STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G242	A. BUILDING ______ B. WING ______	07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINISTER	**1111 WESTRIDGE ROAD GREENSBORO, NC 27405**

(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 privacy was maintained for 6 of 6 clients (#1, #2, #3, #4, #5 and #6) during medication administration. The findings are: Observations in the group home on 7/13/21 at 7:05 AM revealed client #2 to transition to the medication room to prepare for medication administration. Further observations revealed staff G to dispense client #2's medication, offer medication education and place the medication in a cup as the client stood in the open entryway with no door for privacy. Continued observations revealed client #2 to take her medication as other clients stood in the hallway and entered their bedrooms. At no point during the observation was client #2 offered privacy during medication administration. Observations in the group home at 7:15 AM revealed client #5 to transition to the medication room via wheelchair. Observations revealed staff G to administer medications to client #5 with the door ajar to an adjacent bedroom and an open entryway with no door for privacy. Further observations revealed two clients to stand in the hallway facing the medication room while client #5 received her medication. At no point during the observation did staff prompt the clients to move away from the entryway nor did she offer privacy to client #5 by closing the adjoining door	W 130	W 130 The nurse will in service all staff on ensuring clients #1,#2, #3, #4, #5 and #6 privacy is provided during medication administration. A privacy screen or curtain for the doorway will be purchased for the purpose of privacy while clients are receiving medications. The clinical team will monitor through medication assessments 2x a week for one month and on a routine bases thereafter. In the future the Qualified Professional will ensure all Staff are trained to ensure privacy during medication administration.	By: 9/13/21

DHSR - Mental Health
AUG 09 2021
Lic. & Cert. Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature], QP	QP	8-4-2021

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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W 130	Continued From page 1 to a client's bedroom. Observations at 7:30 AM revealed client #4 to transition to the medication room with staff assistance. Further observation revealed staff G to administer client #4's medication while staff and clients were walking down the hallway. At no point during the observation did staff offer client #4 privacy during medication administration. Observations at 7:45 AM revealed client #6 to enter the medication room with staff assistance. Further observations revealed client #6 to take her medications while standing which could be seen from the hallway. At no point during the observation period was client #6 offered privacy during medication administration. Observations at 8:00 AM revealed client #1 to transition to the medication room for medication administration. Further observations revealed client #1 take her medications while standing in the open entryway of the medication room which could be viewed from the hallway. Observations did not reveal client #1 to be offered privacy during medication administration. Observations at 8:15 AM revealed client #3 to transition to the medication room via wheelchair. Further observations revealed client #3 to receive her medication administration without being offered privacy. It is important to mention that the entryway to the medication room did not have a privacy screen or door installed to ensure privacy during medication administration.	W 130		

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W 130	Continued From page 2 Interview with staff G on 7/13/21 at 8:00 AM revealed that she keeps the adjoining door ajar between client #6's room and the medication room just in case the client has a fall, seizure or needs assistance. Further interview with staff G verified that the entryway to the medication room has not had a privacy screen or door for quite some time. Continued interview with staff G confirmed that all clients should be offered privacy during medication administration. Interview with the qualified intellectual disabilities professional (QIDP) on 7/13/21 verified that the entry way to the medication room does not have a privacy screen or door to ensure privacy during medication administration. Further interview with the QIDP confirmed that all clients have a right to privacy during medication administration.	W 130		
W 436	SPACE AND EQUIPMENT 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 adaptive equipment as recommended for 2 sampled clients (#5 and #6). The findings are:	W 436		

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W 436	Continued From page 3 A. The facility failed to ensure that adaptive equipment was offered to client #5 as prescribed. For example: 1. The facility failed to provide client #5 a dycem mat as prescribed during meals. Afternoon observations in the group home on 7/12/21 at 6:00 PM revealed client #5 to participate in the dinner meal. The dinner meal consisted of the following: lasagna, garden salad, sliced apples, garlic toast and sugar free beverage. Further observation revealed client #5 to participate in the dinner meal using the following adaptive equipment: built up long handle spoon, high sided sectional plate, a shirt protector and 2 handle cups with straws. At no point during the dinner meal was client #5 offered a dycem mat. Morning observations in the group home on 7/13/21 at 8:15 AM revealed client #5 to participate in the breakfast meal. The meal consisted of the following: 4 French toast slices, 2 hard boiled eggs, water and sugar free beverage. At no point during the breakfast meal was client #5 offered a dycem mat. Review of the record for client #5 on 7/13/21 revealed a person centered plan (PCP) dated 4/9/21. Further review of the record revealed an occupational therapy (OT) assessment dated 3/20/19 which indicates that client #5 has the following adaptive equipment to minimize choking risk: T-rocker knife, dycem mat, lap tray, built up handle spoon, high sided sectional plate and handle cup with straw. Continued review of the record revealed that client #5 has a history of	W 436	W 436 A: 1, 2 and 3 The Habilitation Specialist will in-service all staff on client #5's adaptive equipment to include use of the dycem mat, lap tray and rocker knife. In addition, staff will be in-serviced on client #5's diet consistency to ensure meals are cut into ¼ inch pieces with staff assistance using the rocker knife.	

