-					FORM	M APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G078		, í			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 08/24/2021	
		B. WING _				
NAME OF PROVIDER OR SUPPLIER WATSON'S GROUP HOME				310 ELWELL AVENUE		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	x			(X5) COMPLETION DATE
BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage behavior must never for an active treatment point This STANDARD is result of the second interviews, the facility techniques to manage were incorporated interprogram for 1 of 3 sate finding is: Morning observations 8/24/21 from 5:45 AM #3 to refuse to particing upon several prompts observation revealed #3 go to the medication medication administra Observation revealed the living room area at continued to escalate 6:40 AM revealed clies client #2 in the chest of Observation revealed remaining clients to the maintain the safety of Subsequent observat staff F to request for of kitchen area and part in which she refused. revealed staff G to en and client #3 to hit the) e inappropriate client be used as a substitute for rogram. not met as evidenced by: ns, record review and failed to ensure all e inappropriate behavior o an active treatment mpled clients (#3). The a in the group home on I to 7:15 AM revealed client pate in active treatment of form staff. Continued staff G to request that client on room to participate in ation in which she refused. client #3 to continue to sit in as the client's voice . Further observation at ent #3 to scream and hit two times with a closed fist. staff to escort the heir rooms in order to all clients. ion at 7:00 AM revealed client #3 to enter into the icipate in the breakfast meal Additional observation ter into the living room area e staff in the groin area with	W2	288			
	-	 E		TITLE		(X6) DATE
	S FOR MEDICARE & DE DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER S GROUP HOME SUMMARY ST. (EACH DEFICIENC REGULATORY OR I MGMT OF INAPPRO BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage behavior must never an active treatment put This STANDARD is r Based on observatio interviews, the facility techniques to manage were incorporated inte program for 1 of 3 satisfinding is: Morning observations 8/24/21 from 5:45 AW #3 to refuse to partici upon several prompts observation revealed #3 go to the medication medication administra Observation revealed #3 go to the medication client #2 in the chest Observation revealed the living room area at continued to escalate 6:40 AM revealed clies client #2 in the chest Observation revealed the living room area at continued to escalate finding clients to the maintain the safety of Subsequent observation revealed staff G to en and client #3 to hit the a book bag. Staff G to en and client #3 to hit the	CORRECTION IDENTIFICATION NUMBER: 34G078 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all techniques to manage inappropriate behavior were incorporated into an active treatment program for 1 of 3 sampled clients (#3). The finding is: Morning observations in the group home on 8/24/21 from 5:45 AM to 7:15 AM revealed client #3 to refuse to participate in active treatment upon several prompts from staff. Continued observation revealed staff G to request that client #3 go to the medication room to participate in medication administration in which she refused. Observation revealed client #3 to continue to escilate. Further observation at 6:40 AM revealed client #3 to scream and hit client #2 in the chest two times with a closed fist. Observation revealed staff to escort the remaining clients to their rooms in order to maintain the safety of all clients. Subsequent observation at 7:00 AM revealed staff F to request for client #3 to enter into the kitchen area and participate in the breakfast meal in which she refused. Additional observation revealed staff G to enter into the living room area and client #3 to hit the staff in the groin area with a book bag. Staff G was observed	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A .BUILDI 34G078 SOVIDER OR SUPPLIER 34G078 B. WING_ SOVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI. TAG MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) W2 Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. W2 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all techniques to manage inappropriate behavior were incorporated into an active treatment program for 1 of 3 sampled clients (#3). The finding is: Morning observations in the group home on 8/24/21 from 5:45 AM to 7:15 AM revealed client #3 go to the medication room to participate in medication administration in which she refused. Observation revealed staff G to request that client #3 go to the medication room to participate in medication administration in which she refused. Observation revealed client #3 to continue to sit in the living room area as the client's voice continued to escalate. Further observation at 6:40 AM revealed client #3 to scream and hit client #2 in the chest two times with a closed fist. Observation revealed staff to scream the remaining clients to their rooms in order to maintain the safety of all clients. Subsequent observation at 7:00 AM revealed staff F to request for client #3 to enter into the kitchen area and participate in the breakfast meal in which she ref	S FOR MEDICARE & MEDICAID SERVICES or DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING	S FOR MEDICARE & MEDICAID SERVICES 0° DEFICIENCIES (x1) PROVIDENSIPPLERCIAL IDENTIFICATION NUMBER (x2) MULTIFICE CONSTRUCTION A BULIDING 346078 B. WING STREETADDRESS. CITY. STATE. JP CODE 1310 EUVELLAYENUE GREENSORO, NC 27420 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL MEDILATORY ON LSS DEMINIPANCE MORANTICK) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) PROVIDENS PLAN OF CORRECTION MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. W 288 Moming observations, record review and interviews, the facility failed to ensure all techniques to manage inappropriate behavior were incorporated into an active treatment program for 1 of 3 sampled clients (#3). The finding is: W 288 Morning observations in the group home on 8/24/21 from 5:45 AM to 7:15 AM revealed client #3 to the medication room to participate in medication administration in which she refused. Observation revealed client \$10 continue to it in the living room area as the client's voice continue to escalarte in the provemend to the remaining dients to their rooms in order to maintain the safety of all clients. Subsequent observation at 7:00 AM revealed staff F to request for client #3 to enter into the Kitchen area and participate in the breakits meal in which she refused. Additional observation revealed staff G to request for client in the group marea and client #3 to the treatment and client #3 to thit the stift in the grow area and client #3 t	MENT OF HEALTH AND HUMAN SERVICES OMB NC SFOR MEDICARE & MEDICALD SERVICES OMB NC CORRECTION INTERFORMENCES INTERFORMENCES

