STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G078	A. BUILDING _____ B. WING _____	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSON'S GROUP HOME	1310 ELWELL AVENUE GREENSBORO, NC 27420

(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 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 update the individual habilitation plan (IHP) annually for 1 of 5 audit clients (#2). The finding is: Review on 7/8/25 of client #2's record revealed an IHP dated 5/29/25. Interview on 7/9/25 with the administrator revealed an IHP meeting has not been conducted due to scheduling conflicts.	W 260	Watson's Group Home QIDP and Program Director will ensure that all individual program plans are reviewed and revised annually Client #2's IPP meeting was held 7/15/25. The new IPP has been placed in their program book. A calendar will be prepared and maintained annually to detail and schedule all IPPs and IPP deadlines. Calendar will be submitted to Administrator to ensure deadlines are met. The Watson Group Home Team will meet quarterly to discuss upcoming IPPs. WGH QIDP will make notations in their quarterly reviews whether IPPs are current or need to be revised. These dates will be reported to the Administrator quarterly.	9/9/25
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the behavior support plan (BSP) for 2 of 5 audit clients (#4 and #6) was reviewed and monitored by the human rights committee (HRC). The findings are: A. Review on 7/8/25 of client #4's record revealed a BSP. Further review of the record revealed the last consent by the HRC was signed on 11/13/23. B. Review on 7/8/25 of client #6's record revealed a BSP. Further review of the record revealed the last consent by the HRC was signed on 4/15/23.	W 262	The Watson Group Home Team & Human Rights Committee will review, monitor and approve all BSPs and only implement BSPs with written consent from guardians and HR Committee. The Program Director will meet with the committee to review client #4 & client #6's BSP and place updated BSP in the program book. The program director will assure all consents are signed and current. QIDP will confirm annually that HRC consents are current and in compliance and notify Administrator of any findings not in compliance. RECEIVED AUG 07 2025 DHSR-MH Licensure Sect	9/9/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chrissy Watson — TITLE: Program Director — (X6) DATE: 8/1/25

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 262	Continued From page 1 Interview on 7/9/25 with the administrator confirmed no updated consents for client #4 and #6 could be located during the survey.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the behavior support plan (BSP) for 2 of 5 audit clients (#4 and #6) were only conducted with the written informed consent of a legal guardian. The findings are: A. Review on 7/8/25 of client #4's record revealed a BSP. Further review of the record revealed the last consent signed by the legal guardian was on 11/6/23. B. Review on 7/8/25 of client #6's record revealed a BSP. Further review of the record revealed the last consent signed by the legal guardian was on 4/7/23. Interview on 7/9/25 with the administrator confirmed no updated consents for client #4 and #6 could be located during the survey.	W 263	The Watson Group Home Team & Human Rights Committee will review, monitor and approve all BSPs and only implement BSPs with written consent from guardians and HR Committee. The Program Director will meet with the committee to review client #4 & client #6's BSP and place updated BSP in the program book. The program director will assure all consents are signed and current. QIDP will confirm annually that BSP consents are current and in compliance and notify Administrator of any findings not in compliance.	9/9/25
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,	W 436	The WGH team will ensure all clients' dentures, eyeglasses, hearing aids and other devices needed will be used properly and maintained in good condition.	9/9/25

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W 436	Continued From page 2 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 ensure client #4 was taught to use and make informed choices about the use of his eyeglasses. This affected 1 of 5 audit clients. The finding is: During observations in the home throughout the survey on 7/8/25 - 7/9/25, client #4 was not observed wearing eyeglasses. Review on 7/9/25 of client #4's individual habilitation plan (IHP) dated 5/28/25 revealed in the vision section, "On 12/17/2024 Saw Ophthalmologist for follow - up for secondary cataract, glaucoma, suspect diabetes. Full exam, no sugar noticed. Diagnoses of cataracts, glaucoma suspect. Gave prescription for glasses. Will work on glasses. Follow - up in one year." Review on 7/9/25 of client #4's ophthalmology healthcare appointment summary dated 12/17/2024, revealed "Treatment provided - new prescription for glasses." Review on 7/9/25 of client #4's Quarterly Nurse Assessment for 10/2024 - 12/2024, signed by the nurse on 02/02/2025, revealed, "Maintain visual ability with use of glasses." Interview on 7/9/25 with Staff A revealed client #4 does not wear glasses. Interview on 7/9/25 with Staff B revealed client #4 wore glasses in the past, but has not had a pair of glasses "in some time."	W 436	When the glasses arrive (ordered on 8-1-2025) proper usage of glasses being worn will be monitored via checklist daily by direct care staff. QIDP and Program Director along with RN will monitor quarterly.	

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W 436	Continued From page 3 Interview on 7/9/25 with the administrator revealed client #4 should be provided with and taught to make good choices regarding eyeglasses.	W 436		