

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G117</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/28/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MEADOWVIEW HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2723 BOBWHITE CIRCLE WINGATE, NC 28174</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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**W 262 PROGRAM MONITORING & CHANGE**  
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 observation, record review and interview, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The finding are:

Observations throughout the recertification survey from 10/27/25-10/28/25 revealed exterior door alarms on exit doors of the facility. Continued observation revealed the door to chime loudly as staff, clients, and the surveyors entered and exited the facility.

Review of facility documentation on 10/28/25 did not reveal current human rights committee (HRC) limitation consents for clients #1, #2, #3, #4, #5 and #6. Continued review of the facility documentation did not reveal door chimes or alarms to be used as behavior support interventions for the clients.

Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/28/25 confirmed that the door alarms were not documented on the written informed consent to be reviewed by the HRC annually.

**W 263 PROGRAM MONITORING & CHANGE**  
CFR(s): 483.440(f)(3)(ii)

The committee should insure that these programs

**W 262**

VP of Operations will ensure that all 6 clients receive HRC for door exit chimes by 12/26/2025.

VP of Operations will work with Monarch's QM department to ensure that a tracking system is implented to monitor HRC.

Target Completion date: 12/26/2025

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DHSR-MH Licensure Sect

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kevin Clark, Vice President of Operations</i>	TITLE <b>11/13/2025</b>	(X6) DATE
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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.

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**W 263** Continued From page 1  
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:  
Based on observation, record reviews and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 6 out of 6 audit clients (#1,#2,#3,#4 #5 and #6). The findings are:  
  
Observations in the home throughout the recertification survey on 10/27/25 and 10/28/25 revealed alarms to sound on all exit doors when clients, staff and surveyors entered or exited the home.  
  
Review on 10/28/25 of clients #1, #2, #3, #4, #5, and #6 clinical record revealed no written guardian consent for alarms on exit doors.  
  
Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/28/25 confirmed that the door alarms were not documented on the written informed consent for the guardians of clients #1, #2, #3, #4, #5, and #6 to review and sign annually.

**W 263**  
  
VP of Operations will ensure that all 6 clients receive HRC for door exit chimes by 12/26/2025.  
  
VP of Operations will ensure that all 6 clients HRC consents are signed and paproved by legal guardian  
  
VP of Operations will work with Monarch's QM department to ensure that a tracking system is implmented to monitor HRC.  
  
Target Completion date: 12/26/2025

**W 368** DRUG ADMINISTRATION  
CFR(s): 483.460(k)(1)  
  
The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.  
This STANDARD is not met as evidenced by:  
Based on observation, record review and interview, the facility failed to ensure all medications were administered in compliance with the physician orders for 2 of 6 audited clients

**W 368**

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W 368 Continued From page 2  
(#4 and #5). The findings are:

Observation in the group home on 10/28/25 at 7:36 AM revealed client #1, client #2, client #4, and client #5 to participate in the breakfast meal. Further observations revealed that the clients consumed the breakfast meal that consisted of scrambled eggs, whole wheat toast, and hashbrowns. Continued observations at 7:47 AM revealed client #5 to participate in the morning medication administration and for client #4 to receive her medications following the breakfast meal.

Review of records for client #4 on 10/28/25 revealed physician's orders (P.O.) dated 9/1/25. Review of the 9/1/25 P.O.'s revealed that client #4 is prescribed Levothyroxine tab 25 MCG to be administered at 8:00 AM. Levothyroxine is to be administered 30 minutes prior to a meal on an empty stomach and not to be given with other medications. Client #4 received prescribed Levothyroxine tab 25 MCG after the breakfast meal.

Review of records for client #5 on 10/28/25 revealed P.O.'s dated 9/1/25. Review of the 9/1/25 P.O.'s revealed that client #5 is prescribed Levothyroxine tab 125 MCG to be administered at 6:00 AM. Levothyroxine is to be administered 30 minutes prior to a meal on an empty stomach and not to be given with other medications. Client #5 received prescribed Levothyroxine tab 125 MCG after breakfast meal.

Interview with residential manager (RM) on 10/28/25 confirmed that client #4 and client #5 were administered morning medications after the breakfast meal.

W 368

RM or Designee will ensure that Meadowviews assigned LPN will retrain all staff on medication administration to include medications that should be given on empty stomachs.

RM or Designee will conduct 2 weekly medication observations for 5 weeks.

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W 368 Continued From page 3 W 368

Interview with the facility nurse on 10/28/25 confirmed the 9/1/25 P.O.'s for client #4 and client #5 to be current. Further interview with the facility nurse revealed that staff should administer all medications as prescribed. Continued interview revealed that the facility nurse will ensure staff are trained to ensure prescribed medications are given on an empty stomach when required.

W 473 MEAL SERVICES W 473  
CFR(s): 483.480(b)(2)(ii)

Food must be served at appropriate temperature. This STANDARD is not met as evidenced by:  
Based on observations and interview the facility failed to ensure food was served at the appropriate temperature. This potentially affected all clients living in the home (#1, #2, #3, #4, #5 and #6). The finding is:

Observations in the home on 10/28/25 at 6:30am revealed staff were preparing breakfast to include hash brown, toast, eggs, coffee, milk, and water. Continued observations revealed at 6:38am the clients' food was plated and placed on the dining table covered with a paper towel; along with two cups of coffee for client #1 and #2. Further observations revealed staff prompted clients to start breakfast at 7:35am. Additional observations revealed the food and the coffee were not reheated nor was a thermometer used to check the temperature of the food.

Interview on 10/28/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that the food should have been reheated when it has been sitting out on the table

RM or designee will retrain all staff on Monarch's Food Storage and Kitchen Cleanliness Policy to include that all food must be served within 15 minutes of removal from heating unit or cooling.

RM or designee will conduct 2 weekly medication observations for 5 weeks.

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W 473	Continued From page 4 for a long period of time.	W 473		
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