	-	D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		34G160	B. WING			03/	12/2025
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 WESTRIDGE ROAD		
				Ģ	GREENSBORO, NC 27405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
W 130	PROTECTION OF CL CFR(s): 483.420(a)(7		w	130			
	The facility must ensu Therefore, the facility treatment and care of This STANDARD is r Based on observation failed to assure privace #4, #5) during care ar are: A. Observations in the 5:28 PM, revealed sta common hallway of th pants away from the of pants, then tell the cli- changed. This conver by staff and other clie B. Observations in the revealed a medication hallway of the home w high traffic area for th observation revealed medication area at 7:1 medications. Continue client #4 to enter the p and to receive medication balk back and forth th and to have conversa administering the medication 8:05 AM revealed all dining room table with present. Further observation that state to surveyor that	are the rights of all clients. must ensure privacy during personal needs. not met as evidenced by: ns and interviews, the facility by for 3 sampled clients (#1, nd treatment. The findings e group home on 3/11/25 at aff to approach client #4 in a lie home, pull client #4's client's body, look inside the ent he needed to be sation could be overheard ints as well as surveyor. e group home on 3/12/25 n cart located in a common which was observed to be a le clients and staff. Further client #1 to enter the D7 AM and to receive ed observations revealed medication area at 7:30 AM ation. Subsequent d several clients and staff to prough the medication area tions with the staff					

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 03/14/2025

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.

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 34G160 B. WING 03/12/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1609 WESTRIDGE ROAD** WESTRIDGE GREENSBORO, NC 27405 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) W 130 Continued From page 1 W 130 Interview with the qualified intellectual disabilities professional (QIDP) on 3/12/25 confirmed that all clients should be given privacy during care and treatment and that staff should not discuss any client's personal care or treatment in the presence of others. W 249 **PROGRAM IMPLEMENTATION** W 249 CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a continuous active treatment program consisting of needed interventions were identified in the Person-Centered Plan (PCP) for 1 sampled client (#3) relative to implementing training objectives relative to rate of eating. The finding is: Afternoon observations on 3/11/25 at 6:00PM revealed client #3 to sit at the dining table and participate in the dinner meal. Further observations revealed client #3 to eat at a fast pace without redirection from staff. Continued observations revealed client #3 to finish his meal at 6:09PM.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: OM8W11

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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 ___ 34G160 B. WING 03/12/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1609 WESTRIDGE ROAD** WESTRIDGE GREENSBORO, NC 27405 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 2 W 249 Morning observations on 3/12/25 at 7:58AM revealed client #3 to participate in the breakfast meal. Further observations revealed client #3 to again eat at a fast pace. Continued observations revealed client #3 to complete his meal at 8:05AM. Review of the record for client #3 on 3/12/25 reveled a PCP dated 6/16/24. Further review of the 6/2024 PCP revealed client #3 should receive prompting from staff to eat at a slower pace. Interview with the qualified intellectual disabilities professional (QIDP) on 3/12/25 revealed staff have been trained to monitor when client #3 is eating during mealtimes. Continued interview with the QIDP verified staff should have prompted client #3 to eat at a slower pace to prevent choking. W 460 FOOD AND NUTRITION SERVICES W 460 CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interview, the facility failed to provide specially prescribed diets for 2 of 4 sampled clients (#1 #4). The findings are: A. The facility failed to provide honey thickened liquids during medication administration for client #4 as prescribed. For example, Morning observations on 3/12/25 at 7:35AM

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/14/2025 MAPPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G160	B. WING				03/	12/2025	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, S	TATE, ZIP CODE			
WESTRID	GE				1609 WESTRIDGE ROAD GREENSBORO, NC 27	405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAC	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 460	to participate in media Further observation in #4's medication and s applesauce. Continue staff to spoon the con- client #4's mouth. Ad 7:40AM revealed staff and serve it to the clien revealed client #4 to if and to regurgitate the At no point during the did staff prepare client thickened consistency. Review of the record revealed a physician's indicated the client ha I/DD profound, hiatal spastic diplegia, cons disease, GERD, and Further review of the the client should have consistency and emp every three bites or s in the throat. Interview with the fac intellectual disabilities 3/12/25 revealed staff provide all liquids for thickened consistency aspiration. Further in verified client #4 shou water at a honey thick	are medications for client #4 cation administration. evealed staff to crush client stir the medication into ed observations revealed tents of the medication into ditional observations at f to pour a glass of water ent. Subsequent observation mmediately begin gagging contents of the medication. medication administration t #4's water to a honey y as prescribed. for client #4 on 3/12/25 s order dated 3/11/25 which as the following diagnoses: hernia, cerebral palsy with tipation, salivary gland Esophageal Obstruction. physician's order indicated e thickened liquids to honey ty the client's mouth after ips to help decrease residual ility nurse and qualified a professional (QIDP) on f have been trained to client #4 at a honey y to prevent choking and/or terview with the QIDP ild have been provided kened consistency during	W	460					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/14/2025 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	_	(X3) DATE COMPI	SURVEY
		34G160	B. WING			03/*	12/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,		-	
WESTRID	GE			1609 WESTRIDGE ROAL GREENSBORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 460	Continued From page followed as prescrived Observations in the g 6:00 PM revealed clie meal consisting of chi steamed vegetables a time during the dinner packet of Benecalorie drink. Observations in the g 8:00 AM revealed clie breakfast meal consis cereal and breakfast r a yogurt of his choice Review of the records person-centered plan 6/12/24 and a Nutritio 1/30/25 which specifie calorie weight gain, his consistency, double p deep-fried foods, no s BBQ sauce, vinegar, grapefruit, etc.) Bener meal, yogurt of choice 4 oz BID, high calorie time. Interview with the qua professional (QIDP) of the Benecalorie has b	e 4 d. For example: roup home on 3/11/25 at ant #1 to consume the dinner icken and dumpling soup, and whole wheat toast. At no r meal did staff provide a to add to client #1's food or roup home on 3/12/25 at ent #1 to consume the sting of Cream of Wheat sausage links. At no time neal did staff offer client #1 for client #1 revealed a (PCP) for client #1 dated nal Evaluation dated es the following diet: 2000 eart healthy, GERD, ground oortions of meals, no spicy foods, no ketchup, no acidic juices (orange, calorie 1 packet at dinner e at breakfast, Resource 2.0 snack once a day at snack	W 4				
W 472	3/6/25 and that client provided with the Ben according to his press MEAL SERVICES CFR(s): 483.480(b)(2	ecalorie and yogurt cribed diet.	W 4	.72			

