	-	ID HUMAN SERVICES					APPROVED
			(10)	T / C ·			0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	PLETED
		34G162	B. WING			09/	07/2022
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GUILFOR	ר#2				1800 STRATHMORE DRIVE		
GUILFOR	5#2				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)		(X5) COMPLETION DATE
	GOVERNING BODY CFR(s): 483.410(a)(1 The governing body m budget, and operating This STANDARD is m Based on observation governing body and m exercise general polic direction over the faci damage to the facility in a timely manner. T Observations conduct keypad gated fence of to be open and broke revealed the left entra another area of the fac observations of the fac to the front bumper to frame of the van. Interview with staff D damage to the gate a one year although he damage occured. Fur revealed the group ho secured vehicle for tra day program, outings, revealed the group ho secured vehicle for tra day program, outings, revealed the group ho secured vehicle for tra day program when clients appointments.) must exercise general policy, g direction over the facility. not met as evidenced by: n and interviews, the management failed to cy, budget and operating lity by failing to assure fence and van was repaired The finding is: ted of the group home on 9/6/22 revealed the gate n. Further observations ance gate leaning up against ence. Continued terility van revealed damage to be coming apart from the on 9/6/22 revealed the nd van had been at least did not know when the ther interview with staff D ome does not have a ansportation to and from the , etc. Continued interview one utilizes a van at the day a need to attend doctor's alified intellectual esional (QIDP) on 9/7/22 re of the condition the facility operable due to being	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
	involved in an accider administration was co	nt. The QIDP further verified onsidering replacing the no decision had been made					
LABORATORY I	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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/14/2022 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE	
		34G162	B. WING			09/	07/2022
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GUILFOR) #2				800 STRATHMORE DRIVE REENSBORO, NC 27410		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
W 104	Continued From page	91	w	104			
		f relative to its delivery date. the QIDP verified the group					
	home does not have a day to day basis but t doctors' appointments the QIDP revealed ad the condition of the br have not been secure	a secured van to utilize on a ransportation is provided for s. Continued interview with Iministration is also aware of roken gate and repair dates ed.					
W 130	9/7/22 confirmed the a inoperable van and br verify when both repa because of delays. C FA confirmed the grou	LIENTS RIGHTS	w	130			
	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 observation and interview, the facility failed to ensure privacy during treatment and care of personal needs for 6 of 6 clients relative to medication administration. The finding is:						
	survey revealed the n adjacent to the dining Continued observatio receive their medicati and for the door to ren duration of each medi	room and kitchen area. n revealed each client to ons in the medication room main wide open for the					

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		34G162	B. WING		0	9/07/2022
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	1	
GUILFOR	D #2			0 STRATHMORE DRIVE EENSBORO, NC 27410		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 130 W 249	revealed client #1 to room's doorway and room to tap staff F or 3's medication admin observation revealed medication room duri administration of clien others in the home so outside the medicatio during the survey per provided to client's du administration. Interview with staff F disabilities developm 9/7/22 revealed cond administration while I not a common practio facilities nurse on 9/7 should be offered to e medication unless the justification. PROGRAM IMPLEM CFR(s): 483.440(d)(1 As soon as the interd formulated a client's i each client must rece treatment program co interventions and ser	dance in the medication to enter into the medication in the shoulder during client # distration. Subsequent staff E to enter the ling the medication int #5 while client #1 and ocialized and interacted on room door. At no point riod was privacy offered or uring medication and the facilities qualified ental professional (QIDP) on fucting medication eaving the is door open is ce. Interview with the 7/22 revealed that privacy every client during ere is a behavioral ENTATION I) lisciplinary team has individual program plan, eive a continuous active	W 130			

