DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/13/2025 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A BUILDING COMPLETED 34G111 B. WING 06/10/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **PILOTVIEW** 209 PILOT VIEW DRIVE **KING, NC 27021** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 104 **GOVERNING BODY** W 104 CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, record review, and W104 interview, the governing body and management failed to exercise general policy and operating To ensure that routine cleaning of the group direction over the facility by failing to ensure home, the TL will: routine cleaning, routine extermination, and maintenance repairs at the group home were 1. Inservice staff regarding LTSS Shift Checklists completed in a timely manner. The finding is: for 1st, 2nd, and 3rd shifts which includes cleaning responsibilities. Observations throughout the 6/9 - 6/10/25 survey 2. RM and RTL will check and monitor Shift revealed repairs inside the group home to include Checklists to ensure that all cleaning duties are a large hole in the wood laminate floor located in being completed for the next 90 days. the living room and dining room with debris still present in and around the hole. Continued 3. RTL will Inservice RM on Environmental observations in the living room revealed a large Checklist and RM will complete the glue trap containing numerous bugs to include Environmental Checklist monthly for the next 90 days to ensure any maintenance issues are dead spiders' and centipedes, a large glue trap immediately entered into the Facility Ticket beside a recliner chair with peanut butter in the system. center, and a large easy set mouse trap behind the couch. Further observations revealed a large 4. RM will submit a Maintenance Ticket easy set mouse trap in the pantry. Subsequent to request extermination services to observations revealed the floors throughout the ensure services are provided on a monthly home in the kitchen, dining room, hallways and routine basis. living room to contain dirt, dried substances, and debris. Additionally, the front door has a broken doorbell with wires exposed. Review of maintenance records on 6/10/25 revealed a work order (WO) completed by the qualified intellectual disabilities professional (QIDP) on 6/10/25 to fix the doorbell after records indicated that maintenance did not complete a

dated 6/5/25 for holes in the dining room and

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

WO during walk through completed on 6/5/25. Continued review of records revealed a WO

Shiela Marshall

QP/RTL

06/26/2025

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.

