	-	ID HUMAN SERVICES					APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
34G018			B. WING _			07/17/2018		
NAME OF PROVIDER OR SUPPLIER SPRINGDALE LANE GROUP HOME				93	TREET ADDRESS, CITY, STATE, ZIP CODE 34 SPRINGDALE LANE ASTONIA, NC 28052			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR REGULATORY OR LSC IDENTIFYING INFORMATION) T			K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
W 137	Therefore, the facility have the right to retain personal possessions This STANDARD is r Based on record revis failed to ensure 1 of a non-sampled client (# retain personal posses electronics. The findi A. The facility failed to assured the right to a relative to electronics Review of records for revealed an individua 10/25/17. Review of communication object a "Kindle". Review of objective dated 11/1/7 follow a picture symbol less verbal prompts, a consecutive months. communication object throughout the day st schedule with 3 pictur client #1 will take the box, then complete the further referenced the	2) ure the rights of all clients. must ensure that clients n and use appropriate and clothing. not met as evidenced by: ew and interview, the facility 3 sampled clients (#1) and 1 2) were provided the right to essions relative to ng is: to assure client #1 was personal possession . For example: or client #1 on 7/17/18 I support plan (ISP) dated the ISP revealed a tive that included the use of	W1	37	DEFICIENCY)			
	professional (QIDP) r	ualified intellectual disabilities evealed client #1 has a e that is kept in the group						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 07/25/2018

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.

	-	D HUMAN SERVICES				FORM): 07/25/2018 1 APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	0. 0938-0391 SURVEY LETED
34G018		B. WING		_	07/	17/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SPRINGDALE LANE GROUP HOME				934 SPRINGDALE LANE GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 137	home office. The QID group home office is a client's do need to as the office to obtain an with the QIDP revealed device is kept in the of and to keep other clie client's room and takin with the QIDP verified device could be charg and there has been in taken by another clier B. The facility failed to assured the right to a relative to electronics Observation in the g revealed the QIDP to device, belonging to of group home office while electronic device for a Review of records for revealed an ISP dated ISP revealed a living a will complete the step to open and participat hard copy book with r gather materials nece book, 75% of the time Interview with the QI personal IPAD is kept home to charge the d client's from entering it. The QIDP further i office is always kept of	DP further indicated the always kept open however k for assistance in going into y items. Further interview ed client #1's electronic office to charge the device ant's from entering the ng it. Subsequent interview I the client's electronic ged from the client's room o history of the item being nt. o assure client #2 was personal possession . For example: roup home on 7/17/18 pull out a electronic tablet client #2, from a desk in the ile attempting to locate an	W 137				

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	COMPLETED		
	34G018		B. WING		07/17/2018			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
SPRINGD	ALE LANE GROUP HOM	E		934 SPRINGDALE LANE GASTONIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
W 137	to obtain any items. the QIDP verified the could be charged from	e 2 Subsequent interview with client's electronic device m the client's room and there of the item being taken by	W 13	7				
W 249	CFR(s): 483.440(d)(1 As soon as the interd formulated a client's i each client must rece treatment program co interventions and ser and frequency to sup) isciplinary team has ndividual program plan, tive a continuous active	W 24	9				
	Based on observatio interview, the team fa interventions to addre	not met as evidenced by: n, record review and staff ailed to assure sufficient ess the communication bled clients (#1 and #5).						
	A. The team failed to interventions to addre needs for client #1. F	ess the communication						
	client #1 revealed the non-verbal and staff p prompting and verbal observed supporting his morning routine to bathroom, hand wash	brompting him using physical izations. Staff was client #1 with transitions of						

