		AND HUMAN SERVICES			Ο		APPROVED 0938-0391	
				TIPLE CONSTRUCTION		E SURVEY PLETED		
	34G162		B. WING			08/30/2023		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GUILFOF	GUILFORD #2				800 STRATHMORE DRIVE REENSBORO, NC 27410			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 130	PROTECTION OF CFR(s): 483.420(a)		W 1	30				
	The facility must en Therefore, the facilit treatment and care This STANDARD i Based on observat interviews, the facilic clients (#2 and #3) personal care. The A. During observatii 6:52 am, Staff C wa bedroom getting dr observed sitting on completely unclothe was open approxim #2 could be seen fr During additional of 8/30/23 at 7:41 am bathroom, pull his p door to the bathroo could be seen from Review on 8/30/23 Program Plan (IPP) information in regate ensure his privacy. Review on 8/30/23 Behavior Inventory the area of closing	asure the rights of all clients. ity must ensure privacy during of personal needs. s not met as evidenced by: tions, record reviews and ity failed to ensure 2 of 6 audit were afforded privacy during findings are: tons in the home on 8/30/23 at as assisting client #2 in his essed. Client #2 was the edge of the bed, ed. The door to the bedroom hately 6 - 8 inches and client from the hallway. bservations in the home on revealed client #2 to enter the bants down and urinate. The m was open and client #2 the hallway. of client #2's Individual) dated 1/8/23 revealed no rds to client #2's Adaptive (ABI) dated 1/2/22 revealed in the door for privacy, client #2 ce and cannot perform any of						
	Disabilities Profess	3 with the Qualified Intellectual ional (QIDP) and Residential evealed staff should close the						

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 09/01/2023

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.

		AND HUMAN SERVICES				FORM	09/01/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G162	B. WING			08/3	30/2023
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GUILFOF	RD #2				800 STRATHMORE DRIVE REENSBORO, NC 27410		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 130	his privacy. B. During observati 7:05 am, Staff A wa in his bedroom to g Client #3 was obse undressed. The do and client #3 could Review on 8/30/23 revealed no informa ability to ensure his Review on 8/30/23 reveled in the area client #3 has no ind perform any of the Interview on 8/30/27 revealed staff shou during personal car STAFF TRAINING CFR(s): 483.430(e) The facility must pre- initial and continuin employee to perfor efficiently, and com This STANDARD is Based on observat failed to ensure sta properly dispose of finding is:	ons in the home on 8/30/23 at is observed assisting client #3 et changed and dressed. rved laying on the bed, oor to his bedroom was open be seen from the hallway. of client #3's IPP dated 8/9/23 ation in regards to client #3's privacy. of client #3's ABI dated 9/2/21 of closing the door for privacy, lependence and cannot behavior independently. 3 with the QIDP and RTL ld close the door for client #3 re to ensure his privacy. PROGRAM 0(1) ovide each employee with g training that enables the m his or her duties effectively, petently. s not met as evidenced by: tions and interviews, the facility ff were sufficiently trained to unused medications. The	W 1		DEFICIENCY)		
	on 8/30/23 at 7:00 a	s of medication administration am, staff A and client #6 went room. Staff A retrieved the					

Facility ID: 921935

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 09/01/2023 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		34G162	B. WING	·		08	/30/2023
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GUILFOF	RD #2				1800 STRATHMORE DRIVE GREENSBORO, NC 27410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 189 W 249	Staff A read the nar medication to the cl each medication ou small paper cup, the client. The client the the medications into fell out of the client" floor. Staff A picked placed it in the trash nurse to request ins dropped pill. Staff A dropped pill into a z it to the office, then dose. Staff A then a from the bubble car Interview with Staff revealed that she co pill. Interview with the fa staff should be train unadministered me proper disposal and medications in the F PROGRAM IMPLE CFR(s): 483.440(d) As soon as the inte formulated a client's each client must reat treatment program interventions and so and frequency to su	client #6 from the cabinet. ne and dosage of each ient, had the client punch it of the bubble pack into a en handed the cup to the en raised the cup and poured to their mouth. One of the pills is mouth and landed on the the pill up from the floor and in can, then called the facility structions for handling the was instructed to place the ipper close bag and transport administer a replacement dministered the 8/31/23 dose d to the client. A on 8/30/23 at 7:40 am build not locate the dropped acility nurse revealed that all dications to the nurse for to never dispose of nome. MENTATION	W -				