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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 34G162 B. WING 09/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1800 STRATHMORE DRIVE GUILFORD #2** GREENSBORO, NC 27410 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 249 Continued From page 3 W 249 reviews, the facility failed to assure a continuous active treatment program was provided to support the achievement of the objectives identified in the person centered plans for 6 of 6 clients (#1, #2, #3, #4, #5, and #6) The findings are: A. The facility failed to provide adequate active treatment to engage client #2, #3, #4 and #5 during large amounts of unstructured time. For example: Afternoon observations in the group home on 9/6/22 from 4:00 PM to 6:30 PM revealed clients #2, #3, and #4 to sit in the living room area with the television on. Continued observation revealed client #6 to sit in a recliner in his bedroom. Further observations at 4:25 PM to 5:10 PM to revealed clients #6, #2, #4, and #3 to participate in showers then return to their rooms. Further observations revealed at 5:30 PM all clients to sit and participate in dinner, go to the bathroom and return to their rooms. Subsequent observation revealed client #2, #3, #4, and #6 unengaged without activity for 90 of the 150 minutes of observations. At no point during the observation period were clients offered choices in leisure activities. Morning observations in the group home on 9/7/22 from 6:30AM to 9:00 AM revealed five of six clients in their bedrooms with the door closed. Continued observations at 7:05 AM to 7:54 AM revealed clients #1, #2, #3, #4, #5, and #6 to participate in medication administration then return to their rooms or sit in the livingroom until breakfast was ready. Further observation at 8;10 AM revealed staff G to inform staff H that breakfast was ready. Subsequent observations at 8:15 AM revealed clients #1, #2, #3, #4, #5,

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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 ____ 34G162 B. WING 09/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1800 STRATHMORE DRIVE GUILFORD #2** GREENSBORO, NC 27410 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 249 Continued From page 4 W 249 and #6 to sit at the dining table to participate in breakfast with their plates already prepared and placed on the table for them. Additional observations between 8:25 AM to 8:30 AM revealed clients to take their dishes to the kitchen. Clients #2, #3, and #4 to return to the living room while client #1, #5 and #6 to return to their rooms. Further observation at 8:47 revealed staff H to prepare all clients for loading the van to be transported to the day program. At no point during the observation period were clients offered choices in leisure activities and unengaged without activity for 90 minutes. Review of the record for client #1 revealed a person centered plan (PCP) dated 3/4/22. Review of the PCP revealed training objectives to address stating home address, iron shirt, carry up to \$1.00, properly cough/sneeze in his elbow, wash hands thoroughly and tolerate wearing a mask. Review of the record for client #2 revealed a PCP dated 1/8/22. Review of the PCP revealed training objectives to address laundry, money management, daily routine, wash hands, cough/sneeze in his elbow and communication. Review of the record for client #3 revealed a PCP dated 10/24/21. Review of the PCP revealed training objectives to address toothbrushing, remove dishes from table, identify body parts, put clothing protector in basket, wash hands and behavior. Review of the record for client #4 revealed a PCP dated 1/24/22. Review of the PCP revealed training objectives to address putting on a belt, prepare veggies on stove, money management,

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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 ____ 34G162 B. WING 09/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1800 STRATHMORE DRIVE GUILFORD #2** GREENSBORO, NC 27410 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 249 Continued From page 5 W 249 brush teeth, tolerate wearing a mask, cough/sneeze in elbow, wash hands and behavior. Review of the record for client #5 revealed a PCP dated 6/14/22. Review of the PCP revealed training objectives to address best health, washing hands, wear a mask, cough/sneeze in his elbow, state current address and improve continuity and security. Review of the record for client #6 revealed a PCP dated 4/28/22. Review of the PCP revealed training objectives to address tolerate wearing glasses, wash hands thoroughly, put clothes in proper storage area, money management, communication, sweep dining room floor, and behavior. Interview with the qualified intellectual disabilities professional (QIDP) on 9/7/22 revealed all clients' training objectives are current. Continued interview with the QIDP verified that staff should offer leisure activities during periods of inactivity. Further interview with the QIDP revealed that staff should implement active training programs specific to clients' program goals and ensure that all clients are offered meaningful activities throughout the day. B. The facility failed to assure clients (#1, #2, #3, #4, #5, and #6) practice good health relative to hand washing and teeth brushing For example: Afternoon observations in the group home on 9/6/22 from 4:00 PM to 6:30 PM revealed clients #2, #3, and #4 to sit in the living room area with the television on. Continued observation revealed client #6 to sit in a recliner in his

