DEPART	DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV										
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039											
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED					
		34G341	B. WING _	_		09/06/2018					
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE							
WOODIN	IG PLACE GROUP HO	OME			12 WOODING PLACE						
					INGS MOUNTAIN, NC 28086						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE				
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)		W 24	49							
	formulated a client's each client must re- treatment program interventions and se and frequency to su	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the I in the individual program									
	This STANDARD is not met as evidenced by: Based on observation, record review and interview, the team failed to ensure a communication objective was implemented with sufficient frequency to support the achievement of the objective for 1 of 3 sampled clients (#4). The finding is:										
	4:05 PM to 5:00 PM non-verbal and com and gestures. Staff client #4 verbally, w language. Client #4 of time included go with preparing and	group home on 9/5/18 from I revealed client #4 to be municating with head nods f were observed to prompt rith gestures, and use of sign 4's activities during this period ing to the bathroom, assisting having a snack, receiving g a card game and going e van.									
	to 8:25 AM revealed include going to the medications, assist brushing teeth, taki the van. At 7:45 AM	tions on 9/6/18 from 6:20 AM d client #4's activities to e bathroom, receiving ing with and having breakfast, ng out trash, and getting on <i>M</i> , a staff member asked the hed with breakfast. Client #4									

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

(X6) DATE

PRINTED: 09/07/2018

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.

TITLE

DEPAR ⁻ CENTEI	FORM	INTED: 09/07/2018 FORM APPROVED IB NO. 0938-0391							
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G341	B. WING		09/	06/2018			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
WOODIN	NG PLACE GROUP HO	OME	112 WOODING PLACE KINGS MOUNTAIN, NC 28086						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE			
W 249	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 did not respond, and the staff member demonstrated the sign for "finished" and prompted the client to demonstrate the sign. This was the only time during all observations that client #4 was prompted to use a manual sign. Review of the record for client #4 on 9/6/18 revealed an individual support plan (ISP) dated 8/9/18. Review of the ISP revealed a current communication objective for the client to use sign language to express wants and needs with 80 percent accuracy for three consecutive months. Further review of the objective revealed the signs included: bathroom; eat; drink; outside; music; more; finished; yes and no. The directive steps for the objective indicated the client should be given the opportunity to express desires using sign language. If the client did not respond with sign language, then staff should model the sign in attempt to get the client to repeat the sign. The steps for the objective also indicated it should be run several time a day. Interview with the qualified intellectual disabilities professional on 9/6/18 confirmed staff should have completed the communication program as prescribed during multiple opportunities to assure the achievement of the objective.		W 249						

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 956948

If continuation sheet Page 2 of 2