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		AND HUMAN SERVICES				FORM	09/01/2023 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G162	B. WING			08/:	30/2023	
NAME OF F	PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>		
GUILFOF	RD #2				800 STRATHMORE DRIVE REENSBORO, NC 27410			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 249	Continued From pa	ige 3	W 2	49				
	Based on observat interviews, the facil clients (#1, #2, #3, continuous active tr of needed intervent in the Individual Pro	s not met as evidenced by: tions, record reviews and ity failed to ensure 6 of 6 audit #4, #5 and #6) received a reatment program consisting tions and services as identified ogram Plan (IPP) in the areas n, program guidelines, and t. The findings are:						
	A. Clients were not assist with meal pre	provided the opportunity to eparation.						
	5:00 pm until 5:35 p prepare the dinner was observed to wa was observed to tel room and watch tel	s in the home on 8/29/23 from om, Staff C was observed to meal. At 5:08 pm, client #1 alk into the kitchen. Staff C Il client #2 to go into the living evision. At no time during the by client prompted to nner prep.						
	8/30/23 at 7:27 am the breakfast meal. #1 walked into the I go sit in his bedrood At no time during th	bservations in the home on revealed Staff A to prepare At 7:32 am, client kitchen and Staff A told him to m until breakfast was ready. he observation was any client pate in the preparation of						
	Disabilities Profess Team Lead (RTL) c	3 with the Qualified Intellectual ional (QIDP) and Residential confirmed clients should be ispects of meal prep.						
	B. Client #2's eating	g guidelines were not followed.						

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	09/01/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		34G162	B. WING				08/3	30/2023
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE	, ZIP CODE	-	
GUILFOF	RD #2				800 STRATHMORE DRIVE GREENSBORO, NC 27410)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD	BE	(X5) COMPLETION DATE
W 249	Continued From pa	ge 4	W 2	249				
	the dinner meal and meal revealed clien #2 was observed to times and eat at a r the observations we him to slow down a							
	revealed the followi 1. Staff will follow di 2. Staff will cue clien himself.	of client #2's IPP dated 1/8/23 ng eating guidelines: iet and consistency. nt #2 to slow down and pace wipe his mouth periodically.						
		3 with the QIDP and RTL s eating guidelines should be eal.						
	C. Client #2's comn followed.	nunication program was not						
	the home throughou 8/30/23, staff were to do various things his medications, etc	s at the day program and in ut the survey on 8/29/23 - observed to prompts client #2 s such as eat, watch TV, take c. At no time throughout the 2 presented with objects to						
	revealed a program	of client #2's IPP dated 1/8/23 for client #2 to make a choice h two real object choices.						
		3 with the QIDP and RTL s communication program is be followed.						

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		AND HUMAN SERVICES				FORM	: 09/01/2023 APPROVED . 0938-0391
		· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G162	B. WING			08	/30/2023
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GUILFOF	RD #2				300 STRATHMORE DRIVE REENSBORO, NC 27410		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 249	 D. Client #4's whee During observation: survey on 8/29/23 - observed to self-pro- his wheelchair. A s observed to be han no time during the o utilized to ensure client Interview on 8/30/2 confirmed the whee at all times during a is safe. E. Client #3 did not During observation: survey on 8/29/23 - observed to ambula rolling walker while during the observat Review on 8/30/23 revealed client #3 a rolling walker. Interview on 8/30/23 revealed client #3 a rolling walker. Interview on 8/30/24 revealed that client IPP meeting that he attending the vocat QIDP and RTL con- current IPP, client # the morning until the 	 In the home throughout the 8/30/23, client #2 was opel or be pushed by staff in seatbelt on the wheelchair was aging down on both sides. At observations was the seatbelt lient #2's safety. With the QIDP and RTL elchair seatbelt should be used ambulation to ensure client #2 wear his AFO's. s in the home throughout the 8/30/23, client #3 was ate around his home with a wearing socks. At no time tions did client #3 wear AFO's. of client #3's IPP dated 8/9/23 ambulates using AFO's and a With the QIDP and RTL #3's guardian requested at his e only wear the AFO's while ional center. However, the firmed that based on the #3 should be wearing them in e afternoon. 	W 2		DEFICIENCY)		
	The facility must ke	ep all drugs and biologicals					

