31/24. Review of licated his diet order to be 3 mechanical soft, nectar wo quarts of fluid daily, no				

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W 474	caffeine, no grapefr Interview with facilit confirmed the diet of Continued interview diet means food sh bite-sized pieces wi processor, or can b Interview with the q professional on 4/9	ruit.  ry dietician on 4/9/25  order for client #1 is current.  revealed a mechanical soft ould be modified into ith the use of a blender or food be done by hand with a knife. ualified intellectual disability //25 confirmed staff are uring clients receive their diet	W 47	74			