DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	_			OMB NO	<u>). 0938-0391</u>	
			l` í		LE CONSTRUCTION		E SURVEY PLETED	
		34G169	B. WING	WING1			11/17/2020	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
FRIENDWAY GROUP HOME				202 FRIENDWAY ROAD				
	AT GROOP HOME				GREENSBORO, NC 27409			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 130	CFR(s): 483.420(a)(7 The facility must ensu		w	13	0			
	treatment and care of							
	Based on observatio failed to assure that p	not met as evidenced by: ns and interviews, the facility rivacy was maintained for 4 6, and #4). The findings are:						
	A. The facility failed t maintained for client # administration. For e	#1 during medication						
	4:30 PM revealed clie in front of the medicat Continued observatio cup with medication a could be observed by and exiting the kitche revealed client #1 to t drink a glass of water medication room door no point during the ob offered privacy during administration.	r as directed by staff C.At oservation was client #1 Jher medication						
	(HCS) on 11/17/20 ver receive medication in the door closed to en- the facility nurse on 1 clients should receive	-						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

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

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.

PRINTED: 12/03/2020

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/03/2020 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
34G169			B. WING			_	11/17/2020		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
FRIENDW	AY GROUP HOME				202 FRIENDWAY ROAD GREENSBORO, NC 274	409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 130	medication in the medication in the medication in the medication administration. The C clients have a right to medication administration. The C clients have a right to medication administration. The C clients have a right to medication administration. The C clients have a right to medication administration. The C client for clie	#1 should have received her dication room with the door acy during medication QIDP also confirmed that all privacy when receiving ation. be ensure privacy was #2 while in her room. For but home throughout the 11/16/20 from 4:30 PM to ff C to enter client #2's room knocking on the door. n revealed staff C to enter om various times throughout d without a request to enter but her services coordinator vealed that all clients should ir rooms whether the door is ntinued interview with the t staff C should have e room of client #2 before view with the qualified ental professional (QIDP) f should not enter female knocking on the door and Subsequent interview with hed that all clients should ir rooms at all times.	W	130					

If continuation sheet Page 2 of 7

	-	D HUMAN SERVICES				FORM	D: 12/03/2020 A APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /		E CONSTRUCTION	(X3) DATE	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		34G169	B. WING _			11/	17/2020	
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				20	202 FRIENDWAY ROAD			
FRIENDW	AY GROUP HOME			G	GREENSBORO, NC 27409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
W 130	from 6:00 PM - 6:15 F up from the living room room, leaving his bed observation revealed undressing next to his open. Further observe enter client #4's bedro directive for client #4's and come out of the ro observed to exit the c opened. Subsequent #4 to put his clothes b observed by all passe observation revealed with the door left oper provided privacy while Interview with the HC client #4 should have changing clothes and bedroom. Further inte confirmed staff should #4's door prior to ente #4 to close his bedrood D. The facility failed to maintained for client # example: Observation period on 8:15 AM revealed clie participating in a pictuo observation period wit to enter her room. At	roup home on 11/16/20 PM revealed client #4 to get m recliner and to enter his room door open. Continued client #4 to begin a bed with the bedroom door ation revealed staff B to boom and to provide a verbal to put his clothes back on oom. Staff B was then lient's room leaving the door observation revealed client back on which could be ersby. Additional client #4 to lay on his bed h. At no time was client #4 e undressing in his room. S on 11/17/20 confirmed been provided privacy when when staff entered the erview with the QIDP d have knocked on client ering then prompted client om door or closed it for him. o ensure privacy was #3 while in her room. For roup home throughout the 11/17/20 from 6:45 AM to ent #3 to sit in her room are activity. Continued staff A to enter and exit rious times throughout the thout knocking or requesting	W	130				