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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 ___ 34G160 B. WING 03/12/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1609 WESTRIDGE ROAD** WESTRIDGE GREENSBORO, NC 27405 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 472 Continued From page 5 W 472 Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure food was served in the appropriate quantity for 2 sampled clients (#2 and #5). The finding is: Observations in the group home on 3/11/25 during the evening meal revealed all clients to be served canned chicken and dumpling soup, toast and a vegetable medley. Further observation revealed the meal to be served family style, with no measuring tools used to assist clients with portioning food on their plates, and all clients served themselves slices of toast. Subsequent observation revealed client #2 to eat 2 slices of toast along with the other items. Additional observation revealed that the prescribed menu for an 1800 calorie diet indicated one slice of toast to be the correct portion size. Observations in the group home on 3/12/25 during the breakfast meal revealed all clients to be served cereal and breakfast sausage links. Further observation revealed the meal to again be served family style with clients using a ladle to serve themselves the cereal and staff to place sausage links on each client's plate. Subsequent observations revealed no effort made by staff to measure the food clients served themselves and the servings appeared to be larger than called for by the prescribed menu. Review of client #2's record on 3/12/25 revealed a person-centered plan (PCP) dated 9/12/24. Review of the PCP revealed client #2 to be prescribed an 1800 calorie, weight loss, heart healthy 1/2" chopped consistency diet, second

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPI	LE CONSTRUCTION	(X3) DA	OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 34G160			. ,		· · ·	COMPLETED		
		B. WING		03/12/2025				
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE				
WESTRID	GE			1609 WESTRIDGE ROAD GREENSBORO, NC 27405				
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
W 474	Continued From page	e 7	W 47	4				
		roup home on 3/12/25 at						
		e breakfast meal to be cream						
		oreakfast sausage links. on revealed staff #2 cereal						
	and sausage in whole							
	observation revealed	•						
		o assistance from staff to						
	modify his food to $\frac{1}{2}$ "	chopped consistency.						
	Review of client #2's	record on 3/12/25 revealed						
		an (PCP) dated 9/12/24.						
		evealed client #2 to be						
		alorie, weight loss, heart consistency diet, second						
		ny vegetables only, fruit and						
	vegetable snacks onl	у.						
	Interview with the qua	alified intellectual disabilities						
	professional (QIDP)	on 3/12/25 confirmed client						
	-	Further interview with the						
	always be followed as	cially modified diets should						
W 475	MEAL SERVICES	s presented.	W 47	5				
	CFR(s): 483.480(b)(2	2)(iv)						
	Food must be served	with appropriate utensils.						
		not met as evidenced by:						
		ns, record reviews and						
		r failed to ensure clients						
		s active treatment program interventions as identified in						
		Plan (PCP) relative to						
		uipment during mealtimes.						
	This affected 4 of 5 c findings are:	lients (#2, #3, #4, #5). The						
	A. The facility failed to	o provide adaptive						
	equipment for clients							

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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 ___ 34G160 B. WING 03/12/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1609 WESTRIDGE ROAD** WESTRIDGE GREENSBORO, NC 27405 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) W 475 Continued From page 8 W 475 rocker t knives to cut their food during the dinner meal. For example, Afternoon observations on 3/11/25 at 5:45PM revealed clients to assist staff with setting the table for the dinner meal. Further observations revealed the following menu items for the dinner meal: chicken, vegetable, and dumpling soup, mixed vegetables, 1 slice of whole wheat bread, fruit, milk, and water. Continued observations revealed clients #2, #3, and #5 to eat the toast in whole form. At no point during the observation did staff offer a rocker t knife to clients #2, #3, and #5 as prescribed. Review of the record for client #2 on 3/12/25 revealed an OT assessment dated 12/5/24 which indicated the client uses a rocker t knife during mealtimes. Further review of the 12/2024 OT assessment revealed client #2 should have a 1/2" diet consistency. Review of the record for client #3 revealed a PCP dated 6/16/24 which indicated the client uses the following adaptive equipment during mealtimes: plate guard, rocker t knife, and dycem mat. Review of the record for client #5 revealed an OT Assessment dated 9/16/24 which indicated the client uses the following adaptive equipment during mealtimes: rocker t knife and plate guard. Further review of the 9/2024 OT assessment revealed client #5 overstuffs his mouth. Interview with the qualified intellectual disabilities professional (QIDP) on 3/12/25 verified that the training objectives and adaptive equipment for clients #2, #3, and #5 were current. Further interview with the QIDP verified that staff have

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