STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G169	A. BUILDING _____ B. WING _____	11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDWAY GROUP HOME	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 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 interviews, the facility failed to assure that privacy was maintained for 4 of 6 clients (#1, #2,#3, and #4). The findings are: A. The facility failed to ensure privacy was maintained for client #1 during medication administration. For example: Observations in the group home on 11/16/20 at 4:30 PM revealed client #1 to stand in the kitchen in front of the medication administration door. Continued observation revealed staff C to pass a cup with medication and yogurt to client #1 which could be observed by clients and staff entering and exiting the kitchen. Further observation revealed client #1 to take the medication and drink a glass of water in front of the closed medication room door as directed by staff C. At no point during the observation was client #1 offered privacy during her medication administration. Interview with the Health Services Coordinator (HCS) on 11/17/20 verified that all clients should receive medication in the medication room with the door closed to ensure privacy. Interview with the facility nurse on 11/17/20 confirmed that all clients should receive medication administration in the medication room with the door closed to ensure privacy. Interview with the qualified intellectual disabilities professional (QIDP)	W 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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confirmed that client #1 should have received her medication in the medication room with the door closed to ensure privacy during medication administration. The QIDP also confirmed that all clients have a right to privacy when receiving medication administration.

B. The facility failed to ensure privacy was maintained for client #2 while in her room. For example:

Observation in the group home throughout the observation period on 11/16/20 from 4:30 PM to 6:30 PM revealed staff C to enter client #2's room various times without knocking on the door. Continued observation revealed staff C to enter and exit client #2's room various times throughout the observation period without a request to enter the client's room.

Interview with the health services coordinator (HCS) on 11/17/20 revealed that all clients should receive privacy in their rooms whether the door is opened or closed. Continued interview with the HCS also verified that staff C should have requested to enter the room of client #2 before entering. Further interview with the qualified intellectual developmental professional (QIDP) verified that male staff should not enter female clients' rooms without knocking on the door and requesting to enter. Subsequent interview with the QIDP also confirmed that all clients should receive privacy in their rooms at all times.

C. The facility failed to provide privacy for client #4 during dressing. For example:

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Observations at the group home on 11/16/20 from 6:00 PM - 6:15 PM revealed client #4 to get up from the living room recliner and to enter his room, leaving his bedroom door open. Continued observation revealed client #4 to begin undressing next to his bed with the bedroom door open. Further observation revealed staff B to enter client #4's bedroom and to provide a verbal directive for client #4 to put his clothes back on and come out of the room. Staff B was then observed to exit the client's room leaving the door opened. Subsequent observation revealed client #4 to put his clothes back on which could be observed by all passersby. Additional observation revealed client #4 to lay on his bed with the door left open. At no time was client #4 provided privacy while undressing in his room.

Interview with the HCS on 11/17/20 confirmed client #4 should have been provided privacy when changing clothes and when staff entered the bedroom. Further interview with the QIDP confirmed staff should have knocked on client #4's door prior to entering then prompted client #4 to close his bedroom door or closed it for him.

D. The facility failed to ensure privacy was maintained for client #3 while in her room. For example:

Observations in the group home throughout the observation period on 11/17/20 from 6:45 AM to 8:15 AM revealed client #3 to sit in her room participating in a picture activity. Continued observation revealed staff A to enter and exit client #3's room at various times throughout the observation period without knocking or requesting to enter her room. At no point during the observation period did staff A knock on client #3's

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W 130	Continued From page 3 door or request to enter her room. Interview with the HCS on 11/17/20 verified that staff A should have knocked on client #3's door and requested to enter prior to walking into her room. Continued interview with the HCS also confirmed that all staff should request to enter a client's room whether the door is open or closed to respect privacy of the client. Further interview with the QIDP confirmed that clients should be afforded privacy in their rooms at all times.	W 130		
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 system for drug administration failed to assure all drugs were administered according to physician's orders for 1 non-sampled client (#1). The finding is: Observations in the group home at 7:20 AM on 11/17/20 revealed client #1 was prompted by staff to go to the medication room to receive her morning medications. Continued observation revealed staff to punch pre-packaged medications consisting of cetirizine hcl, lisinopril, vitamin D3, and calcium magnesium. Further observation revealed staff to then add vita sprout and mineral rich into a medication cup and transfer it to a small brown bowl to crush. Subsequent observation revealed staff to pour the crushed medications into a medication cup	W 368		

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W 368	Continued From page 4 and to give it to client #1 followed with a cup of water. Review of client #1's record on 11/17/20 revealed physicians orders dated 6/1/20 through 9/30/20 stated if tablets or capsules are partially broken down, do not repeat dosage. Continued review of record did not indicate that client #1's medications should be crushed. Interview with the health service coordinator (HSC) on 11/17/20 revealed she was not aware if client #1's medications should be crushed. Interview with the qualified intellectual developmental professional (QIDP) verified she was not certain whether or not client #1's medications should be crushed. Further interview with the QIDP confirmed all client medications should be administered according to physician's orders.	W 368		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation and interview, the system for drug administration failed to assure 2 of 2 clients (#1 and #6) observed during medication administration were provided the opportunity to participate in medication self-administration or provided training related to the name, purpose	W 371		

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and side-effects of medications administered. The findings are:

A. The system for drug administration failed to assure client #1 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 7:20 AM on 11/17/20 revealed client #1 was prompted by staff to go to the medication room to receive her morning medications. Continued observations revealed client #1 to receive her morning medications consisting of cetirizine hcl, lisinopril, vitamin D3, calcium magnesium, vita sprout, and mineral rich. Further observations revealed staff to pour client #1 crushed medications into a medication cup and to give it to the client followed with a cup of water. Subsequent observations revealed at no time during the medication administration was there teaching of medication names, purposes or side effects of client #1's medications.

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 medication. 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 QIDP confirmed staff should have provided teaching to client #1 during her medication administration regarding the names, purpose and side effects.

B. The system for drug administration failed to

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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 revealed client #6 to receive her morning medications 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.

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 QIDP confirmed staff should have provided teaching to client #6 during her medication administration regarding the names, purpose and side effects.