STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **34G180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/18/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD #3	**2600 PLEASANT RIDGE ROAD , SUMMERFIELD, North Carolina, 27358**

(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
W0369	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 ensure medications were administered without error. This affected 1 of 6 audited clients (client #5) during medication administration. The finding is: Morning observations in the group home on 3/18/26 at 7:43 AM, client #5 was observed to enter the medication room with staff D and to be administered the following medications: levothyroxin 50 mcg, omeprazole 20mg, aripiprazole 2mg, tamsulosin 0.4mg, vitamin D3 2000 IU 500mg, nifedipine 20mg and lactulose 15ml. Continued observations revealed client #5 to swallow all medications followed by the lactulose 15ml dispensed in a medication cup at 7:46 AM. Further observations revealed staff D to check client #5's blood pressure which read 158/106. Review on 3/18/26 of client #5's physician's orders dated 3/18/26 revealed that the levothyroxine 50mcg prescription indicates this medication is to be administered at 6:30 AM. Continued review of the physician's order revealed medication nifedipine 20mg, client's #5 blood pressure and pulse should be checked prior to administering. Interview with the facility nurse on 3/18/26 confirmed that client #5's physician order is current. Further interview with the nurse revealed client's levothyroxine medication should have been administered between 5:30 AM and 7:30 AM. Continued interview revealed staff should administer all medications in accordance with the client's physician order.	W0369		
W0382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2)	W0382		

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 reverse for further 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.

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

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W0382	Continued from page 1 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 observation and interview, the facility failed to ensure medications remained locked except when being administered. This affected 3 of 6 audited clients (#1, #2 and #4). The finding is: During morning medication administration observations on 3/18/26 at 7:20 AM, 7:43 AM and 8:05 AM, Staff D was observed to walk out of the medication room. Continued observations revealed staff D to leave surveyor, clients #1, #4 and #2 in the room in an unlocked medication cabinet to go to the kitchen. Further observations revealed Staff D to leave the kitchen, then walk back into the medication room on three separate occasions. Interview with the facility nurse on 3/18/26 revealed staff should never leave anyone in the medication room without supervision and all medications should be secured when not in use.	W0382		
W0474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is NOT MET as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve food in a form consistent with the developmental level of 4 of 6 audited clients (#2, #3, #4 and #6). The findings are: A. The facility failed to provide client #2 with prescribed diet. For example: Observations in the group home on 3/17/26 at 6:00 PM revealed client #2 to participate in the dinner meal which consisted of mandarin orange chicken, rice and spinach, served in whole consistency. At no time during the dinner meal was staff observed to provide the client with a one inch pieces diet. Additionally, during observations client #2 did not have any difficulty with consuming the breakfast meal. Observations in the group home on 3/18/26 at 8:10 AM revealed client #2 to participate in the breakfast meal	W0474		

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W0474	Continued from page 2 which consisted of prune juice, pancakes and scrambled eggs, served in whole consistency. At no time during the breakfast meal was staff observed to provide the client with a one inch pieces diet. Additionally, during observations client #1 did not have any difficulty with consuming the breakfast meal. Review of client #2's record on 3/18/26 revealed a Person-Centered Plan (PCP) dated 8/1/25. Review of the PCP revealed a nutritional assessment dated 6/25/22 for client #2 to be prescribed a regular, heart healthy, diabetic, one inch consistency diet. Seconds of meat fruit and vegetables if desired. Omit egg salad, oatmeal or oat bran cereal 1 day a week at breakfast, sugar free snacks and beverages. One can Glucema by mouth at bedtime. Interview with the facility nurse and Qualified Intellectual Disabilities Professional (QIDP) on 3/18/26 confirmed client #2's prescribed diet. Continued interview with the facility nurse and QIDP confirmed specially modified diets should be followed as prescribed. B. The facility failed to provide client #3 with prescribed diet. For example: Observations in the group home on 3/17/26 at 6:00 PM revealed client #3 to participate in the dinner meal which consisted of mandarin orange chicken, rice and spinach, served in whole consistency. At no time during the dinner meal was staff observed to provide the client with a one-inch pieces diet. Additionally, during observations client #2 did not have any difficulty with consuming the breakfast meal. Review of client #3's record on 3/18/26 revealed a PCP dated 8/31/25. Review of the PCP revealed a nutritional assessment dated 3/27/24 for client #3 to be prescribed a regular 2000 calories, heart healthy, low sodium, whole consistency. Staff to assist client #3 with cutting meats to one-inch pieces. Interview with the facility nurse and QIDP on 3/18/26 confirmed client #3's prescribed diet. Continued interview with the facility nurse and QIDP confirmed specially modified diets should be followed as prescribed. C. The facility failed to provide client #4 with prescribed diet. For example: Observations in the group home on 3/18/26 at 8:10 AM revealed client #4 to participate in the breakfast meal	W0474		

