STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G242	A. BUILDING _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINISTER	1111 WESTRIDGE ROAD GREENSBORO, NC 27405

(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	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 ensure 6 of 6 audited clients (#1, #2, #3, #4, #5, #6) were provided opportunities for choice and self-management during mealtimes. The finding is: Morning observations on 8/20/25 at 7:15 AM revealed staff to prompt clients (#1, #2, #3, #5, and #6) to sit at the dining table to prepare for the breakfast meal. Further observations revealed staff to assist clients in pouring their cereal and milk into a bowl. Continued observations revealed clients cereal and milk to sit for approximately 12 minutes prior to consuming the breakfast meal. At no point during the observation were clients offered the opportunity to eat their breakfast without waiting for client #4 to finish her medication administration. Subsequent observations from 7:25AM -7:40 AM revealed staff to leave breakfast on the table for client #4 uncovered. Interview with the qualified intellectual disabilities professional (QIDP) on 8/20/25 revealed staff should have allowed clients to make their cereal with milk and eat immediately to prevent the clients from having to wait and prevent the cereal from becoming soggy. Further interview with the QIDP revealed staff should not have made the clients wait until client #4 finished with medication administration and re-joined the group for the breakfast meal.	W 247		

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

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W 249	PROGRAM IMPLEMENTATION 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 review and interviews, the facility failed to ensure that a continuous active treatment program consisting of needed interventions were implemented as identified in the person-centered plan (PCP) for 1 of 6 audited clients (#4). The finding is: Observations in the facility on 8/20/25 at 7:30 AM revealed client #4 to sit at the dining room table to prepare for the breakfast meal. Further observations revealed staff to assist client #4 with standing from the table and transitioning to the medication room and to not use the gait belt. Observations revealed staff to place both hands on the client's shoulders during ambulation. Continued observations at 7:37AM revealed staff to assist client #4 with ambulating to the dining room table without using the gait belt around the client's waist. Observations did not reveal staff to use client #4's gait belt to assist with ambulation as prescribed while transitioning the client to and from the medication room. Review of the record for client #4 on 8/20/25 revealed a PCP dated 2/13/25 which indicated	W 249		

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W 249	Continued From page 2 the client should wear a gait belt when walking and have a staff member walk next to the client with hands-on guidance due to seizures and balance. Review of the physical therapy (PT) assessment dated 8/28/23 revealed the gait belt should be worn daily with contact guard assistance due to seizure activity and "poor independence standing balance". Interview with the qualified intellectual disabilities professional (QIDP) on 8/20/25 revealed client #4 does not have ambulation guidelines to assist with using the client's gait belt while transitioning throughout the facility. Further interview with the QIDP revealed staff have been trained to use client #4's gait belt as prescribed.	W 249		
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 observations, record reviews and interviews, the facility failed to assure all drugs were administered without error for 1 of 6 audited clients (#4). The finding is: Observations in the home on 8/20/25 at 7:37 AM revealed client #4 to be assisted to the dining room table for the breakfast meal. Further observations revealed that client #4 had hot cereal, water and apple juice for the breakfast meal. At no time during the observations was staff observed to provide client #4 with prescribed prunes or prune juice. Review of records for client #4 on 8/20/25	W 369		

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W 369	Continued From page 3 revealed physician orders (PO) dated 8/20/25. Review of the PO's revealed client #4 to be prescribed a 2000+ calorie chopped diet, double portions at lunch and dinner, Benecalorie BID, prunes or prune juice daily at breakfast, milk on cereal at breakfast, and vanilla Boost. Interview with staff D on 8/20/25 revealed that prune juice is kept in the cabinet located in the kitchen. Further observations revealed several bottles of prune juice to be in the cabinet unopened. Interview with the facility nurse on 8/20/25 confirmed that client #4's PO's to be current. Continued interview with the facility nurse confirmed that the staff should have provided client #4 prunes or prune juice with the breakfast meal.	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure all drugs were secured appropriately as required for 1 of 6 audited clients (#4). The finding is: Observations in the group home on 8/20/25 revealed client #4's prescribed medication Daybue to be stored in the door of the refrigerator located in the kitchen. Further observations revealed the open box of client #4's prescribed medication to be stored in a locked black box and 3 unopened boxes to be in the door of the	W 382		