TITLE

(X6) DATE

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G111		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER PILOTVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 209 PILOT VIEW DRIVE KING, NC 27021		06/10/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	living room floor. The fa surveyor with requested the home. Interview on 6/10/25 withe facility had a mouse traps throughout the howith the QIDP revealed WO's to repair the holes dining room; however, it will take place. Further it verified that the floors the not been cleaned for so have taken place with the ensure cleaning takes p NURSING SERVICES CFR(s): 483.460(c) The facility must provide services in accordance of this STANDARD is not Based on record review services failed to meet the (#5) by failing to monitor weight gain. The finding Review of records on 6/2 revealed a person-center 6/6/25. Continued review diagnosis of Mild Intellect Disabilities, Down Syndring Type 1, and seasonal all records revealed a nutritie 6/4/25 for client #5 to be diabetic diet with carbony	the QIDP verified that and maintenance put me. Continued interview that maintenance had in the living room and it is unknown when repairs interview with the QIDP proughout the home had me time and meetings ne home manager (HM) to lace. I clients with nursing with their needs. The red plan (PCP) dated of the PCP revealed a stual Developmental ome, Diabetes Mellitus ergies. Further review of ional evaluation dated prescribed a regular ydrate counting by staff.	W 331	W331 1. Nursing, QP, RM will work with the Dietitian to update menu to include foo substitutions to meet #5 diabetic diet w carbohydrate counting by staff. To be completed by 7/7/25.	d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G111	B. WING				
NAME OF PROVIDER OR SUPPLIER PILOTVIEW		2	STREET ADDRESS, CITY, STATE, ZIP CODE 209 PILOT VIEW DRIVE KING, NC 27021		6/10/2025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	
	7/24-161 lbs.; 8/24-0. lbs.; 11/24-175 lbs.; 1 2/25-185 lbs.; 3/25-13 5/25-19 lbs. 7; 6/25-1 client has had a 33 pomonths with a current which is in the obesity. Review of the facility's a set menu for all indinot indicating a regula Continued review of the are no guidelines specifient #5 has no diet in Review of client #5's l 6/10/25 revealed that insulin-dependent (Tyreview revealed that insulin-dependent (Tyreview revealed that intake, and the amour balanced. Further revihas a Dexcom system levels and ensures the The client has had 6 hyear relative to her block interview with the qual professional (QIDP) or client #5 does better with client's behaviors a interview with the QID will take snacks from the amounts of foods while interview with the QID not participate with the facility with the	g 9/24-164 lbs.; 10/24-175 2/24-178 lbs.; 1/25-0; 34 lbs.; 4/25-192 lbs.; 96 lbs. Additionally, the pund increase in the last 12 to weight of 196 pounds of category. Is menu on 6/10/25 revealed exiduals in the group home for diet or a diabetic diet. The menu revealed that there destrictions. Diabetes protocol on the client is pe 1) diabetic. Continued the client is pe 1) diabetic. Continued the client's insulin, food that of exercise need to be ewe revealed that client #5 that measures her glucose to delivery of needed insulin. The cospital visits over the past and sugar levels. Iffied intellectual disabilities the 6/10/25 revealed that the client the pantry and will eat large to on home visits. Further prevealed that client #5 will the pantry and will eat large to on home visits. Further prevealed that client #5 will percise.	W 331	1. Nursing, QP, RM will work with mer provider(s) to address #5 excessive who by following continuity of care by which the physician-led care team are coope involved in ongoing health care managed. 2. Nursing will monitor #5 weekly and a for excessive weight. 3. Nursing, QP, RM will work with the update menu to include food substituting #5 diabetic diet with carbohydrate courstaff. To be completed by 7/7/25. 4. Nursing, RM and TL will ensure that diet is being followed by completing the OBSERVATION form for 60 days.	eight gain h #5 and ratively gement. as needed Dietitian to ons to meet nting by	Implementation 6/30/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		34G111	B. WING		06/10/2025	
NAME OF PROVIDER OR SUPPLIER PILOTVIEW		1 2	STREET ADDRESS, CITY, STATE, ZIP CODE 209 PILOT VIEW DRIVE KING, NC 27021	06/10/2025		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES STATEMENT OF DEFICIENCIES ON THE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION DATE	