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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 MAME OF PROVIDER OR SUPPLIER 34G162 B. WING 08/30/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1800 STRATHMORE DRIVE GREENSBORO, NC 27410 1800 STRATHMORE DRIVE GREENSBORO, NC 27410 (X3) DATE SURVEY COMPLETED			AND HUMAN SERVICES			FORM	09/01/2023 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GUILFORD #2 STREET ADDRESS, CITY, STATE, ZIP CODE (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 CORRECTIVE (EACH OFFICIENCY) PROVIDER'S PLAN OF CORRECTIVE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x4) DATE W 382 Continued From page 6 locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure all medications and biological's remained locked except when being prepared for mediation administration for 1 out of 6 clients (#6). The finding is: Morning observations in the home on 8/30/23 revealed staff C and client #6 to enter the medication room at 7:00 am for the purpose of administering the morning medications. Continued observations revealed staff C to assist client #6 to punch several medications into a paper cup from their bubble packs. Further observations at 7:09 am revealed staff C to leave the medication room and close the door, leaving	STATEMENT				E CONSTRUCTION		
BIO 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X9) W 382 Continued From page 6 locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure all medications and biological's remained locked except when being prepared for mediation administration for 1 out of 6 clients (#6). The finding is: Morning observations in the home on 8/30/23 revealed staff C and client #6 to enter the medication room at 7:00 am for the purpose of administering the morning medications. Continued observations revealed staff C to leave the medication room at 7:09 am revealed staff C to leave the medication room and close the door, leaving 1800 STRATHMORE DRIVE GREENSBORO, NC 27410			34G162	B. WING	 	08/;	30/2023
GUILFORD #2 GREENSBORO, NC 27410 Image: Construct of the second state of the second state of the medication room at 7:00 am for the purpose of administering the morning medications. Continued observations revealed staff C to leave the medication room and close the door, leaving ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Comments of the second should be crossed administration. W 382 Continued From page 6 W 382 W 382 W 382 Index of the second state	NAME OF I	PROVIDER OR SUPPLIER				-	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE W 382 Continued From page 6 locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure all medications and biological's remained locked except when being prepared for mediation administration for 1 out of 6 clients (#6). The finding is: W 382 Morning observations in the home on 8/30/23 revealed staff C and client #6 to enter the medication room at 7:00 am for the purpose of administering the morning medications. Continued observations revealed staff C to assist client #6 to punch several medications into a paper cup from their bubble packs. Further observations at 7:09 am revealed staff C to leave the medication room and close the door, leaving	GUILFO	RD #2					
locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure all medications and biological's remained locked except when being prepared for mediation administration for 1 out of 6 clients (#6). The finding is: Morning observations in the home on 8/30/23 revealed staff C and client #6 to enter the medication room at 7:00 am for the purpose of administering the morning medications. Continued observations revealed staff C to assist client #6 to punch several medications into a paper cup from their bubble packs. Further observations at 7:09 am revealed staff C to leave the medication room and close the door, leaving	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
with open cup directly next to the client. Interview with the facility nurse confirmed that staff should not leave a client in a room where previously dispense medications are present and that, if staff must leave the room, they must take the client out of the room as well. W 440 EVACUATION DRILLS W 440 CFR(s): 483.470(i)(1) W 440 at least quarterly for each shift of personnel. W 440 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at least quarterly for each shift. The finding is: Review on 8/29/23 of the facility's fire drills for July 2022 - August 2023 revealed no recorded		locked except wher administration. This STANDARD i Based on observation failed to assure all for remained locked ex- mediation administric (#6). The finding is: Morning observation revealed staff C and medication room at administering the m Continued observation revealed staff C and medication room at administering the m Continued observation spaper cup from the observations at 7:00 the medication room surveyor and client room while the medic paper cup directly m Interview with the fa staff should not lear previously dispenses that, if staff must le the client out of the EVACUATION DRI CFR(s): 483.470(i)() at least quarterly for failed to ensure fire quarterly for each s Review on 8/29/23	n being prepared for s not met as evidenced by: tions and interviews, the facility medications and biological's accept when being prepared for ration for 1 out of 6 clients and client #6 to enter the to a for the purpose of norning medications. tions revealed staff C to assist several medications into a ir bubble packs. Further 9 am revealed staff C to leave m and close the door, leaving #6 alone in the medication dications remained in the next to the client. acility nurse confirmed that we a client in a room where e medications are present and ave the room, they must take room as well. LLS (1) r each shift of personnel. s not met as evidenced by: eview and interview, the facility drills were conducted at least thift. The finding is: of the facility's fire drills for				