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W 382	Continued From page 4 refrigerator unsecured. Review of records on 8/20/25 revealed a company policy regarding medication storage requirements. Further review of the policy revealed that medications requiring refrigeration must be stored in the refrigerator in a locked container unless there is a refrigerator designated for medications in a locked area. Interview on 8/20/25 with facility nurse revealed that client #4's prescribed medication can be kept in the refrigerator with regular foods. Further interview with facility nurse revealed that the client's opened prescribed medication was kept locked and staff were currently using the opened box to administer to the client.	W 382		
W 460	FOOD AND NUTRITION SERVICES 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, documentation review and interview, the facility failed to assure clients residing in the facility were offered the variety of foods listed on the menu. This affected 6 of 6 audited clients in the facility (#1,#2, #3, #4, #5 and #6). The finding is: Observation in the facility at 7:20 AM on 8/20/25 revealed clients to be served the following menu items during the breakfast meal: ¾ cup cold cereal, 8 oz. 2% milk, and decaf coffee. Observations did not reveal clients receiving ½	W 460		

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W 460	Continued From page 5 cup of stewed prunes and 2 slices raisin toast according to the prescribed menu. Continued observations did not reveal staff to offer clients an alternative to the menu items not available. Interview with staff A on 8/20/25 revealed that the stewed prunes and raisin toast were not available in the facility. Further interview with staff revealed they had not been to the store to secure the items that were missing from the breakfast menu. Interview with the qualified intellectual disabilities professional (QIDP) on 8/20/25 revealed staff should have offered the clients substitute menu items. Further interview with the QIDP revealed staff should not have provided only cereal and milk during the breakfast meal.	W 460		
W 463	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 6 audited clients (#1 and #3) received their specialty diet as prescribed. The findings are: A. The facility failed to provide client #1 with prescribed specialty diet. For example, Observations in the group home on 8/19/25 at 5:42 PM revealed client #1 to participate in the dinner meal to include 3 oven cooked chicken strips, black eyed peas, and a mixed vegetable medley. Further observations revealed the staff to pour "Sweet Baby Rays Barbecue sauce" all over	W 463		

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W 463	Continued From page 6	W 463		

client #4's chicken. Continued observations revealed the client to consume the dinner meal.

Review of records on 8/20/25 for client #1 revealed a physician's order (PO) with dietician recommendations dated 8/13/25. Continued review of the POs revealed that client #1 is prescribed an 1800 calorie diabetic diet whole consistency with no added sugar, ½ portions of desserts.

Interview on 8/20/25 with the facility nurse confirmed client #1's diet as prescribed. Continued interview with the facility nurse confirmed that staff should have provided client #1 with her prescribed diet to provide an alternative sauce on chicken or no sauce.

B. The facility failed to provide client #3 with prescribed specialty diet. For example,

Observations in the group home on 8/19/25 at 5:26 PM revealed client #3 to participate in the dinner meal to include 3 oven cooked chicken strips, black eyed peas, and a mixed vegetable medley. Further observations revealed that client #3 to pour "Sweet Baby Rays Barbecue sauce" all over the chicken. Continued observations revealed the client to consume the dinner meal.

Observations in the group home on 8/20/25 at 7:24 AM revealed client #3 to participate in the breakfast meal to include Rice Chex cereal with milk. Further observations at 7:31 AM revealed the client to prepare coffee with pure cane sugar without measuring. Continued observations revealed the client to consume the breakfast meal.

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W 463	Continued From page 7 Review of records on 8/20/25 for client #3 revealed a nutritional assessment (NA) dated 5/27/24. Continued review of NA revealed that client #3 is prescribed a diabetic diet whole consistency, weight loss, 1800 calorie diet. Interview on 8/20/25 with the facility nurse confirmed client #3's diet as prescribed. Further interview with the facility nurse confirmed that staff should have provided client #3 with her prescribed diet to provide an alternative sauce on chicken or no sauce. Continued interview with the facility nurse revealed that staff should have offered the client with a sugar substitute to add to her coffee.	W 463		