

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G108	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026
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NAME OF PROVIDER OR SUPPLIER GATEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1508 GATEWOOD AVENUE , GREENSBORO, North Carolina, 27405
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W0249	<p>PROGRAM IMPLEMENTATION</p> <p>CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure a continuous active treatment program with needed interventions as identified in the person-centered plan (PCP) in the area of adaptive dining equipment. This affected 2 of 4 audit clients (#1 and #2). The findings are:</p> <p>A. Observations in the home on 5/5/26 at 5:19pm revealed client #2 to enter the dining room for dinner. Client #2 was provided with the following adaptive equipment: high sided plate, plate guard, dycem mat, built-up handled spoon and a clothing protector.</p> <p>Additional observations in the home on 5/6/26 at 8:21am revealed client #2 to enter the dining room for breakfast. Client #2 was provided with the following adaptive equipment: high sided plate, plate guard, dycem mat, built-up handled spoon and a clothing protector. At 8:40am, client #2 was observed to ask staff for a fork to help him eat his waffles. Staff provided client #2 with a regular fork.</p> <p>Review on 5/5/26 of client #2's PCP dated 2/16/26 revealed client #2 is supported with the following adaptive dining equipment: divided scoop plate, dycem mat, clothing protector and built-up handled utensils.</p> <p>Interview on 5/6/26 with the qualified intellectual disabilities professional (QIDP) confirmed client #2 should have been provided with his divided dish and a built-up handled form.</p>	W0249		
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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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W0249	Continued from page 1 Observations in the group home on 5/5-5/6/26 revealed client #1 to consume the entire dinner meal and breakfast meal. Further observations revealed the client to eat her meals with a regular plate, pink coated spoon, 2 regular cups, and shirt protector. Continued observations revealed client #1 to be fed her meals and liquids with Thick it. There was some coughing during the breakfast meal. At no time during observations did staff provide the client with prescribed nose cup. Review of records for client #1 on 5/6/26 revealed a PCP dated 11/10/25. Further review of the PCP revealed a physician's order (P.O.) dated 5/6/26 for the client to be prescribed with the following adaptive equipment: regular plate, pink coated spoon, and nosy cup. Interview on 5/16/26 with the facility nurse confirmed that client #1's P.O.'s was current. Further interview with the qualified intellectual disabilities professional (QIDP) revealed that the nose cup was discontinued; however, no physician orders discontinuing nose cup were provided during survey.	W0249		
W0340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is NOT MET as evidenced by: Based on observations and interview, the facility failed to ensure staff were sufficiently trained to follow medication refusal procedures for 1 of 4 audited clients (#14). The finding is: Observations at Gatewood on 5/6/26 at 7:11 AM PM revealed the home manager (HM) to prepare the morning medications for client #14 in the medication room. Further observations revealed the HM to prepare all medications in applesauce, pour prescribed Lactulose in clear medication cup, and carry a tube of cream to apply to the client's forearm. Continued observations revealed HM to enter hallway and administer client #14's medications in applesauce, the client refused the prescribed Lactulose, and the HM applied the	W0340		

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W0340	Continued from page 2 client's prescribed cream to the left forearm. Staff were observed to enter the medication room, make a note on the computer and throw the prescribed Lactulose into the trash can. At no time were staff observed to notify the nursing staff of the clients' refusal. Interview on 5/6/26 with the facility nurse confirmed that nursing was not notified of client #14's refusal of his prescribed Lactulose. Further interview with the facility nurse revealed that staff would have been directed to pour the medication down the sink to dispose of refused medication.	W0340		
W0368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 4 audited clients (#1) was administered medication in compliance with the physician orders. The finding is: Observation in the group home on 5/6/26 at 8:05 AM revealed client #1 to enter the medication administration room with staff assisting as to prepare for medication administration. Continued observations revealed client #1 to be given medications in chocolate pudding and Valproic Acid oral solution. Review of records for client #1 on 5/6/26 revealed physician orders (P.O.) dated 5/6/26. Review of the 5/6/26 P.O.'s revealed that client #1 is prescribed Trulance Tab 3 MG take 1 tablet by mouth once every day for chronic constipation. Client #1 was not observed to be administered her prescribed Trulance during medication administration. Interview with the facility nurse on 5/5/26 confirmed the 5/6/26 P.O.'s for client #1 to be current. Further interview with the facility nurse revealed that client #1 should have been given her prescribed medication.	W0368		
W0369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that	W0369		

