| DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM AP | | | | | | | |
|---|--|--|--|-----|---|--------|----------------------------|
| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | D. 0938-0391 |
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | · , | ` ' | | | · · · | E SURVEY PLETED |
| | 34G161 | | B. WING | | | 04 | /06/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | - | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | - "" | | | | 416 BOXWOOD DRIVE | | |
| GUILFOR | D #1 | | | | GREENSBORO, NC 27410 | | |
| (X4) ID PREFIX | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | BE | (X5) COMPLETION DATE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROF DEFICIENCY) | RIATE | DATE |
| W 249 | PROGRAM IMPLEMI CFR(s): 483.440(d)(1 | | w | 249 | 9 | | |
| | As soon as the interd formulated a client's i | isciplinary team has ndividual program plan, | | | | | |
| | treatment program co | - | | | | | |
| | and frequency to sup | vices in sufficient number port the achievement of the | | | | | |
| | plan. | n the individual program | | | | | |
| | Based on observatio | not met as evidenced by: ns, record review and | | | | | |
| | sampled clients (#1, # | failed to ensure 2 of 3 #6) and 1 non-sampled continuous active treatment | | | | | |
| | identified in the perso | f needed interventions as n centered plan (PCP) ds and privacy. The findings | | | | | |
| | are: | | | | | | |
| | A. The facility failed t | o ensure a program iet consistency during meals | | | | | |
| | was implemented with | n sufficient frequency to client #1. For example: | | | | | |
| | 5:30 PM to 5:50 PM r | oup home on 4/6/21 from evealed client #1 to sit in his | | | | | |
| | | ng table and participate in | | | | | |
| | | n consisted of: salisbury | | | | | |
| | | potatoes, applesauce, and | | | | | |
| | | ervation revealed client #1 | | | | | |
| | | spoon and attempt to cut | | | | | |
| | - | bite sized pieces. Further | | | | | |
| | | client #1 to use hands at | | | | | |
| | | up his steak serving then his mouth using his fingers. | | | | | |
| | - | | | | | | |
| LABURATORY | 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: 04/19/2021

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 04/19/2021 APPROVED . 0938-0391 |
|--------------------------|---|---|---------------------|---------------------------------------|--|-------------------------------|---|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | _ | (X3) DATE SURVEY COMPLETED | |
| | | 34G161 | B. WING | | | 04/0 | 6/2021 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, S | TATE, ZIP CODE | | |
| GUILFORI | D #1 | | | 16 BOXWOOD DRIVE GREENSBORO, NC 27 | '410 | | |
| (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 ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| W 249 | monitor client #1 thron no verbal or physical into one inch size piec his fingers to eat. Review of records for a person centered pla Review of the PCP re a regular diet, second sodium diet, whole m consistency. Continue revealed the need to aspiration with signs the Monitor for choking, of congestion during or in Staff should follow die written during all mean Further review of the occupational therapy 2/22/19. Review of the meats should be cut the Continued review of the Health and Safety gos prevent choking. Foll and choking hazards. Interview with the inter disabilities profession should follow client #1 prescribed. Continued verified client #1's state meat into one inch piece redirection when the or | n revealed staff to visually ughout the dinner meal with redirection to cut his meat ces or to address the use of client #1 on 4/6/21 revealed an (PCP) dated 4/10/20. evealed a diet consistency of ls as desired; 2 grams of eats cut into one inch red review of the PCP monitor for choking and/or to look for that included: coughing, drooling and immediately following meals. et and eating guidelines as ltimes. PCP revealed an (OT) evaluation dated ne OT evaluation revealed o one inch consistency. he OT evaluation revealed a al is in place to monitor and ow aspiration precautions | W 249 | | | | |
| | | mented as prescribed to | | | | | |

