STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G161	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD #1	416 BOXWOOD DRIVE GREENSBORO, NC 27410

(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 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure implementation of policies and procedures to prohibit neglect were implemented relative to ensuring the appropriate re-training of staff after a client death that was linked to improper administration of CPR. The finding is: A review of internal facility documents on 12/18/19 revealed an incident which involved client #4 on 11/26/19 that led to the clients death. Further review of internal documentation revealed a facility investigation dated 11/26/19 and completed on 12/3/19 with substantiated findings of neglect by the facility qualified intellectual disability professional (QIDP) and the facility administrator. Review of the 11/26/19 investigation revealed the involved staff, A & B, on shift during the incident involving client #4, were immediately suspended while awaiting the outcome of the facility investigation. Further review revealed a North Carolina Incident Response Improvement System (NC IRIS) report which pertained to client #4's 11/26/19 incident. Review of the NC IRIS report revealed the facility promptly notified the Guilford County Department of Social Services, client #4's legal guardian, the local management entity and completed the Healthcare Personnel Registry 24-hour report and the 5-day working report.	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G161	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD #1	416 BOXWOOD DRIVE GREENSBORO, NC 27410

(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 149	Continued From page 1	W 149		

Review on 12/18/19 of the facility's internal investigation of client #4's 11/26/19 incident revealed on 11/26/19 at 9:09 am client #4 was sitting in his usual front passenger seat on the facility van. Client #4 was reported to be eating a blueberry muffin, given to him by group home staff A. Further review revealed while client #4 was seated in the van awaiting for transport to the facility vocational center, he suddenly began to choke on the blueberry muffin, gasp for air, turn blue and ultimately become unresponsive. Continued review revealed during this time group home staff A attempted cardiopulmonary resuscitation (CPR) techniques (Heimlich Maneuver) on client #4 as he was still seated in the van. Subsequent review revealed client (#2) also seated in the van exited the van to physically alert the other group home staff member B located inside the home, doing laundry, to go help client #4 on the van of which she did. Subsequently, staff B contacted 911 emergency responders for assistance.

Additional review on 12/18/19 of the facility's investigation report of client #4's 11/26/19 incident revealed both staff A & B together, also, attempted CPR techniques (Heimlich Maneuver) on client #4 while he was still seated in the van, until emergency responders arrived. Further review revealed both staff A & B stated they were physically unable to transfer client #4 from his front passenger seat to the ground to properly perform CPR techniques, as they were each trained. A review of staff trainings revealed staff A and B were trained on CPR procedures separately, on 2/20/19 and 7/31/19 respectively. Subsequent review of the 11/26/19 internal facility investigation revealed while staff A was aware of client #4's diet consistency (food in one-inch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G161	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD #1	416 BOXWOOD DRIVE GREENSBORO, NC 27410

(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 149	Continued From page 2	W 149		

sized pieces) and eating guidelines to ensure his safety, she had provided client #4 a warmed, cut up blueberry muffin because he had not consumed any breakfast that morning. In addition, staff A was unaware client #4 was not allowed to eat on the van.

Continued review on 12/18/19 of the facility investigation report and the NC IRIS report revealed client #4 received 911 emergency response assistance. Client #4 was subsequently transported to Cone Hospital and admitted on 11/26/19 at 10:05 AM for cardiac arrest due to suspected aspiration. Further review on 12/18/19 of the Cone Health hospital report dated 11/26/19 noted emergency responders performed CPR efforts for 10-15 minutes and suctioned large amounts of food from his airways. Further review of the 11/26/19 Cone Health report revealed client #4 may have sustained about a five minute delay before an effective CPR intervention was performed by emergency responders at the scene.

Ongoing review of records and documentation revealed client #4 arrived at Cone Health pulseless, apneic and received extensive, continuous critical care supportive management for multiple organ systems failure. Further review revealed concern for extensive brain damage, flail chest and a poor prognosis. Ongoing review revealed client #4 passed on 11/27/19 at Cone Health, sometime after his family had decided to cease all continuous, critical care supportive measures.

Review on 12/18/19 of the facility investigation report dated 11/26/19 revealed conclusions that the facility substantiated neglect of staff A towards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G161	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD #1	416 BOXWOOD DRIVE GREENSBORO, NC 27410

(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 149	Continued From page 3	W 149		

client #4 because the staff failed to follow client #4's prescribed eating guidelines by allowing the client to eat on the van. Further review revealed staff A also failed to correctly perform the Heimlich procedure on client #4, as she had learned in her initial CPR training on 2/20/19 with the facility. While neglect was not substantiated for staff B, the report noted staff B failed to ensure the proper client/staff ratio was followed during van loading.

Continued review on 12/18/19 of the facility investigation report dated 11/26/19 revealed recommendation actions to include the termination of staff A & B, re-training for all staff on client diets, food consistency and implementation of eating guidelines. In addition, review revealed the facility clinical team would conduct increased supervision in the group home with unannounced visits two times a week for one month.

Review on 12/18/19 of facility documentation revealed the facility implemented recent global staff trainings relative to eating on the facility van, client/staff ratios on van loading and abuse, neglect, exploitation, and client rights. Subsequent document review revealed the facility failed to provide specific intervention or training, beyond a QIDP in-service, to prevent improper administration of CPR procedures.

Interview on 12/18/19 with the facility nurse confirmed staff should have had immediate training on CPR procedures, especially post a client death linked to improper CPR administration by staff. Further interview confirmed staff training on CPR procedures is needed to ensure staff appropriately perform life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G161	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD #1	416 BOXWOOD DRIVE GREENSBORO, NC 27410

(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 149	Continued From page 4 saving measures to clients. Interview on 12/18/19 with the QIDP and the facilty administrator confirmed staff are initially trained in CPR by a certified/licensed CPR trainer. Continued interview with the QIDP and facility administrator verified staff had not been re-trained on performing CPR procedures by a certified CPR trainer, since the recent death event of a client for which neglect was substantiated by the facility because of the improper use of CPR techniques, by staff. Further interview confirmed the facility needed to globally implement CPR re-training for staff to ensure staff know the proper CPR techniques to ensure client health and safety.	W 149		