Facility ID: 921935

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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 08/30/2023 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 ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 440 Continued From page 7 W 440 fire drills for October 2022, November 2022, December 2022, January 2023, February 2023, March 2023, April 2023, and June 2023. Interview on 8/30/23 with the Qualified Intellectual Disabilities Professional (QIDP) and Residential Team Lead (RTL) confirmed no fire drill reports could be located for the missing months. W 474 MEAL SERVICES W 474 CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve food and beverages in a form consistent with the developmental level for 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). The findings are: A. The facility failed to ensure that client #4 received food that was consistent with their developmental level and prescribed diet. For example: During observations in the home on 8/29/23 at 5:35 pm revealed client #4 eating dinner. The dinner meal consisted of ground chicken, softened squash, several saltine crackers served in whole form, juice which was thickened and milk that was not thickened. During the dinner meal, client #4 was observed to overstuff his mouth with the saltine crackers, and cough several times. During additional observations in the home on 8/30/23 at 7:52 am revealed client #4 eating breakfast which consisted of oatmeal, stewed prunes and milk. The milk was served from a

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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 08/30/2023 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 ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 474 Continued From page 8 W 474 pitcher that Staff B stated was thickened the day before. Review on 8/29/23 of client #4's Individual Program Plan (IPP) dated 2/11/23 revealed a diet order of weight loss, heart healthy, food consistency is whole. Review of diet guidelines posted in the home on 8/29/23 revealed a diet order for client #4 of weight loss, heart healthy, ground moistened meats, 1/2" cooked vegetables and soft fruits, no breads until swallow study is done and thickened liquids. Interview on 8/30/23 with Staff A and Staff C revealed they were unsure the level of which client #4's liquids should be thickened. Interview with Staff B revealed client #4 is on nectar thick liquids. Staff B also revealed that the pitcher of milk was thickened on the day prior, and this does not conflict with how thick the liquid gets. Interview on 8/30/23 with the Facility Nurse, Qualified Intellectual Disabilities Professional (QIDP) and Residential Team Lead (RTL) revealed client #4 has recently experienced a regression in his skills, which is why his diet was recently downgraded until a swallow study is completed. Further interview revealed that client #4's liquids should not be thickened the day before being served as that does not provide the correct consistency, and that he should not have received crackers at the dinner meal. B. The facility failed to ensure that client #2 received food that was consistent with their developmental level and prescribed diet. For example:

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		AND HUMAN SERVICES				FORM	09/01/2023 APPROVED 0938-0391
		l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
34G162			B. WING			08/:	30/2023
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	-	
GUILFOF	RD #2				800 STRATHMORE DRIVE REENSBORO, NC 27410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 474	Continued From pa	ige 9	W 4	74			
	5:35 pm revealed c consisted of chicke crackers. The chic	s in the home on 8/29/23 at lient #2 eating dinner which n, squash and saltine ken was cut into small pieces, saltine crackers were served					
		of client #2's IPP dated 1/8/23 sisting of regular, heart stency.					
	confirmed client #2' should have been n C. The facility failed received food that v	3 with the QIDP and RTL 's saltine crackers and squash nodified to 1/2" consistency. I to ensure that client #6 was consistent with their and prescribed diet. For					
	evening meal on 8, served oven fried cl whole pieces of yell crackers served in v Client #6 drank all c eat, then ate the en breaks, without drin prompted client	e group home during the /29/23 revealed client #6 was hicken cut to various sizes, low squash and several saltine whole form, juice and milk. of his juice before beginning to htire plate of food taking few hking any of their milk. Staff the meal to "slow down."					
	(IPP) dated 5/10/23 "Regular, heart hea liquids - CHOKING PRECAUTIONS - o drinking if coughing sips, alternate betw	t's Individual Program Plan B, the client's diet order is, althy, 1 inch consistency, thin AND ASPIRATION client should stop eating and g, eat slowly, no straws, small geen food and drink, sit upright r 60 minutes after each meal."					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/01/2023 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G162	B. WING	÷		08/	30/2023	
NAME OF F	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE			
GUILFO	RD #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	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 474	Continued From pa	age 10	W	474				
		QIDP and RTL on 8/30/23 f should monitor client #6's g all meals,						

Facility ID: 921935