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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 ____ 34G162 B. WING 09/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1800 STRATHMORE DRIVE GUILFORD #2** GREENSBORO, NC 27410 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) Continued From page 6 W 249 W 249 bedroom. Further observations at 4:25 PM to 5:10 PM to revealed clients #6, #2, #4, and #3, to participate in showers then return to their rooms. Further observations revealed at 5:30 PM all clients to sit and participate in dinner, go to the bathroom and return to their rooms. At no point during observation period were clients prompted to wash their hands before dinner. Morning observations in the group home on 9/7/22 from 6:30AM to 9:00 AM revealed five of six clients in their bedrooms with the door closed. Continued observations at 7:05 AM to 7:54 AM revealed clients #1, #2, #3, #4, #5, and #6 to participate in medication administration then return to their rooms or sit in the livingroom until breakfast was ready. Further observation at 8:10 AM revealed staff G to inform staff H that breakfast was ready. Subsequent observations at 8:15 AM revealed clients #1, #2, #3, #4, #5, and #6 to sit at the dining table to participate in breakfast with their plates already prepared and placed on the table for them. At no point during the observation period were clients prompted to wash their hands before breakfast or brush their teeth. Review of the record for client #1 revealed a person centered plan (PCP) dated 3/4/22. Review of the PCP revealed training objectives to address stating home address, iron shirt, carry up to \$1.00, properly cough/sneeze in his elbow, wash hands thoroughly and tolerate wearing a mask. Review of the record for client #2 revealed a PCP dated 1/8/22. Review of the PCP revealed training objectives to address laundry, money management, daily routine, wash hands,

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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 34G162 B. WING 09/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1800 STRATHMORE DRIVE GUILFORD #2** GREENSBORO, NC 27410 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) Continued From page 7 W 249 W 249 cough/sneeze in his elbow and communication. Review of the record for client #3 revealed a PCP dated 10/24/21. Review of the PCP revealed training objectives to address toothbrushing, remove dishes from table, identify body parts, put clothing protector in basket, wash hands and behavior. Review of the record for client #4 revealed a PCP dated 1/24/22. Review of the PCP revealed training objectives to address putting on a belt, prepare veggies on stove, money management, brush teeth, tolerate wearing a mask, cough/sneeze in elbow, wash hands and behavior. Review of the record for client #5 revealed a PCP dated 1/8/22. Review of the PCP revealed training objectives to address laundry, money management, daily routine, wash hands, cough/sneeze in his elbow and communication. Review of the record for client #6 revealed a PCP dated 4/22. Review of the PCP revealed training objectives to address tolerate wearing glasses, wash hands thoroughly, put clothes in proper storage area, money management, communication, sweep dining room floor, and behavior. Interview with the QIDP on 9/6/22 revealed all client training objectives were current. Continued interview with the QIDP verified that all clients should have washed their hands before all meals and brushed their teeth to improve dental care. W 382 DRUG STORAGE AND RECORDKEEPING W 382 CFR(s): 483.460(l)(2)

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		MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		MB NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	IG	- (*	COMPLETED
		34G162	B. WING			09/07/2022
NAME OF PI	ROVIDER OR SUPPLIER		Т	STREET ADDRESS, CITY,	STATE, ZIP CODE	
GUILFOR	D #2			1800 STRATHMORE DRI GREENSBORO, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
W 382	Continued From page	9 8	w a	82		
	locked except when h administration. This STANDARD is r Based on observatio interviews, the facility medications were not administering to 6 of 0 A. Client #3 was not medication during the medication pass on 9 medications into a 1 of dispenser prior to the example: Morning observations AM revealed client #3 assistance from staff medications were not paper medicine cup of accompanied by five cups with client initial written on the paper of belonged. The only p for the client be fed th with applesauce by sir revealed no training v learn about his medic how to increase the s medications. Addition client #3 to have acce (#1, #2, #4, #5, and # medicine cup dispense	not met as evidenced by: ins, record reviews and failed to assure dispensed before 6 clients. The findings are: taught to administer his own e observed morning 07/22 as staff F punched his oz paper medicine cup medication pass. For a in the group home at 7:07 b to receive medication with F. Client #3's three ted to be located in a 1 oz dispenser on the desk additional 1 oz medication s of (#1, #2, #4, #5, and #6) cup to identify the resident it participation by client #3 was he medication from the cup taff F. Further observation was provided for client #3 to cations, their side effects or pelf-administration of nal observation revealed ess his peers medication #6) located in the 1 oz paper ser on the desk.				
		r client #3 revealed a (PCP) dated 10/24/21. or client #3 revealed goals				