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W0369	<p>Continued from page 3 all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record reviews and interviews, the facility failed to assure all drugs were administered without error for 2 of 4 audited clients (#1 and #14) observed during medication administration. The findings are:</p> <p>A. The facility failed to administer all prescribed medications without error for client #1. For example:</p> <p>Observations in Gatewood on 5/6/25 at 8:05 AM revealed client #1 to enter the medication administration room and prepare for medication administration. Further observations revealed the staff to obtain the medications from the cart, pouring medications into cup containing chocolate pudding. Continued observations revealed client #1 to be administered PEG 3350 powder poured in a cup containing crushed medications, Valproic Acid oral solution, and chocolate pudding. Subsequent observations at 8:30 AM revealed client #1 to consume her breakfast meal and not be provided with prescribed Carnation Instant Breakfast.</p> <p>Review of records for client #1 on 5/6/26 revealed physician's orders (PO) dated 5/6/26. Review of the PO's revealed medications prescribed at 8:00 AM to be Senna-Time 8.6MG, Valproic Acid Oral Solution 250/5ML, Vitamin D3 2000 IU, Baclofen 10MG, Equetro CAP 300MG, Magnesium Glycinate 100MG CAP (2), Multivitamin Tab Adult, Trulance Tab 3MG (not administered), PEG 3350 Powder mix 17 grams (1 Capful) with 4 oz prune juice and take by mouth once every day for constipation. Further review of PO's revealed that client #1 did not receive prescribed nutritional supplement one packet of Carnation Instant Breakfast.</p> <p>Interview with the facility nurse on 5/6/26 confirmed that client #1's P.O.'s to be current. Continued interview with the facility nurse confirmed that the staff should have prepared and administered all prescribed medications for the client as ordered by the physician.</p> <p>B. The facility failed to administer all medications without error for client #14. For example:</p> <p>Observations in Gatewood on 5/6/25 at 7:11 AM revealed the home manager (HM) prepared client #14's medications in the medication administration room. Further observations revealed the HM</p>	W0369		

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W0369	<p>Continued from page 4</p> <p>punched all medications including Levothyroxin Tab into a small medicine cup containing applesauce and poured the PEG 3350 Powder on top mixing all together. Continued observations revealed the HM poured Lactulose -10 MG solution into a clear medicine cup; however, the client refused the medication. Subsequent observations revealed client #14 was fed his medications mixed with applesauce.</p> <p>Review of records for client #14 on 5/6/26 revealed P.O.s dated 5/6/26. Review of the P.O.'s for client #14 revealed medications prescribed at 8:00 AM to be Baclofen Tab 20MG, Calcium+D3, Cetirizine Tab 10MG, Desvenlafax Tab 100MG ER, Hydroxyz HCL Tab 25MG, Lactulose-10MG/15ML solution, Lamotrigine Tab 100MG, Metformin Tab 1000MG, Montelukast Tab 10MG, OMEGA-3 Fish CAP 1000MG, Pregabalin CAP 50MG, Tacrolimus Ointment 0.1%, Trulance Tab 3MG, Vitamin D3 2000 IU, Levothyroxin Tab 88MCG take 1 tablet by mouth every morning for hypothyroidism (TAKE 30 MINUTES BEFORE BREAKFAST OR OTHER MEDICATIONS). Additionally, mix PEG3350 powder 17 grams (1 Capful) in 8 oz. of favorite beverage and take by mouth once every day for constipation.</p> <p>Interview with the facility nurse on 5/6/26 confirmed that client #14'sPO's to be current. Continued interview with the facility nurse confirmed that the staff should have administered all prescribed medications as ordered by the physician.</p>	W0369		