DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION SUILDING		(X3) DATE SURVEY COMPLETED	
		34G161	B. WING _			07/26/2023	
NAME OF PROVIDER OR SUPPLIER GUILFORD #1			,	STREET ADDRESS, CITY, STATE, ZIP CODE 416 BOXWOOD DRIVE GREENSBORO, NC 27410			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		DATE	
W 472	CFR(s): 483.480(b)(2 Food must be served This STANDARD is r Based on observatio interview, the facility is served in the approprict clients (#2). The finding the breakfast meal reparticipate in a breakfoot oatmeal, scrambled econtinued observation client #2 to be served assistance two double two double portions of observation revealed used to gage the appor scrambled eggs sets subsequent observation request and be served oatmeal. Additional of #2 to request and be portions of scrambled revealed client #2 to othim. Review of records on revealed a person-ce 3/30/23 indicating the #2 is 1800 calorie we seconds of fruits and review of the record redated 2/3/23 for client diet is "1800 calorie we cut to ½" consistency vegetables." Further revealed an occupation	in appropriate quantity. not met as evidenced by: ns, record review and failed to assure food was iate quantity for 1 of 4 ng is: oup home on 7/26/23 during vealed client #2 to fast meal consisting of eggs, orange juice and milk. n of the breakfast revealed with hand over hand e portions of oatmeal and of scrambled eggs. Further no measuring devices were ropriate portion of oatmeal erved to client #2. ion revealed client #2 to d second double portions of observation revealed client served a second double I eggs. Final observation consume all the food served	W 2			(YE) DATE	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G161	B. WING			07/	26/2023
	GUILFORD #1 416 BOXWOOD DRIVE		EET ADDRESS, CITY, STATE, ZIP CODE BOXWOOD DRIVE EENSBORO, NC 27410				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 472	as regular consistenc 1/2."	client #2's diet is described y 2000 calorie with meats to with the qualified intellectual	W	172			
W 474	prescribed diet for clie accurately reflected in Continued interview vicient #2 should have were in proportions coprogram plan. MEAL SERVICES CFR(s): 483.480(b)(2)	ent #2 to be current and n his PCP and assessments. vith the QIDP verified that received food items which onsistent with all his)(iii)	W	174			
	developmental level of This STANDARD is r Based on observation interview, the facility f	in a form consistent with the of the client. not met as evidenced by: ns, record review, and failed to assure 1 of 4 clients a medically prescribed. The					
	5:35 PM revealed cliedinner meal consisting hamburger-steak patt squash, fruit cup, sug beverage and water. The revealed client #2 to be hamburger steak patt assistance. Further of #2 to consume the sat whole form by picking large bites out of it.	ry, mashed potatoes, gravy, ar free-crystal light Continued observation be served a whole Salisbury y with hand over hand beservations revealed client disbury hamburger-steak in yit up with a fork and taking					
	Review of records on revealed a person-ce	7/26/23 for client #2 ntered plan (PCP) dated					

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		34G161	B. WING _			07/26/2023	
NAME OF P	ROVIDER OR SUPPLIER D #1			STREET ADDRESS, CITY, STATE, ZI 416 BOXWOOD DRIVE GREENSBORO, NC 27410	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
W 474	client #2's diet to be 1 ½" meats, seconds of Continued review of t physician's order date states client #2's diet diet, with meats cut to seconds of vegetable client #2's record reve therapy assessment of client #2's diet is deso consistency 2000 calc consistency." Interview with the qua professional (QIDP) of #2's prescribed diet as	ew of the PCP revealed 1800 calorie weight loss with a fruits and vegetables. The record revealed a ed 2/3/23 for client #2 which is "1800 calorie weight loss o ½" consistency, may have s." Subsequent review of ealed an occupational (OT) dated 7/7/23 in which cribed as regular orie with meats to ½ alified intellectual disabilities on 7/26/23 confirmed client is listed in the program ew with the QIDP confirmed its should always be	W 2	474			