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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 34G162 B. WING 09/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1800 STRATHMORE DRIVE GUILFORD #2** GREENSBORO, NC 27410 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 382 Continued From page 9 W 382 for: toothbrushing, removal dishes from table, identify body parts put clothing protector in basket, behavior, and wash hands. B. Client #5 was not taught to administer his own medication during the observed morning medication pass on 9/7/22 as staff F had punched his medications into a 1 oz paper medicine cup dispenser prior to the medication pass. For example: Morning observations in the group home at 7:30 AM revealed client #5 receiving medication with assistance from staff F. Client #5's eight medications were noted to located in a 1 oz paper medicine cup dispenser on the desk accompanied by five additional 1 oz medication cups with client initials of (#1, #2, #4, and #6)) written on the paper cup to identify the resident it belonged. The only participation by client #5 was for staff F to hand client #5 his 1 oz cup of medications to place in his mouth and a cup of water to drink to swallow his medications. Further observation revealed no training was provided for client #5 to learn about his medications, their side effects or how to increase the self-administration of medications. Additional observation revealed client #5 to have access to the medication of client #1. #1, #3,#4, and #6). Review of records for client #5 revealed a person-centered plan (PCP) dated 6/14/22. Review of the PCP for client #5 revealed goals for: best health, wear mask, wash hands, property cough/sneeze in elbow, improve independent living skills, state current address, and improve continuity and security.

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/14/2022 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY
		34G162	B. WING		_	09/0	07/2022
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
GUILFOR	ר #2		1	800 STRATHMORE DRIVE	E		
	5 #2		0	GREENSBORO, NC 274	110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 382	Continued From page	• 10	W 382				
	medication during the on 9/7/22 as staff F has into a 1 oz paper medi the medication pass. Morning observations AM revealed client #4 room with staff F. Clien noted to located in a f dispenser on the desk additional 1 oz medicat of (#5 and #6) written the resident it belonger revealed no training will learn about his medic how to increase the simedications. Addition client #4 to have acce and #6) located in the dispenser on the desk Review of records for person-centered plan Review of the PCP for for: put on belt, prepa behavior, count mone brush teeth, tolerate will cough/sneeze in elbor thoroughly. D. Client #6 was not medication during the on 9/7/22 as staff F has into a 1 oz paper medi the medication pass.	in the group home at 7:30 to enter the medication ent #4's medications were 1 oz paper medicine cup 3 accompanied by two ation cups with client initials on the paper cup to identify ed. Further observation vas provided for client #4 to ations, their side effects or elf-administration of hal observation revealed tess his peers medication (#5 1 oz paper medicine cup c. r client #4 revealed a (PCP) dated 1/24/22. r client #4 revealed goals re veggies on stove, by consistently up to \$1.00, vearing a mask, w, and wash hands taught to administer his own morning medication pass ad punched his medications licine cup dispenser prior to For example:					
	Morning observations	in the group home at 7:45					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/14/2022 APPROVED . 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	-	(X3) DATE COMP	SURVEY
		34G162	B. WING			09/0	07/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
GUILFORD) #2			1800 STRATHMORE DRIV			
				GREENSBORO, NC 27	'410		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 382	room with staff F. Clie noted to located in a 1 dispenser on the desk additional 1 oz medica of written on the pape resident it belonged. revealed no training w learn about his medic how to increase the se medications. Addition client #6 to have acce peers. Review of records for person-centered plan Review of the PCP for for: trim nails, tolerate hands thoroughly, put area, identify the use behavior, and sweep E. Client #2 was not to medication during the on 9/7/22 as staff F ha into a 1 oz paper med the medication pass. Morning observations AM revealed client #2 room with staff F. Clie noted to be located in dispenser on the desk revealed no training w learn about his medic how to increase the se medications. Addition	to enter the medication ent #6's medications were l oz paper medicine cup a accompanied by two ation cups with client initials er cup to identify the Further observation vas provided for client #6 to ations, their side effects or elf-administration of nal observation revealed ss to the medication two r client #6 revealed a (PCP) dated 4/28/22. r client #6 revealed goals wearing glasses, wash clothes in proper storage of money, communication, dining room floor. aught to administer his own morning medication pass ad punched his medications icine cup dispenser prior to For example: in the group home at 7:53 entering the medication ent #2's medications were a 1 oz paper medicine cup a. Further observation ras provided for client #2 to ations, their side effects or elf-administration of nal observation revealed	W 382				
		al observation revealed ss to the medication of one					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/14/2022 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE S COMPL	SURVEY
		34G162	B. WING		_	09/0	7/2022
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, ST			
GUILFOR	D #2		-	000 STRATHMORE DRIVI REENSBORO, NC 274			
(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 B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 382	Continued From page	: 12	W 382				
	operate washing mac daily routing, cough/s hands, and communit F. Client #1 was not i medication during the on 9/7/22 as staff F hi into a 1 oz paper medic the medication pass. Morning observations revealed client #1 to e room with staff F for m Client #1's medication 1 oz paper medicine of Further observation re provided for client #1 medications, their sid the self-administration Review of records for person-centered plan Review of the PCP fo for: state home addre \$1.00, properly cough hands thoroughly, tole behavior. Interview with staff F or common practice to o door to allow for priva staff F revealed it is a have clients participat administration by pun	(PCP) dated 1/8/22. r client #2 revealed goals to hine, identify coins, tolerate neeze in elbow, wash cation. taught to administer his own emorning medication pass ad punched his medications dicine cup dispenser prior to For example: a in the group home 8:00 AM enter into the medication nedication administration. Is were noted to located in a cup dispenser on the desk. evealed no training was to learn about his e effects or how to increase in of medications. r client #1 revealed a (PCP) dated 3/4/22. r client #3 revealed goals ess, iron shirt, carry up to h/sneeze in elbow, wash erate wearing a mask and on 9/7/22 revealed it is close the medication room icy. Continued interview with lso common practice 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 ____ 34G162 B. WING 09/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1800 STRATHMORE DRIVE GUILFORD #2** GREENSBORO, NC 27410 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 382 Continued From page 13 W 382 revealed they were "behind scheduled so staff F dispensed the clients medications into the individual 1 oz medication cups to speed up the morning medication administration". Interview with the qualified intellectual disabilities professional (QIDP) on 9/7/22 revealed that it is not common practice to leave the medication room door open during medication administration. Further interview with the QIDP revealed staff are to allow clients to participate in their medication administration and staff are not to pre-punch medications beforehand. Interview with the facility nurse on 9/7/22 revealed all staff have been trained on all medication administration procedures and all staff will be trained. W 436 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 observation, record review, and interview the facility failed to provide teaching for 2 clients (#5 and #6) relative to eyeglasses. The finding is: A. Observation in the group home on 9/6/22 from 6:00 PM to 6:30 PM revealed client #5 to return home from an appointment without his eyeglasses on his face. Continued observation in the group home on 9/7/22 from 6:45 AM to 8:25