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ____ 34G161 B. WING 04/06/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 416 BOXWOOD DRIVE **GUILFORD #1** GREENSBORO, NC 27410 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 2 W 249 W 249 support the needs of client #6 relative to aspiration guidelines. For example: Afternoon observations in the group home on 4/5/21 from 5:35 PM to 5:50 PM revealed client #6 to participate in the dinner meal, which included: salisbury steak, gravy, mashed potatoes, applesauce, and water. Continued observation revealed client #6 to eat at a fast pace and consume large bites of mashed potatoes and salisbury steak with a spoon. At no point during the dinner meal was client #6 prompted to slow his rate of eating, drink a sip of water between bites or eat smaller bites of food. Morning observations in the group home on 4/6/21 from 7:50 AM to 8:00 AM revealed client #6 to participate in the breakfast meal which included: oatmeal with raisins and cinnamon, 1 tsp. sugar, 2 whole slices of cheese toast, and a glass of milk and water to drink. Continued observation revealed client #6 to eat at a fast pace, consume large bites of oatmeal and eat a whole piece of toast using both hands. At no point during the meal observation was client #6 prompted to slow his rate of eating, drink a sip of water between bites or eat smaller bites of food. It should also be noted that staff did not offer to cut up client #6's toast into bite size pieces during the observation. Review of the records for client #6 on 4/6/21 revealed a PCP dated 11/15/20 which indicated client #6 to have a history of seizures, choking, and coughing. Further review of the PCP for client #6 revealed a nutritional evaluation dated 9/23/20 that included aspiration precautions during mealtimes. Continued review of the nutritional evaluation revealed staff should