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	-	ND HUMAN SERVICES				FORM	: 12/03/2020 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
34G169		B. WING			11/1	17/2020	
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	<u></u>	
FRIENDWAY GROUP HOME				02 FRIENDWAY ROAD	409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 130	Continued From page door or request to ent		W 130				
W 368	staff A should have kr and requested to enter room. Continued inter confirmed that all staff client's room whether to respect privacy of t with the QIDP confirm afforded privacy in the DRUG ADMINISTRAT CFR(s): 483.460(k)(1)	TION ) administration must assure ninistered in compliance with	W 368				
	Based on observation interview, the system failed to assure all dru	for drug administration ugs were administered n's orders for 1 non-sampled					
	11/17/20 revealed clie to go to the medication morning medications. revealed staff to punc medications consistin vitamin D3, and calciu observation revealed and mineral rich into a transfer it to a small b Subsequent observat	ng of cetirizine hcl, lisinopril, um magnesium. Further staff to then add vita sprout a medication cup and					

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	-	ID HUMAN SERVICES				FORM	): 12/03/2020 1 APPROVED
CENTER	<u>S FOR MEDICARE &amp; I</u>	MEDICAID SERVICES	-			<u>OMB NO</u>	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G169	B. WING		_	11/*	17/2020
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
FRIENDWAY GROUP HOME				02 FRIENDWAY ROAD	409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 368	- 15		W 368				
	and to give it to client water.	#1 followed with a cup of					
W 371	physicians orders data stated if tablets or cap down, do not repeat d record did not indicate medications should be Interview with the hea (HSC) on 11/17/20 rev client #1's medications Interview with the qua developmental profes was not certain wheth medications should be with the QIDP confirm	e crushed. alth service coordinator vealed she was not aware if s should be crushed. alified intellectual ssional (QIDP) verified she her or not client #1's e crushed. Further interview hed all client medications ed according to physician's	W 371				
	that clients are taught medications if the inte determines that self-a	ndministration of medications active, and if the physician					
	Based on observation for drug administration clients (#1 and #6) ob administration were p participate in medicati	not met as evidenced by: n and interview, the system n failed to assure 2 of 2 oserved during medication rovided the opportunity to ion self-administration or ted to the name, purpose					

