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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G355	A. BUILDING ______ B. WING ______	05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD IV	404 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 observation, record review and interview, the facility failed to assure that privacy was maintained for 1 of 6 clients (#5) during personal care. The finding is: Observation in the group home on 5/15/23 at 4:45 PM revealed client #5 to finish with dinner meal. Continued observation revealed staff A to prompt client #5 to go and use the bathroom. Further observation revealed client #5 to enter the bathroom and use the toilet with the door open. Subsequent observation revealed staff A to approach the bathroom while the client was toileting and knock on the door frame prompting client #5 to wash his hands. Observation revealed staff A to walk away and to not close the bathroom door for privacy. Observation in the group home on 5/16/23 at 6:29 AM revealed staff D to prompt client #5 to go and use the bathroom. Continued observation revealed client #5 to enter the bathroom and use the toilet with the door open and light off. Further observation revealed the client to exit the bathroom and go into the sitting area next to the dining room. At no time during this observation was staff observed to close the bathroom door for privacy. Review of record on 5/16/23 for client #5 revealed a person-centered plan dated 7/7/22. Continued review of record for client #5 revealed an adaptive behavior inventory (ABI) dated 6/1/21.	W 130	W 130 Staff will be in-serviced by the QP regarding privacy for client #5 specifically closing the bathroom door when using the bathroom. This will be monitored by assessments in the home twice a week for a period of one month, then on a routine basis thereafter. In the future, the QP will ensure privacy is ensured for all people in the home.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Felicia Davis	QP	7-20-23

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 Further review of the ABI revealed client #5 has no independence and cannot close the bathroom door for privacy. Interview with the qualified intellectual disabilities professional (QIDP) on 5/16/23 verified that staff should be observing privacy during personal care by closing the client's bathroom door. Continued interview with the QIDP revealed that staff should be with client #5 during toileting.	W 130		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have evidence that the person-centered plan (PCP) for 2 of 6 clients (#3 and #4) were revised and updated at least annually as required. The findings are: A. The facility failed to revise and update the PCP at least annually for client #3. For example: Review of records for client #3 on 5/15/23 revealed a PCP dated 1/19/22. Continued record review revealed client #3 to have no evidence of a current updated PCP. Interview with the qualified intellectual disability professional (QIDP) on 5/16/23 verified that a current PCP for client #3 could not be located during the survey. Further interviews with the QIDP confirmed that all clients should have an updated PCP review at least annually.	W 260	W 260 QP's will be in-serviced by the Administrator that the PCP must be revised and updated at least annually. This will be monitored through routine chart reviews by the clinical team. In the future the QP will ensure each PCP is updated at least annually.	

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W 260	Continued From page 2 B. The facility failed to revise and update the PCP at least annually for client #4. For example: Review of records for client #4 on 5/15/23 revealed a PCP dated 5/3/22. Continued record review revealed client #4 to have no evidence of a current updated PCP. Interview with the QIDP on 5/16/23 verified that a current PCP for client #4 could not be located during the survey. Further interviews with the QIDP confirmed that all clients should have an updated PCP review at least annually.	W 260		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 1 of 6 clients (#3) observed during medication administration. The finding is: Observation in the group home on 5/16/23 at 7:00 AM revealed staff A to punch medications into a medicine cup for client #3. Continued observation revealed the medications placed in the cup to be Omega 3 Fish Oil 1000 mg capsule, Clozapine 25 mg 1 tablet, Simethicone 180 mg 1 capsule, Divalproex 500 mg 2 tablets, Acidophilus capsule, Montelukast 10mg 1 tablet, and Magnesium Oxide 400 mg 1 tablet. Further observation revealed staff A to measure Lactulose 10 g/15 ml 30 cc in a separate small cup, then mix the Lactulose with Kool-Aid in another cup, and to	W 369	W 369 All staff will be in-serviced by the nurse regarding medication pass and ensuring people receive all the medications as prescribed. This will be medication pass observations two times a week for 4 weeks then on a routine basis thereafter. In the future, the QP and Nursing will ensure medications are given as prescribed.	

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W 369	Continued From page 3	W 369		

measure Polyethylene glycol powder 17 g and mix it with water in a third cup. Subsequent observation revealed client to drink the cup containing Lactulose, then to take all remaining medications with the water containing Polyethylene glycol. Additional observation revealed client #3 to leave the medication room at 7:02 AM and to receive no further medications prior to the end of morning observations at 8:25 AM. Observation on 5/16/23 at 7:00 AM during medication administration revealed client #3 was not administered Clonazepam and Montegrity.