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		D HUMAN SERVICES				FORM	D: 07/25/2018	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED		
		34G018	B. WING			07/17/2018		
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-		
SPRINGDALE LANE GROUP HOME					934 SPRINGDALE LANE GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
W 249	and verbal gestures of there were no observi- group home on 7/16/- outing the client particle Review of records for revealed an individua 10/25/17. Review of communication object Review of the commu- client #1 will follow a p when given 4 or less time for 6 consecutive of the communication revealed throughout t client's schedule with transition client #1 will it in the box, then com- methodology further r kindle device to addred daily schedule. Interview with the qua professional (QIDP) of communication object and should have been the ISP. Further inter confirmed there was n the group home for the know why. B. The team failed to interventions to addred needs for client #5. F	ing for a walk with physical only. It should be noted ations of client #1 in the 17 due to a community cipated in with staff. or client #1 on 7/17/18 I support plan (ISP) dated the ISP revealed a tive implemented 11/1/17. Inication objective revealed picture symbol schedule verbal prompts, 100% of the e months. Additional review objective methodology he day staff will set up the 3 picture cues. At each I take the picture off and put nplete the task. The eferenced the use of a ess leisure time in client #1's tive was a current objective in mplemented as written in view with the QIDP no communication board in e client although she did not	W	249				
		group home on t #5 revealed the client to be taff was observed prompting						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/25/2018 / APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION		(X3) DATE	
		34G018	B. WING			_	07/	17/2018
NAME OF PF	ROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
SPRINGD	ALE LANE GROUP HOM	E			34 SPRINGDALE LANE			
				Ģ	GASTONIA, NC 28052			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				(X5) COMPLETION DATE
W 249	Continued From page 4 the client using physical prompting and verbalizations. Staff was further observed supporting client #5 with various transitions throughout the survey to include going to the med room, participating in leisure activities, going to the bathroom, hand washing, setting the table, meal participation, showering and going for a walk with physical and verbal gestures with the exception of a picture cue used for medication administration on 7/17 only. Review of records for client #5 on 7/17/18 revealed an ISP dated 9/20/17. Review of the ISP revealed a communication evaluation dated 10/8/17 to identify client #5 to have poor socialization skills, and conversation skills to be almost non-existent. Further review of the communication evaluation revealed receptive visual support in the form of schedules, calendars, and task sequence should be used to increase the client's understanding and develop her independence. Interview with the group home manager (HM) on 7/17/18 revealed client #5 has picture cues that should be used for all transitions of the client to support communication deficits. Further interview with the facility HM revealed client #5 will gather the picture cues at times and lose them causing the need for new cards currently to be made. Interview with the QIDP verified client #5 should have been supported with transitions with picture cues as indicated in the current communication assessment.		W :	371				
	The system for drug a	administration must assure						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/25/2018 M APPROVED	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
	34G018		B. WING			07/	/17/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
SPRINGDALE LANE GROUP HOME				9	934 SPRINGDALE LANE			
SPRINGE	ALL LANE GROUP HOM	L		9	GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 371	Continued From page	e 5	w	371				
	that clients are taught medications if the inte determines that self-a	t to administer their own erdisciplinary team administration of medications ective, and if the physician		0				
	Based on observatio interviews, the system failed to assure 2 of 2 observed during the r provided the opportur medication self-admir teaching related to na	nedication pass were hity to participate in						
	assure client #5 was the name, purpose or medications received	inistration of medication						
	4:20 PM revealed clie to the medication administration of after #5 was observed to w administration closet staff accessed all mer medications into a pa to the client with no e purpose or side effect observed to take all n water poured by staff area. Observation or	rnoon medications. Client valk to the medication and stand near staff while dications, punched all per cup and handed the cup ducation relative to name, ts. The client was further nedications with a cup of and exit the medication						

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	-	D HUMAN SERVICES				FORM	: 07/25/2018 1APPROVED
· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		34G018	B. WING		_	07/ [,]	17/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
SPRINGDALE LANE GROUP HOME				34 SPRINGDALE LANE ASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 371	picture cue, direct clie closet for administrati Continued observatio medications and punc paper cup while provi relative to name and p Review of records for revealed a medication assessment dated 6/6 medication self admin revealed client #5 to b to punch out medication card. Additional revie the ability to get medi card to the medication Interview with medica 7/16/18 revealed she client #5 relative to m had a change in medi medication. Interview 7/17/18 revealed client with education relative effects with the admin Further interview with should have been pro- hand over hand assis administration of all m B. The system for dru assure client #1 was p the name, purpose or medications received participate in the admin received. For examp Observation on 7/17/7	ent #5 to the medication on of morning medications. In revealed staff to access all chall medications into a ding education to the client purpose of medications. client #5 on 7/17/18 in self administration 6/18. Review of the histration assessment be inconsistent with dexterity on from the medication we revealed client #5 to have cation from the medication in cup. tion administration staff on only provides education to edications if the client has ications such getting a new with the facility nurse on it #5 should be provided e to name, purpose and side histration of all medications. nursing revealed client #5 ovided the opportunity to t with participating in the hedications.	W 371				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/25/2018 1 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		· /	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
34G018			B. WING			07/	17/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SPRINGD	ALE LANE GROUP HOM	E		934 SPRINGDALE LANE GASTONIA, NC 28052			
(X4) ID PREFIX TAG				(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 371	for administration of n Continued observatio medications and punc paper cup while provi relative to name and The client was observ with water and exit the Review of records for revealed a medication assessment dated 6/6 medication self admin revealed client #1 to h assistance to punch of medication card. Inte 7/17/18 revealed client provided the opportur	norning medications. n revealed staff to access all ch all medications into a ding education to the client purpose of medications. ved to take all medications e medication area. client #1 on 7/17/18 n self administration 6/18. Review of the nistration assessment	W 3	71			

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