FORM CMS-2567(02-99) Previous Versions Obsolete

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | FOR | D: 04/19/2021 M APPROVED D. 0938-0391 | | |
|--------------------------|--|---|---------------------|--|-------------|---|--|--|
| | | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | |
| | | 34G161 | B. WING | | 04 | /06/2021 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | STR | REET ADDRESS, CITY, STATE, ZIP COD | E. | | | |
| GUILFORI | D #1 | | | BOXWOOD DRIVE EENSBORO, NC 27410 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | | |
| W 249 | mouth, encourage sm between bites, promp and spoon, remain up monitor throughout th and appropriate sized Interview with the horverified that staff have aspiration guidelines the client during meal with the HM verified th and objectives for clie interview with the HM aspiration guidelines prescribed. Interview with the inter disabilities profession that client #6's progra Further interview with that program objective aspiration guidelines prescribed during mean C. The facility failed objectives were imple support the needs for For example: Observations in the g AM revealed staff to p bathroom. Observatio enter and use the bat Continued observatio | nsure he does not overfill his nall bites, encourage liquids of client #6 to use his napkin oright, use no straws and he meal to ensure safe pace d bites. me manager (HM) on 4/6/21 e been trained on client #6's and have been monitoring times. Further interview that all of the interventions ent #6 are current. Continued confirmed that client #6's should be followed as erim qualified intellectual hal (QIDP) on 4/6/21 verified an objectives are current. In the interim QIDP confirmed es for client #6 relative to should be followed as altimes. to ensure that program emented as prescribed to for client #2 relative to privacy. roup home on 4/6/21 at 7:55 prompt client #2 to use the ons revealed client #2 to exit wash his hands, while pulling | W 249 | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 04/19/2021 APPROVED . 0938-0391 |
|---|---|--|---------------------|--|---|-------------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | - | (X3) DATE SURVEY COMPLETED | |
| | | 34G161 | B. WING | | | 04/0 | 06/2021 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, S | STATE, ZIP CODE | _ | |
| GUILFORI | D #1 | | | 416 BOXWOOD DRIVE GREENSBORO, NC 27 | 7410 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE | 'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| W 249 | Continued From page | ÷ 4 | W 24 | 19 | | | |
| W 436 | staff to prompt client a the bathroom. Additic client #2 to enter and door open. At no poin period did staff offer a client to close the bath privacy. Review of records for a PCP dated 2/23/21. PCP revealed that sta client #2 to close all d issues with disrobing Interview with the HM #2 has a history of dis has to be prompted to privacy. The HM also been trained to assist client to his room, ensible bedroom door or to cl toileting or undressing the HM verified that c are current. The HM client #2's program of as prescribed. Interview with the inter that all of client #2's p current. The interim of interview that staff sho program objectives as privacy while dressing | I on 4/6/21 verified that client srobing in public areas and o close his door to ensure o verified that staff have a client #2 in prompting the suring he closes his ose the door for him while g. Continued interview with lient #2's training objectives additionally confirmed that ojectives should be followed erim QIDP on 4/6/21 verified orogram objectives are QIDP confirmed during the ould follow client #2's s prescribed to ensure g or toileting. MENT | W 43 | 36 | | | |
| | | | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 04/19/2021 APPROVED . 0938-0391 |
|--|---|--|--|--|---|-------------------------------|---|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 34G161 | B. WING | | | 04/(| 06/2021 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA | TE, ZIP CODE | | |
| GUILFOR |) #1 | | | 416 BOXWOOD DRIVE GREENSBORO, NC 2741 | 10 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECT CROSS-REFERENC | PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE |
| W 436 | The facility must furnis and teach clients to us choices about the use hearing and other con and other devices ide | sh, maintain in good repair, se and to make informed e of dentures, eyeglasses, nmunications aids, braces, | W 436 | | | | |
| | Based on observation interview, the facility f have access to adapti recommended for 1 sa non-sampled client (# A. The facility failed t | ampled client (#6) and 1 | | | | | |
| | 4/6/21 from 7:00 AM t #6 to participate in va the group home to inc structured activities, to breakfast items on the kitchen sink and to pa administration. At no period was client #6 o eyeglasses. | o assist with placing e table, take dishes to the articipate in medication point during the observation | | | | | |
| | Review of the PCP re goal to tolerate wearing review of records for the second | an (PCP) dated 11/15/20. evealed an active treatment ng glasses. Continued client #6 revealed a vision 25/19 to include a cataract | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | FOF | ED: 04/19/2021 RM APPROVED IO. 0938-0391 |
|--------------------------|--|---|---------------------------------|--|--------------------------------|--|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | (X3) DA | TE SURVEY MPLETED | |
| | | 34G161 | B. WING | | 0 | 4/06/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | STR | EET ADDRESS, CITY, STATE, ZIP CC | • | |
| GUILFOR | D #1 | | | BOXWOOD DRIVE EENSBORO, NC 27410 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| W 436 | Interview with Staff E eyeglasses for client a medication closet who chances of being lost verified that client #6 following the administ medications and the of the day. Interview witi intellectual disabilities verified that client #6 all times due to vision interview with the QID history of improper ca QIDP also verified clie to eyeglasses at all the locked in the medicat | on 4/6/21 revealed that #6 are kept locked in the en not in use to lessen the or broken. Staff E further is given his eyeglasses tration of his morning client wears them the rest of th the interim qualified professional (QIDP) should wear eyeglasses at deficits. Continued DP verified client #6 had no ure of their eyeglasses. The ent #6 should have access mes and should not be ion room. | W 436 | | | |
| | client #2 were access example: Afternoon observation 4/6/21 from 7:00 AM # #2 to participate in va home that included participate Continued observation revealed the client to coloring pages during during the observation prompt client #2 to we Review of records for a person centered pla Further review of client medical consult dated visual acuity fixation f | client #2 on 4/6/21 revealed an (PCP) dated 2/23/21. | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | | MAPPROVED D. 0938-0391 |
|--------------------------|---|---|-------------------|-----|--|-----------|----------------------------|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ì í | | | (X3) DATE | |
| | | 34G161 | 161 B. WING | | 04/ | /06/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| GUILFOR | D #1 | | | | 16 BOXWOOD DRIVE GREENSBORO, NC 27410 | | |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| W 436 | eyeglasses from accell Interview with Staff E #2's has eyeglasses for medication closet who being lost or broken. client #2 is given his of the administration of the client wears them Interview with the inter- client #2 should wear to vision deficits. Cor QIDP verified client # care of their eyeglass additionally verified th | ess to the client. on 4/6/21 verified that client that are kept locked in the en not in use to prevent Staff E further verified that eyeglasses to wear following morning medications and the rest of the day. erim QIDP on 4/6/21 verified eyeglasses at all times due ntinued interview with the 2 had no history of improper tes. Interview with the QIDP ne eyeglasses for client #2 in the medication room | | 436 | | | |

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