W 368	interview with the reason that and the tear guidelines put in pleased and the tear guidelines put in pleased and the tear guidelines put in pleased and the physician's ord. This STANDARD is Based on observation interviews, the systic failed to assure all compliance with phin the group home. Observations in the revealed client #1 to administration room Staff C removed client does and plant continued observation and staff C placed and staff C plac	nurse confirmed that the client sive weight over the last 12 am agreed to follow the diet ace by the dietician. RATION ()(1) g administration must assure dministered in compliance with ers. Is not met as evidenced by: tions, record review, and tem for drug administration drugs were administered in pysician orders for 1 of 5 clients (#1). The finding is: In home on 6/10/25 at 7:05 AM to enter the medication of and pour a cup of water. The ent #1's medications from the ced them on the desk. It to revealed staff C picked up and removed a container that curther observations revealed client #1 to shake the drops at drops into each of the equent observations revealed ministered Fluorometholone of the client's ears. Additionally, end staff C that she had the rops into client #1's ears. In 6/10/25 for client #1 in's order dated 2/21/25. If the physician orders		W368 1. RM and TL will ensure staff are sufficitrained in Drug Administration to prevent medication errors. 2.RM and TL will ensure that all staff complete the following Drug Administratitrainings: a. Med Management Part 1: Overview b. Med Management Part 2: Understand Meds c. Med Management Part 3: Labels & Documentation d. Med Management Part 4: Administerin Meds 3. Staff observed during 6/10/25 medicate pass, who administered one medication in the incorrect route and not administering second medication, will retake Medication Administration training with the Registere Nurse. The Nurse will complete the Competency Checklist and submit to Education. RM/TL will complete 2 observations of staff completing medication pass. RM/TL will complete competency checklists and submit to Education. All to completed by 7/23/25. 4. RM and TL will complete random medication observations 3X per week for next 60 days to ensure all drugs are administered without error. 5. RM and TL will document observations using the Medication Administration Observation form.	6/30/25 on ing g ion in a in d on be the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD		E CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
		34G111	B. WING		06/10/2025	
NAME OF PROVIDER OR SUPPLIER PILOTVIEW		1 :	STREET ADDRESS, CITY, STATE, ZIP CODE 209 PILOT VIEW DRIVE KING, NC 27021	00/10/2023		
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION E DATE	
W 369	place one drop in the Interview with the 16/10/25 confirmed Fluorometholone 0 prescribed eye drointerview with the 14 an eye appointmenthe physician will deyes. Interview with the 15 confirmed that clienther Fluorometholone 0 place one drop in 15 Continued interview revealed that staff (nurse that eye dropears. Further interview revealed that staff (protocol so that the medication not beint DRUG ADMINISTR CFR(s): 483.460(k) The system for drug that all drugs, includes life administered, at 15 STANDARD is Based on observatinterviews, the facility were administered (#2) observed durinthe finding is:	both eyes every morning. In ome manager (HM) on that client #1 is prescribed and the suspension and has been ps ongoing. Continued the revealed that client #1 had not on 6/10/25 at 9:30 AM and continue eye drops due to dry acility nurse on 6/10/25 at #1 is prescribed and suspension 5 milliliters both eyes every morning. It with the facility nurse acid do not call and notify the sewere placed in client #1's iew with the facility nurse did not follow notification physician can be notified of a gadministered as prescribed. AATION (2)		1. RM and TL will ensure staff are sufficient trained in Drug Administration to prevent medication errors. 2. RM and TL will ensure that all staff complete the following Drug Administration trainings: a. Med Management Part 1: Overview b. Med Management Part 2: Understanding Meds c. Med Management Part 3: Labels & Documentation d. Med Management Part 4: Administering Meds 3. Staff observed during 6/10/25 medication pass, who administered one medication in incorrect route and not administering a secondication, will retake Medication Administration training with the Registered.	on ng g n the ond Implementation 6/30/25 taff it to ation ays t	