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		ID HUMAN SERVICES					FORM	): 12/03/2020 // APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1)           PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
34G169			B. WING			_	11/	17/2020	
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
FRIENDWAY GROUP HOME					02 FRIENDWAY ROAD				
				G	REENSBORO, NC 274	109			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 371	Continued From page	5	w	371					
	and side-effects of me The findings are:	edications administered.							
	assure client #1 was participate in medicat provided training relat and side-effects of me Observations in the g	ug administration failed to provided the opportunity to ion self-administration or ted to the name, purpose edications administered. roup home at 7:20 AM on ent #1 was prompted by staff							
	revealed client #1 to r medications consistin vitamin D3, calcium n mineral rich. Further	Continued observations							
	with a cup of water. S revealed at no time du administration was the	o give it to the client followed Subsequent observations uring the medication ere teaching of medication side effects of client #1's							
	(HSC) on 11/17/20 cc trained to teach client medication. Continue qualified intellectual d (QIDP) confirmed star clients the names, pu effects of their medica with the QIDP confirm provided teaching to c	lisabilities professional ff had been trained to teach rposes and possible side ations. Further interview ned staff should have client #1 during her ation regarding the names,							
	B. The system for dru	g administration failed to							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVE COMPLETED         NAME OF PROVIDER OR SUPPLIER       34G169       B. WING       11/17/202         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       202 FRIENDWAY ROAD GREENSBORO, NC 27409       202 FRIENDWAY ROAD         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE       (COMP		RTMENT OF HEALTH AN ERS FOR MEDICARE & I					FORM	): 12/03/2020 APPROVED 0. 0938-0391
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         FRIENDWAY GROUP HOME         (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)       OCMP         W 371       Continued From page 6 assure client #6 was provided the opportunity to participate in medication self-administration or provided training related to the name, purpose and side-effects of medications administered.       W 371       W 371         Observations in the group home at 7:30 AM on 11/177/20 revealed client #6 was prompted by staff to go to the medication room to receive her morning medications. Continued observations       W 371	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
202 FRIENDWAY ROAD GREENSBORO, NC 27409         (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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMP         W 371       Continued From page 6 assure client #6 was provided the opportunity to participate in medication self-administration or provided training related to the name, purpose and side-effects of medications administered.       W 371       W 371         Observations in the group home at 7:30 AM on 11/1/17/20 revealed client #6 was prompted by staff to go to the medication room to receive her morning medications. Continued observations       W 371       V 371			34G169	B. WING			11/	17/2020
FRIENDWAY GROUP HOME       GREENSBORO, NC 27409         (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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMP DU COMP DU COMP DEFICIENCY         W 371       Continued From page 6 assure client #6 was provided the opportunity to participate in medication self-administration or provided training related to the name, purpose and side-effects of medications administered.       W 371         Observations in the group home at 7:30 AM on 11/17/20 revealed client #6 was prompted by staff to go to the medication room to receive her morning medications. Continued observations       W 371	NAME OF PI	F PROVIDER OR SUPPLIER				TATE, ZIP CODE	-	
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMP DEFICIENCY         W 371       Continued From page 6 assure client #6 was provided the opportunity to participate in medication self-administration or provided training related to the name, purpose and side-effects of medications administered.       W 371       W 371         Observations in the group home at 7:30 AM on 11/17/20 revealed client #6 was prompted by staff to go to the medication room to receive her morning medications. Continued observations       W 371	FRIENDWAY GROUP HOME					'409		
assure client #6 was provided the opportunity to participate in medication self-administration or provided training related to the name, purpose and side-effects of medications administered. Observations in the group home at 7:30 AM on 11/17/20 revealed client #6 was prompted by staff to go to the medication room to receive her morning medications. Continued observations	PREFIX	X (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA		(X5) COMPLETION DATE
<ul> <li>Intervational consisting of gavilam powder, benztropine, divalproex, ferrous sulfate, therems m, vitamin D, vitamin E and clonazepam. Further observations revealed staff to pour pre-packed medications into a medication cup and give to client #6 to take with a cup of water mixed with gavilam powder. Subsequent observations revealed at no time during the medication administration was there teaching of medication names, purposes or side effects of client #6's medications.</li> <li>Interview with the health services coordinator (HSC) on 11/17/20 confirmed staff had been trained to teach clients at least the name of their medications. Continued interview with the qualified intellectual disabilities professional (QIDP) confirmed staff had been trained to teach clients the names, purposes and possible side effects of their medications. Further interview with the QUDP confirmed staff should have provided teaching to client #6 during her medication administration regarding the names, purpose and side effects.</li> </ul>	W 371	<ul> <li>assure client #6 was participate in medicate provided training relate and side-effects of medications in the g 11/17/20 revealed client to go to the medications. revealed client #6 to take with a gavilam powder. Subtrevealed at no time dradministration was the names, purposes or semedications.</li> <li>Interview with the head (HSC) on 11/17/20 confirmed statications consistint medications. Continue qualified intellectual definitions (QIDP) confirmed statications and staticatications and statications and staticatications and sta</li></ul>	provided the opportunity to tion self-administration or ted to the name, purpose edications administered. proup home at 7:30 AM on ent #6 was prompted by staff on room to receive her . Continued observations receive her morning ng of gavilam powder, ex, ferrous sulfate, therems E and clonazepam. Further d staff to pour pre-packed edication cup and give to a cup of water mixed with osequent observations uring the medication ere teaching of medication side effects of client #6's alth services coordinator onfirmed staff had been ts at least the name of their ued interview with the disabilities professional ff had been trained to teach urposes and possible side ations. Further interview ned staff should have client #6 during her ation regarding the names,	W 371				

Facility ID: 921889

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