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/14/2022 MAPPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		34G162	B. WING			09/	07/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GUILFORD) #2				800 STRATHMORE DRIVE		
				G	GREENSBORO, NC 27410	N	0/5)
(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 436	Continued From page		w	436			
		5 to participate in various o get dressed, to participate					
	in his medication adm	ninistration, to participate in					
		get his supplies ready for nd to board the van to go to					
	•	At no point throughout the					
	•	on 9/7/22 was client #5					
	offered or prompted to	o wear his glasses.					
	Review of records for						
		(PCP) dated 6/14/22. r client #5 revealed training					
		best health, wear a mask,					
		cough/sneeze in elbow,					
		living skills, state current continuity and security.					
	Continue review of re	cord reveals a behavior					
	support plan (BSP) da	ated 3/8/22.					
	Review of the BSP a	ddresses client #5's target					
		nd strategies for how staff					
	psychosis-delusions,	client #5's exhibits signs of hallucinations or					
	disorganized thoughts	s or behaviors. Further					
		client #5 revealed a vision with a new prescription and					
		at client #5 requires prompts					
	to tolerate and wear g	lasses.					
	B. Observation in the	group home on 9/6/22 from					
	4:00 PM to 6:30 PM r	evealed client #6 to					
	• •	activities to include: to icipation in the dinner meal,					
	to carry his dinner dis	hed to the sink and to					
	participate in self-care	-					
	offered or prompted to	ons on 9/6/22 was client #6 o wear his glasses.					
		oup home on 9/7/22 from					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 09/14/2022 RM APPROVED IO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		34G162	B. WING			0	9/07/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GUILFORI	D #2				1800 STRATHMORE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 436	7:00 AM until 9:00 AM participate in various and complete his more staff assistance, to participate in the breakfast meal, sink and to board the work placement. At mean offered or prompted to Review of records for a person-centered pla Review of the PCP for objectives to address glasses, put clothes in identify the use of more behavior, sweep dinin Continued review of mathematication continued review of mathematication reflect sleep difficultie intrusive dental process verified both client #5 glasses. Continued in revealed client #5's en bedroom and he weat television. Further int revealed client #6 eye medication room and the glasses to him.	A revealed client #6 to activities to include: to wake ning self-care routine with articipate in medication ch television, to participate to carry his dishes to the homes van to go to his to point throughout the on 9/7/22 was client #6 to wear his glasses. client #6 on 9/7/22 revealed an (PCP) dated 4/28/22 r client #6 revealed training trim nails, tolerate wearing n proper storage area, ney, communication, groom floor, and privacy. ecords for client #6 revealed an (BSP) dated 2/23/21 to s and difficulty tolerating dures. lities qualified intellectual sional (QIDP) on 9/7/22 and #6 wear prescribed netrview with the QIDP ye glasses are kept in his rs them to read and watch terview with the QIDP e glasses are kept in the staff should have offered ON SERVICES) ive a nourishing,		436			