PRINTED: 06/13/2025 FORM APPROVED

STATEMENT OF DEFICIENCIES		(VA) PROVIDENCE OF THE PROVIDE				OMB NO. 0938-0391	
AND PLAN OF CORRECTION		(X2) MULTII (X2) MULTII (X2) MULTII A. BUILDING		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		34G111	B. WING		Or Or	5/10/2025	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		7 10/2023	
PILOTVIE	TAV			209 PILOT VIEW DRIVE			
I ILO I VIE				KING, NC 27021			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 369	Continued From page	ne 5	W 369				
		metholone 0.1 suspension 4	VV 308	This Page Intentionally Left B	Nonk		
	drons into each of the	ne client's ears. Further		This Page Intentionally Left B	Mank		
	observations reveal	ed that staff C punched all					
	nills into medicine or	up and client took whole with					
	water Subsequent	observation revealed that staff					
	C took out the cor d	rops to place in client #1's					
	eves and the survey	rops to place in client #1's					
	vorify prior to placing	or informed staff C to please					
	verified that she had	drops in eyes. Staff C picked up the wrong drops					
	and located the corn						
		o the client. At no time during					
	the medication chas	rvation was staff observed to					
		s prescribed ear drops.					
	Review of records fo	or client #1 on 6/10/25					
	revealed physician's	orders dated 3/30-6/30/25.					
	Review of the physic						
	medications prescrib						
	Amlodipine tab 10 m	g, Fish oil cap 1000 mg,					
	Hydrochlorothiazide	tab 25 mg, Lisinopril tab 40					
	mg, Metformin tab 50	00 MG ER, Pot Chloride tab					
		olol cap 60 mg ER, Vitamin					
	D3 25 MCG, Spironolactone 25 mg, Fluorometholone 0.1% suspension 5 milliliters						
	place one drop in both	th eyes every morning, and					
	Neo/Poly/HC solution	n 1% to instill 4 drops in both					
	ears twice daily at 8:00 AM and 8:00 PM.						
		cility nurse on 6/10/25					
	confirmed client #1's						
	Continued interview						
		did not call and notify the					
		were placed in client #1's					
	ears nor was the nur						
		were not administered.					
		the facility nurse revealed				_	
		w notification protocol so					
		n be notified of medication					
	not being administere	ed as prescribed.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G111	B. WING		06/10/2025	
NAME OF PROVIDER OR SUPPLIER PILOTVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 209 PILOT VIEW DRIVE KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE	
	CFR(s): 483.480(b) Food must be served. This STANDARD is Based on observarinterviews, the faciliappropriate utensils clients (#1, #2, #3, A. The facility failed utensils were provided to provide dient #1 to meal with a place set spoon, knife, napking observation revealed client #1 to meal with a place set spoon, knife, napking observation revealed 2 slices of toast, jelly time during observation provided client #1 with Review of records for revealed a person-compared to the facility of the facility failed and the facility fails and the fails and the facility fails and the fa	and with appropriate utensils. It is not met as evidenced by: Itions, record reviews, and ity failed to ensure all swere provided to 4 of 5 and #5). The findings are: It to ensure all appropriate ded for client #1. For example, In home on 6/9/25 at 5:42 PM or participate in the dinner meal that consisted of a plate, It cups. Continued do the dinner meal included sweet potato fries, and ime during observations was ovide client #1 with a fork and meal. In ome on 6/10/25 at 7:44 AM or participate in the breakfast etting that consisted of a plate, and 2 cups. Continued do the breakfast meal included by, and scrambled eggs. At no tions was staff observed to the a fork. In client #1 on 6/10/25 entered plan (PCP) dated review of the PCP for client by evaluation dated 3/19/25 to an use his silverware (fork, rrectly, but may need some	W 475	N475 1.RM and TL will ensure staff provides all appropriate utensils for clients to include a fork, and spoon. 2.TL will Inservice staff on the appropriate utensils for clients to include a knife, fork, a spoon by 7/10/25. 3.RM and TL will complete random meal observations 3x weekly to ensure clients receive a complete utensil setting for 60 da 4.RM and TL will document using the using MEAL OBSERVATION form for 60 days.	nd 6/30/2025	

