STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G108	A. BUILDING _____ B. WING _____	06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWOOD	1508 GATEWOOD AVENUE GREENSBORO, NC 27405

(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
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interview, the team failed to assure privacy for 2 of 3 sampled clients (#3 and #5) residing in the facility regarding medication administration. The findings are: A. The facility failed to assure privacy during medication administration for client #5. Observations conducted on 6/3/19 revealed staff F administering afternoon medications, accompany client #5 to a medication area in the home from 5:05 - 5:15 PM to administer her medications. Continued observations revealed the medication administration area provided no privacy but was located in a main common area for group activities where several clients were present working on activities with staff members. This medication area was also adjacent to a hallway used by clients and staff to enter or exit the main common area. Further observations revealed clients were administered their medications in the hallway area in plain view as others passed by them during the administering of their medications providing no privacy. B. The facility failed to assure privacy during medication administration for client #3. Observations conducted on 6/4/19 revealed group home manger who was administering morning medications, accompany client #3 to a	W 130	W130 The Nurse will in-service all staff on ensuring clients #3, #5 and all people supported's privacy is provided during medication administration. The clinical team will monitor through Medication Administration observations 2x a week for one month and then on a routine basis to ensure privacy during Medication Administration. In the future, the Qualified Professional will ensure all staff are trained to ensure privacy is provided for all People Supported during medication administration. By 8/2/19 RECEIVED JUN 24 2019 DHSR NH L & C Black Mountain / WRO	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Foster, QP/PM — TITLE — (X6) DATE: 6/20/19

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 130	Continued From page 1 medication area in the home from 7:25 -7:46 AM to administer his morning medications. Continued observations revealed the medication administration area provided no privacy but was located in a hallway adjacent to the medication closet. This medication area was also connected to a main living activity area where several clients were present, working on activities with staff members. Further observations revealed client #3 was administered his medications in the hallway area in plain view as others passed by them during the administering of their morning medications. Subsequent observations revealed no privacy screen or other privacy method was utilized during the administration of medications to client #3 as he received his morning medications. Interview with the group home staff on 6/4/19 revealed the agency most often administers medication in the hallway area as some wheelchairs are difficult to get into the medication room. Continued interview with the group home manager revealed they had not thought of using a screen or other method to provide privacy during medication administration. Continued interview with the facility qualified intellectual disabilities professional (QIDP) confirmed that privacy should have been provided to clients in the home while receiving their morning medications.	W 130	W382 The Nurse will in-service all staff on ensuring all medications are kept locked and not left unattended when they are not being administered. The clinical team will monitor through Medication Administration observations 2x a week for one month and then on a routine basis to ensure medications are secured when not being prepared. In the future, the Qualified Professional will ensure all medications are kept locked and not left unattended when not being administered. By 8/2/19	
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration.	W 382		

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W 382	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all biologicals remained locked except when being administered. The finding is: The medications were left unsecured and unsupervised by the medication technician. Observations conducted on 6/4/19 at 8:57 AM revealed staff A and 1 non-audit client (#1) to be present in the the medication room with the door open and client #1 sitting in the doorway next to the medication cart. Staff A had unlocked the cart and was checking the medication administration record (MAR) for client #1's medications. At that moment, staff H came to the medication door asking a question. Staff A left client #1 in the medication room and walked over to the nearby office to obtain an item, handed it to staff H, then returned to the medication room. Further observation revealed the cart was left open with the key in the lock. Interview on 6/4/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff responsible for administering medications were expected to assure all medications are kept locked except when being prepared for administration.	W 382		