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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 34G162 B. WING 09/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1800 STRATHMORE DRIVE GUILFORD #2** 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 16 W 460 W 460 specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 6 of 6 clients received diets prescribed as ordered. The findings are: Observation in the group home on 9/6/22 at 5:30 PM revealed the start of the dinner meal where no client washed or was prompted to wash their hands for the meal. Continued observation revealed the dinner meal to consist of rice, chicken cut in approximate 1 inch pieces, green peas, gravy, water and apple juice. Further observation revealed the serving utensils to be regular large size mixing spoon. Subsequent observation revealed clients were not offered a full place setting nor were they offered a preferred beverage, milk. Observation in the group home on 9/7/22 at 8:15 AM revealed the start of the breakfast meal no clients washed or was prompted to wash their hands for the breakfast meal. Further observation revealed the meal to consist of cut up pieces of french toast, cut up pieces of sausage, fruit, water and apple juice. Subsequent observation revealed staff G to place each client's plate on the table already prepared and ready for them to consume. Clients were not offered the opportunity to participate in the selection of the food they preferred to eat for breakfast as their plates were prepared and placed on the table for them. A. Observation in the group home revealed client #1 to be served with hand over hand assistance

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/14/2022 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY
		34G162	B. WING		_	09/0	07/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
GUILFORI	D #2			800 STRATHMORE DRIVI REENSBORO, NC 27			
(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 BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 460	regular portion of gree cup full of water and a observation revealed full place setting nor w beverage, milk. Observation in the gro revealed client #1 to or receiving no second s observation revealed breakfast dishes from the kitchen as part of Review of records for nutritional evaluation review of the nutrition #1's current diet is 15 health, 1 inch consiste vegetables, add 2-8 of cholesterol), low sodid sweets, no added salt assistance cutting foo B. Observation in the #2 to be served with the by staff C several larg regular portion of gree apple juice. Continue client #2 to be given s green peas during the Observation in the gro revealed client #2 to receiving no second s observation revealed	ge spoons full of rice, a en peas and chicken and a apple juice. Further clients were not offered a were they offered a preferred oup home on 9/7/22 consume his breakfast servings. Continued client #1 to clear his the table and carry them to his daily chores. client #1 revealed a dated 12/15/21. Further al evaluation revealed client 00 calorie weigh loss, heart ency, double portion of zo f water daily, (low fat, low um, no concentrated t, and, hand over hand do as needed. e group home revealed client hand over hand assistance ge spoons full of rice, a en peas, chicken, water and do observation revealed econds of rice, chicken and e meal. bup home on 9/7/22 consume his breakfast servings. Continued client #2 to clear his the table and carry them to	W 460				