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W0474	Continued from page 3 which consisted of prune juice, pancakes and scrambled eggs, served in a ground consistency. At no time during the breakfast meal was staff observed to provide the client with a pureed diet. Additionally, during observations client #4 did not have any difficulty with consuming the breakfast meal. Review of client #4's record on 3/18/26 revealed a PCP dated 2/6/26. Review of the PCP revealed a nutritional assessment dated 8/28/24 for client #4 to be prescribed a regular 2000 calories, pureed consistency, nectar thickened liquids. Interview with the facility nurse and QIDP on 3/18/26 confirmed client #4's prescribed diet. Continued interview with the facility nurse and QIDP confirmed specially modified diets should be followed as prescribed. D. The facility failed to provide client #6 with prescribed diet. For example: Observations in the group home on 3/18/26 at 8:10 AM revealed client #6 to participate in the breakfast meal which consisted of prune juice, pancakes and scrambled eggs, served in a ground consistency. Continued observations at 8:15 AM revealed client #6 to request and received second servings of pancakes and scrambled eggs. At no time during the breakfast meal was staff observed to provide the client with a pureed diet. Additionally, during observations client #6 did not have any difficulty with consuming the breakfast meal. Review of client #6's record on 3/18/26 revealed a PCP dated 9/11/25. Continued review of the record did not reveal a nutritional assessment. Further review of the PCP and a physician order dated 3/18/26 revealed client #6 to be prescribed a weight loss, 1800 calories pureed consistency diet, nectar thickened liquids, double portions of vegetables, aspiration precautions implemented; full supervision at all times when eating, only eat/drink when alert, stop eating if there are any signs of choking. Interview with the facility nurse and QIDP on 3/18/26 confirmed client #6's prescribed diet. Continued interview with the facility nurse and QIDP confirmed specially modified diets should be followed as prescribed.	W0474		
W0475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv)	W0475		

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W0475	Continued from page 4 Food must be served with appropriate utensils. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to assure that 6 of 6 clients were provided with appropriate utensils to allow each client to eat as independently as possible. The findings are: Observations in the group home on 3/17/26 at 6:00 PM revealed all clients to participate in the dinner meal which consisted of milk, mandarin orange chicken, rice and spinach. Continued observations revealed staff to provide all clients with a spoon only as they participated in the dinner meal. Further observations revealed all clients to consume dinner utilizing the utensil provided with no concerns. Subsequent observations revealed client #3 to cut her chicken with the spoon provided. Additional observations revealed staff to cut client #2's chicken with the spoon provided. At no point during the observation period were clients offered a full place setting of a fork, knife and spoon during the dinner meal. Observations in the group home on 3/18/26 at 8:10 AM revealed all clients to participate in the breakfast meal which consisted of prune juice, pancakes and scrambled eggs. Continued observations revealed staff to provide all clients with a spoon only as they participated in the breakfast meal. Further observations revealed all clients to consume breakfast utilizing the utensil provided with no concerns. Subsequent observations revealed clients #3 and #5 to cut their pancakes with the spoon provided. Additional observations revealed staff to cut client #2's pancakes with the spoon provided. At no point during the observation period were clients offered a full place setting of a fork, knife and spoon during the dinner meal. Interview with the qualified intellectual disabilities professional (QIDP) on 3/18/26 revealed all clients should have been offered a full place setting including a fork, knife and spoon during all meals. Continued interview with the QIDP verified that all clients should be provided with a full place setting to promote independence during mealtimes.	W0475		