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W 436	Continued From page 4 choking. Interview with the qualified intellectual disabilities professional (QIDP) verified that client #5 should have had a dycem mat for all meals to minimize plate slippage. Further interview with the QIDP confirmed that client #5 should have access to all adaptive equipment as prescribed. 2. The facility failed to provide a lap tray to client #5 as prescribed during meals. Observations during the survey period from 7/12/21 - 7/13/21 revealed client #5 to participate in the dinner and breakfast meals. At no point during the observation period did staff provide or offer client #5 a lap tray. Review of the record for client #5 revealed a PCP dated 4/9/21. Further review of the record for client #5 revealed an OT assessment dated 3/20/19 which indicates that the client should use a lap tray to assist with promoting independence during meals. Interview with the QIDP on 7/13/21 verified that client #5 does not like her lap tray and prefers to eat directly from the dining table. Further interview with the QIDP verified that the facility discontinued client #5's lap tray in November 2020. Continued interview with the QIDP confirmed that all of client #5's interventions are current. Additionally, the QIDP confirmed that staff must continued to supply adaptive equipment for client #5 as prescribed until it has been discontinued by an OT professional. 3. The facility failed to consistently utilize interventions and adaptive equipment as	W 436	The clinical team will monitor through mealtime assessments 2x a week for a period of one Month then on a routine basis to ensure client #5 And All people supported have use of adaptive equipment during mealtimes. In the future, the Qualified Professional will ensure staff are trained per the Person Centered Plan to implement the use of all people supported's adaptive equipment.	

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W 436	Continued From page 5 prescribed to minimize choking during meals for client #5. Observations in the group home on 7/13/21 at 8:15 AM revealed client #5 to transition to the dining table to prepare for the breakfast meal. The breakfast meal consisted of the following: 4 French toast sticks, 2 hard boiled eggs, sugar free drink and water. Further observation at 8:37 AM revealed client #5 to pick up the French toast and hard boiled eggs with difficulty. At no point during the breakfast meal did staff offer to cut up client #5's breakfast items using a T-rocker knife into ¼ inch pieces. Review of the record for client #5 revealed a PCP dated 4/9/21. Further review of the record revealed a choking risk assessment dated 3/3/21 which indicates that client #5 must have her meal cut up into ¼ inch consistency with staff assistance. Review of the OT assessment dated 3/20/19 revealed that staff should follow diet consistencies as prescribed for client #5 to avoid choking risks. Interview with the QIDP on 7/13/21 verified that although the t-rocker knife was available, staff did not use the t-rocker knife to cut up the client #5's food into ¼ inch consistency as prescribed. Further interview with the QIDP confirmed that all of client #5's goals and interventions are current. The QIDP also confirmed during the interview that staff should cut client #5's food into ¼ inch consistency using a t-rocker knife during all meals as prescribed.	W 436		

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W 436	Continued From page 6 B. The facility failed to furnish eyeglasses to client #6. For example: Observation in the group home throughout the 7/12-13/21 survey revealed client #6 to participate in various activities, including playing a game with staff, watching television, setting the table and eating without access to her eyeglasses. Continued observation throughout the survey revealed no prompts or directions from staff for client #6 to wear eyeglasses. Review of records for client #6 on 7/13/21 revealed a person-centered plan (PCP) dated 10/30/20. Further review of client #6's record revealed an eyeglasses prescription dated 10/16/19. Continued review of client #6's PCP indicated she wears eyeglasses daily during waking hours. Interview with the qualified intellectual disabilities professional (QIDP) on 7/13/21 verified that an appointment to obtain client #6's eyeglasses was never made prior to the COVID-19 pandemic. Continued interview with the QIDP verified client #6 had an appointment scheduled for 4/28/21, but that appointment was canceled for unknown reasons. Client #6 now has an appointment to obtain her eyeglasses on 10/19/21. Further interview with the QIDP confirmed client #6 should wear and have access to her eyeglasses during waking hours as prescribed.	W 436	B. The Habilitation Specialist will in-service staff on person supported #6 use of eyeglasses per physician orders. The clinical team will monitor to ensure person supported #6 and all people supported are wearing eye glasses as prescribed through interaction assessment 2x a week for a period of one Month and then on a routine basis. In the future, the Qualified Professional will ensure all staff are trained per the Person Centered Plan to implement the use of all people supported's adaptive equipment. By: 9/13/21	

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

July 26, 2021

Sheila Shaw, Facility Administrator
RHA Health Services, LLC.
1508 Gatewood Avenue
Greensboro, NC 27405

Re: Recertification Completed July 13, 2021
Westminister; 1111 Westridge Road, Greensboro, NC 27410
Provider Number #34G242
MHL# 041-105
E-mail Address: sshaw@rhanet.org

Dear Ms. Shaw:

Thank you for the cooperation and courtesy extended during the recertification survey completed July 13, 2021. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is September 13, 2021.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Clarissa Henry at 704-589-2523.

Sincerely,

Clarissa Henry, MHSA, QP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org
QM@partnersbhm.org
_DHSR_Letters@sandhillscenter.org