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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 34G162 B. WING 09/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1800 STRATHMORE DRIVE GUILFORD #2** GREENSBORO, NC 27410 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 460 Continued From page 18 W 460 Review of records for client #2 revealed a nutritional evaluation dated 3/3/21. Further review of the nutritional evaluation revealed client #2's current diet is regular, 1/2 inch consistency, hearth healthy, may use applesauce to give medications, pace as needed due to difficulty with rate of eating, thin liquids, eat/drink only when alert, sit upright 60 minutes after eating, stop eating/drinking if coughing, monitor temperature/lung sounds for change, eat slowly, no straws, small sips, alternate food then liquids, and, stop eating if choking. C. Observation in the group home revealed client #3 to be served with hand over hand assistance by staff C several large spoons full of rice, a regular portion of green peas and chicken and a cup full of water and apple juice. Observation in the group home on 9/7/22 revealed client #3 to consume his breakfast receiving no second servings. Continued observation revealed client #3 to clear his breakfast dishes from the table and carry them to the kitchen as part of his daily chores. Review of records for client #3 revealed a nutritional evaluation dated 7/30/22. Further review of the nutritional evaluation revealed client #3's current diet is weigh gain, 1/2 inch consistency, encourage seconds, high calorie snack BID with milk, may give medications with food, strict aspiration precautions, encourage small bites and slow eating, stop eating if choking, only eat when alert, sit upright 30 minutes after eating, Ensure 1 can BID, 4 oz applesauce, and, yogurt or pudding with lunch daily.

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 09/14/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		E CONSTRUCTION		(X3) DATE	
		34G162	B. WING			_	09/	07/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
GUILFORI	D #2				800 STRATHMORE DRIVE GREENSBORO, NC 274			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 460	 D. Observation in the #4 to be served with h by staff C two large sportion of green peas juice. Observation in the grave revealed client #4 to a receiving no second so observation revealed breakfast dishes from the kitchen as part of Review of records for nutritional evaluation review of the nutrition #4's current diet is we healthy, whole consist seconds of fruits, veg beverages, avoid fried oat bran cereal 2 days margarine. E. Observation in the #5 to be at an appoint meal. Continued obs returned from the app planned to shower an shower. When asked observation on 9/7/22 his dinner meal. Observation in the grave and the grave and the second so fruits and the shower and shower. When asked observation on 9/7/22 his dinner meal. 	e group home revealed client hand over hand assistance poons full of rice, a regular , chicken, water and apple oup home on 9/7/22 consume his breakfast servings. Continued client #4 to clear his the table and carry them to his daily chores. T client #4 revealed a dated 1/27/22. Further al evaluation revealed client eight loss 1800 calorie heart tency, GERD diet, may have gies and low calorie d foods, 1 cup oatmeal of s a week, and limit butter or e group home revealed client tement during the dinner ervation revealed client #5 pointment at 6:30 PM and ad have his dinner after the the following day of 2, client #5 shared he did eat	W	460				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/14/2022 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION		(X3) DATE COMPI	SURVEY
		34G162	B. WING		-	09/	07/2022
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	TE, ZIP CODE	-	
GUILFOR	D #2			00 STRATHMORE DRIVE REENSBORO, 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 CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 460	Review of records for nutritional evaluation #5's current diet is we inch consistency, hea only when alert, sit up stop eating/drinking if temp/lung sounds for straws, small sips, alt stop eating if sighs of #5's 6/14/22 person-of change in diet with a PUREED diet with thi choking/aspiration pre- to remain the same as F. Observation in the #6 to be served with h by staff C several larg regular portion of gree apple juice. Continued client #6 to get secon- gravy. Observation in the gro receiving no second s observation revealed breakfast dishes from the kitchen as part of Review of records for nutritional evaluation review of the nutrition #6's current diet is reg fiber, seconds of vege	client #5 revealed a dated 6/5/22. Further al evaluation revealed client eight loss 1800 calorie, 1 int healthy, thin, eat/drink oright 6 minutes after eating, coughing, monitor change, eat slowly, no ernate food then liquids and choking. Review of client centered plan (PCP) alerts a recent medical event to a n liquids with ecautions/eating guidelines s previously listed. agroup home revealed client hand over hand assistance ge spoons full of rice, a en peas, chicken, water and d observations revealed ds of rice, chicken and bup home on 9/7/22 consume his breakfast servings. Continued client #6 to clear his the table and carry them to his daily chores.	W 460				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 09/14/2022 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G162	B. WING			09/07/2022		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	-		
GUILFORD #2				1800 STRATHMORE DRIVE GREENSBORO, NC 27410				
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE		
W 460	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W	460				

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