PRINTED: 06/13/2025 FORM APPROVED

		NIEDICAID SERVICES			MB NO.0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		34G111	B. WING		06/10/2025	
PILOTVIE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 209 PILOT VIEW DRIVE KING, NC 27021	99.1012020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Interview with the question professional (QIDP) client #1's PCP is curvith the QIDP confirm #1 should be provided consisting of the following and knife). B. The facility failed the utensils were provided utensils were provided to with a place setting the spoon, napkin, and 20 observation revealed hamburger on bun, spineapple. At no times staff observed to proking for the dinner modes of the policy of the pcp date of the PCP for client sevaluation dated 2/20 use his silverware (for the provided of the pcp for client sevaluation dated 2/20 use his silverware (for the following provided of the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for the pcp for client sevaluation dated 2/20 use his silverware (for	palified intellectual disabilities on 6/10/25 revealed that arrent. Continued interview med that all meals for client ed with a full place setting owing utensils (spoon, fork, to ensure all appropriate ed for client #2. For example, home on 6/9/25 at 5:42 PM participate in the dinner meal hat consisted of a plate, 2 cups. Continued If the dinner meal included exweet potato fries, and eduring the observation was vide client #2 with a fork and heal. The one on 6/10/25 at 8:07 AM participate in the breakfast titing that consisted of a plate, and 2 cups. Continued If the breakfast meal included the breakfast meal	W 475	1.RM and TL will ensure staff provides all appropriate utensils for clients to include a knife, fork, and spoon. 2.TL will Inservice staff on the appropriate utensils for clients to include a knife, fork, spoon. 3.RM and TL will complete random meal observations 2x weekly to ensure clients re a complete utensil setting. 4.RM and TL will document using the usin MEAL OBSERVATION form for 60 days.	and	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/13/2025 **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: A. BUILDING COMPLETED 34G111 B. WING 06/10/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 PILOT VIEW DRIVE **PILOTVIEW** KING, NC 27021 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 475 Continued From page 8 W 475 Interview with on 6/10/25 with the QIDP revealed that client #2's PCP is current. Continued interview with the QIDP confirmed that all meals for client #2 should be provided with a full place setting consisting of the following utensils (spoon, fork, and knife). C. The facility failed to ensure all appropriate utensils were provided for client #3. For example, W475 Observations in the home on 6/9/25 at 5:42 PM revealed client #3 to participate in the dinner meal with a place setting that consisted of a plate, 1.RM and TL will ensure staff provides all Implementation appropriate utensils for clients to include a knife, small spoon, napkin, and 2 cups. Continued fork, and spoon. observation revealed the dinner meal included 6/30/25 hamburger on bun, sweet potato fries, and 2.TL will Inservice staff on the appropriate utensils applesauce. At no time during the observation for clients to include a knife, fork, and spoon. was staff observed to provide client #3 with a 3.RM and TL will complete random meal small fork for the dinner meal. observations 2x weekly to ensure clients receive a complete utensil setting. Observation in the home on 6/10/25 at 7:55 AM revealed client #3 to participate in the breakfast 4.RM and TL will document using the using the MEAL OBSERVATION form for 60 days. meal with a place setting that consisted of a plate. spoon, knife, napkin, and 2 cups. Continued observation revealed the breakfast meal included 2 slices of toast, cereal, milk and scrambled eggs. At no time during observation was staff observed to provide client #3 with a small fork. Review of records for client #3 on 6/10/25 revealed a PCP dated 4/30/25, Continued review

use her knife.

of the PCP for client #3 revealed a dietary evaluation dated 4/18/25 to note that client #3 can use a spoon and fork (small ones to decrease the amount of food eaten in a bite) but is not able to

Interview with on 6/10/25 with the QIDP revealed that client #3's PCP is current. Continued

PRINTED: 06/13/2025 FORM APPROVED

STATEMENT	OF DEFICIENCIES	The DICAID SERVICES			OMB NO. 0938-0391	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G111	B. WING		06/10/2025	
NAME OF PROVIDER OR SUPPLIER PILOTVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 209 PILOT VIEW DRIVE KING, NC 27021	00/10/2025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
W 475	interview with the QII for client #3 should b setting consisting of the spoon and small fork. D. The facility failed the utensils were provided. Observations in the horevealed client #5 to put with a place setting the spoon, napkin, and 2 observation revealed hamburger on bun, so applesauce. At no time was staff observed to and knife for the dinner. Review of records for revealed a PCP date of the PCP for client #6 evaluation dated 6/4/2 use silverware (fork, so along with beverage with the QID for client #5's PCP is interview with the QID for client #5 should be	DP confirmed that all meals e provided with a full place the following utensils (small). o ensure all appropriate of for client #5. For example, some on 6/9/25 at 5:42 PM participate in the dinner meal nat consisted of a plate, cups. Continued the dinner meal included weet potato fries, and ne during the observation provide client #5 with a fork er meal. client #5 on 6/10/25 of 6/6/25. Continued review f3 revealed a nutritional 25 to note that client #5 can spoon, and knife) correctly, ware.	W 475	1.RM and TL will einsure staff provides all appropriate utensils for clients to include a k fork, and spoon. 2.TL will Inservice staff on the appropriate ufor clients to include a knife, fork, and spoon. 3.RM and TL will complete random meal observations 2x weekly to ensure clients recomplete utensil setting. 4.RM and TL will document using the using MEAL OBSERVATION form for 60 days.	otensils n.	