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.

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		MEDICAID SERVICES				NO. 0938-039	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: 34G078			, <i>,</i>	PLE CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED	
		B. WING		08/24/2021			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
WATSON	S GROUP HOME			1310 ELWELL AVENUE GREENSBORO, NC 27420			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
W 288	Continued From page		W 2	88			
	the floor and staff rele continued to display I herself. Additional of to sit in the doorway t area which led to the were participating in t observation revealed the kitchen area to be restricting the door fro during the observatio clinical support for gu interventions to be us behaviors.	lient #3 in which she fell to eased the client as she oud vocalizations and talk to oservation revealed staff G to the right of the kitchen dining table where clients the breakfast meal. Further the entry door to the left of e locked with a latch om opening. At no point n period did staff contact idance relative to additional sed to address client #3's for client #3 on 8/24/21 il habilitation plan (IHP)					
	dated 4/14/21. Furth revealed a behavior s 4/16/20 which indicat behaviors such as no physical and verbal a destruction and self-in Continued review of t	er review of the IHP support plan (BSP) dated ed that client #3 has target on-compliance, resistance, ggression, property njurious behaviors (SIBs). the BSP revealed that if					
	participate or if the cli area where her health endangered, a physic limited control walk, a procedure will be use client's elbow and wri from one area to anot therapeutic walk may	cal lift from behind and a					
	Interview with staff G has not seen client #3 behavior. Continued						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 09/03/2021 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G078		B. WING			_	08/24/2021		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WATSON'S GROUP HOME					310 ELWELL AVENUE GREENSBORO, NC 274	120		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 288	Continued From page	2	w	288				
	verified that he attempt	pted to complete a						
		client #3 fell to the floor.						
		luring the interview that						
		d physically aggressive						
		een quite some time since ccurred. Further interview						
		hat staff are to remove all						
	clients from the area :	and send them to their						
		e safety of others and to						
	complete a therapeut							
		escalate. Staff G verified						
	that he contacted the							
		s Professional (QIDP) to aviors. Additional interview						
		hat he did what he could in						
	order to maintain the							
		sistant QIDP on 8/24/21						
		acted her to make her						
	aware that client #3 e	-						
	-	d interview with the Assistant one made her aware that						
		to the door to the left and						
		loorway to the right in order						
		of the clients participating						
		. Further interview with the						
	Assistant QIDP verifie							
		I staff restrict access to any						
	room by blocking and Assistant OIDP verifie	ed during the interview that						
	all staff have received	-						
		tic holds and restrictive						
	interventions. Additio							
	Assistant QIDP confir	med that all of client #3's						
		ntions are current. The						
		confirmed that staff should						
		upport plan for client #3 at all						
	times and utilize appr							
	interventions in order	to maintain the safety of						