Review of records for client #3 on 5/16/23 revealed physician orders dated 4/26/23. Review of the 4/26/23 physician orders revealed medications to be administered at 7:00 AM to include Omega 3 Fish Oil 1000 mg capsule, Clozapine 25 mg 1 tablet, Simethicone 180 mg 1 capsule, Divalproex 500 mg 2 tablets, Acidophilus capsule, Montelukast 10mg 1 tablet, and Magnesium Oxide 400 mg 1 tablet, Lactulose 10 g/15 ml 30 cc, and Polyethylene glycol powder 17 g. Further review of the 4/26/23 physician orders revealed medications to be administered at 8:00 AM to include Clonazepam 1 mg tablet by mouth 3 times daily at 8:00 AM, 4:00 PM and 9:00 PM and Motegrity 2 mg 1 tablet by mouth every day at 8:00 AM. Additional record review revealed entries in the computerized medication administration system indicating that Clonazepam and Motegrity had been administered to client #3 at 7:05 AM.

Interview with the Qualified Intellectual Disability Professional (QIDP) and facility nurse on 5/16/23 confirmed physician orders for client #3 to be current. Continued interview with facility nurse confirmed that client #3 should have received

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W 369	Continued From page 4 Clonazepam and Motegrity during the morning medication administration.	W 369		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the system for drug administration failed to assure 1 of 6 clients (#2) observed during medication administration was provided the opportunity to participate in medication self-administration. The finding is: Observations in the group home on 5/16/23 at 6:35 AM revealed staff A to enter the medication room, remove several bubble packs of medications from a plastic bin, punch each medication from its bubble pack into a small paper cup, fill a glass with water, then call resident #2 into the medication room. Continued observation revealed client #2 to enter the medication room at 6:39 AM, receive a small paper cup of medications from staff A, take all medications with the glass of water provided by staff A and leave the medication room at 6:42 AM. Further observation revealed staff A to provide no identification of any medication nor education regarding purpose or side effects to the client. Additional observations revealed client #2 to be verbal and to engage in extended conversation with staff in other situations.	W 371	W 371 Staff will be in-serviced on encouraging people to be as independent as possible during medication administration, including teaching the person what the meds are and what they are for	

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W 371	Continued From page 5 Review of records for client #2 revealed a person-centered plan (PCP) dated 10/5/22. Continued review of the PCP revealed diagnoses to include attention deficit hyperactivity disorder (ADHD), history of Impulse Control Disorder, IDD moderate, Tardive Dyskinesia, glucose intolerance, hyperopia, and reflective error. Interview with the Qualified Intellectual Disability Professional (QIDP) and facility nurse on 5/16/23 verified client #2 should have been provided the opportunity to participate in medication self-administration based on the client's developmental level.	W 371		
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 furnish prescribed eyeglasses for 1 of 6 clients (#1). The finding is: Observation in the group home throughout the 5/15-5/16/23 survey revealed client #1 to participate in various activities to include coloring, watching television, to participate in meal preparation and pouring drinks, to participate in the dinner and breakfast meal and to participate in medication administration. At no time throughout the survey was staff observed to prompt client #1 to wear prescribed eyeglasses.	W 436	W 436 The team will meet to discuss the use of glasses/goggles for client #1. A program involving the use of glasses will be implemented for him. This will be monitored through assessments in the home and at the vocational center twice a week for a period of four weeks then on a routine basis thereafter. In the future the QP will ensure adaptive equipment is available and in good repair.	

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W 436	Continued From page 6 Review of records for client #1 revealed a person-centered plan (PCP) dated 7/7/22. Continued review of record for client #1 revealed a vision consult dated 10/12/20 with a diagnosis of myopia with astigmatism. Further review of the vision consults revealed client #1 to have a new prescription for eyeglasses. Interview with staff A revealed that staff did not know about any eyeglasses. Continued interview with staff A revealed that client #1 used to wear goggles but he would break them. Interview on 5/16/23 with the qualified intellectual disabilities professional (QIDP) and the facility nurse confirmed that client #1 should be wearing prescribed eyeglasses. Continued interview with the facility nurse revealed that the client had goggles in place; however, he would break them and the facility needs to have something in place for the client's prescribed eyeglasses.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of record and interview, the facility failed to show evidence that quarterly fire drills were conducted with each shift of personnel relative to third shift. The finding is: Review of the facility fire drill reports from 6/22 through 5/23 revealed 4 drills missing evacuation times. Further review of the fire drill reports revealed a second shift drill conducted on 6/17/22, 8/12/22, 9/5/22, 12/5/22, 2/5/23, 3/16/23, 4/14/23 and 5/10/23 and first shift drills completed on 7/4/22, 10/8/22, 11/20/22, and 1/5/23. There	W 440	W 440 Staff will be in-serviced by the QP on the importance and standard of a fire drill on each shift, including third shift. This will be monitored monthly by the unit safety committee. In the future, the QP will ensure all required fire drills are completed.	

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W 440	Continued From page 7 was no additional documentation available about conducting a third shift drill during the review year. Interview with the qualified intellectual disabilities professional (QIDP) on 5/16/23 confirmed facility fire drills should have been conducted quarterly for each shift. Continued interview with the QIDP revealed that staff should be documenting evacuation times.	W 440		