STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G169	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDWAY GROUP HOME	202 FRIENDWAY ROAD GREENSBORO, NC 27409

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure routine repairs and maintenance at the group home were completed in a timely manner. The finding is: Observations throughout the 3/25/25 - 3/26/25 survey revealed several repairs needed inside the group home to include multiple areas of wall damage and ceiling damage from an unknown water leak throughout the home. Further observations revealed sinking areas and popcorn stipple peeling from the ceiling in clients' bedrooms and hallways. Interview with the Program Manager (PM) on 3/25/25 revealed that several work orders for the repairs and painting were placed back in June 2024. The PM revealed that the ceiling was damaged from a water leak and Maintenance stated that they would continue to monitor and will come in to paint the home. Continued interview with the PM revealed she did not know the root cause of the leak and that Maintenance did not return to the home until 1/29/25 for a walkthrough. Further interview with the PM confirmed on 1/29/2025 a walkthrough was completed and documented on an Internal Facility Plan of Correction form. The form did not document the water and wall damage, nor the root cause of the leak in the ceiling. Interview with qualified intellectual disabilities	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G169	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDWAY GROUP HOME	202 FRIENDWAY ROAD GREENSBORO, NC 27409

(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 104	Continued From page 1 professional (QIDP) on 3/26/25 revealed she is aware of the repairs and the water damage. Further interview with the QIDP revealed the agency had a maintenance personnel member who was responsible for completing work orders for several areas but was unable to complete the repairs in a timely manner.	W 104		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure clients were provided opportunities for client choice and not for the convenience of staff for 2 of 6 clients (#3, #4). The finding is: Afternoon observations on 3/25/25 at 5:35PM revealed staff to prompt the clients to the table to prepare for the dinner meal. Further observations revealed staff A to assist client #4 with serving his plate using hand over hand assistance. Continued observations revealed staff A to hold client #4's hands while telling him that he could not eat yet. Subsequent observations revealed staff A to continue holding client #4's hands while talking in a loud tone to client #3 and #4 and stating "you can't eat yet. You have to wait until everyone is ready to eat". Additional observations at 5:40PM revealed staff A to release client #4's hands and allow the client to eat. Interview with the home manager (HM) and qualified intellectual disabilities professional (QIDP) on 3/26/25 verified that staff have trained	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G169	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDWAY GROUP HOME	**202 FRIENDWAY ROAD GREENSBORO, NC 27409**

(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 247	Continued From page 2 the clients to bless their food prior to eating a meal. Further interview with the HM and QIDP revealed that staff should not have held client #3's hands to restrict him from eating his meal. Continued interview with the HM and QIDP revealed that staff should not use a loud tone or restricting a client's hands to prevent a client from eating.	W 247		