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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 ____ 34G078 B. WING 08/24/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1310 ELWELL AVENUE** WATSON'S GROUP HOME GREENSBORO, NC 27420 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 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) W 288 Continued From page 3 W 288 clients in the home. W 436 SPACE AND EQUIPMENT W 436 CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure that clients use and make informed choices relative to eyeglasses as recommended for 2 of 3 sampled clients (#4 and #6). The findings are: A. The facility failed to ensure eyeglasses were used as prescribed for client #4. For example: Observation at the Vocational Center on 8/23/21 at 1:10 PM revealed client #4 to participate in a coloring activity. Continued observations in the group home from 4:30 PM to 6:30 PM revealed client #4 to participate in outside activities such as corn hole, horseshoes and basketball. Further observation at 5:45 PM revealed client #4 to participate in the dinner meal. Morning observations in the group home on 8/24/21 from 5:50 AM to 8:15 AM revealed client #4 to watch television, participate in medication administration and to participate in the breakfast meal. It should be noted that at no time during survey observations on 8/23/21 - 8/24/21 was

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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 **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G078 B. WING 08/24/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1310 ELWELL AVENUE** WATSON'S GROUP HOME GREENSBORO, NC 27420 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID 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) W 436 Continued From page 4 W 436 client #4 observed to wear glasses or for any staff to prompt the client to put on eyeglasses. Review of records for client #4 on 8/24/21 revealed an individual habilitation plan (IHP) dated 9/30/20. Continued review of IHP revealed client #4 is to maintain vision with the use of glasses. Further review of record revealed an eye exam on 7/7/21 which revealed client #4 needs cataract surgery to the right eye. Subsequent review of record revealed a nurse quarterly assessment dated 7/10/21 which revealed client #4 should maintain visual ability with use of glasses. Interview with the facility Director on 8/24/21 confirmed client #4 has prescribed eyeglasses. Continue interview with the Director confirmed client #4 was not wearing his prescribed eyeglasses. Further interview with the Director revealed client #4's prescribed eyeglasses were stored in the office area to hold eyeglasses until cataract surgery; however, no physician order was provided. B. The facility failed to ensure eyeglasses were used as prescribed for client # 6. For example: Observations at the Vocational Center on 8/23/21 at 1:10 PM revealed client #6 to participate in activities such as walk on treadmill, participate in medication administration, and to color a picture. Continued evening observations in the group home on 8/23/21 from 4:30 PM to 6:30 PM revealed client #6 to assist staff C in the kitchen with cooking, setting the dinner table, preparing the dinner plates and eating his dinner meal. Morning observations in the group home on

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 09/03/2021

CENTER STATEMENT (S FOR MEDICARE &	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	FORM OMB NC (X3) DATE	D: 09/03/2021 M APPROVED D: 0938-0391 SURVEY PLETED	
AND PLAN OF CORRECTION IDENTIFICATIO		IDENTIFICATION NOMBER.	A. BUILD	ING _		COMP	LETED	
	34G078		B. WING			08/24/2021		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
WATSON'	S GROUP HOME				1310 ELWELL AVENUE GREENSBORO, NC 27420			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 436	8/24/21 from 5:50 AW #6 to participate in active television, participate administration, eat his the floor. It should be survey observations of prompt client #6 to we Review of records for healthcare appointmeters and the dt 4/2/21. Chealthcare appointmeters and the prescription for ey 4/2/21. Continued int confirmed that client #	I to 8:15 AM revealed client tivities such as watch in medication s breakfast meal, and mop e noted that at no time during on 8/23/21-8/24/21 did staff ear glasses. client #6 revealed a ent summary for an eye	W	436	3			

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