DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G247	A. BUILDING ______ B. WING ______	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINOAK GROUP HOME	3175 BANK ROAD LINCOLNTON, NC 28092

(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 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to document a behavior incident in the community for 1 of 6 clients (#1). The finding is: Review of facility records on 3/14/19 revealed incident reports from 2/2019 through the current survey date with no documented behavior incidents of client #1. Interview with day program staff A on 3/14/19 revealed she recently overheard staff from the facility to report to another staff that on a recent outing to the movies client #1 had a behavior and dropped to the floor and staff carried the client out of the theatre by his arms and legs. Staff A reported she also overheard the staff to report client #1 head butted staff during the behavior at the theatre and the staff responded with "You are dead to me." Further interview with staff A revealed she did not remember the specific day she overheard the report and she had never witnessed physical abuse of client #1 by any staff. Further interview with staff A revealed she reported what she had overheard to her house assistant (staff B). Interview with staff B on 3/14/19 revealed no knowledge or receiving any report of client #1 being carried by staff. Interview with staff B further revealed she was aware from	W 253		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G247	A. BUILDING ______ B. WING ______	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINOAK GROUP HOME	3175 BANK ROAD LINCOLNTON, NC 28092

(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 253	Continued From page 1 communication at the day program among staff that client #1 had a behavior at the movies although she did not know of any other details since she did not work at the group home. Interview with group home staff C and D revealed both staff were present on the outing to the movie theatre on 3/2/19. Interview with staff C and D on 3/14/19 verified client #1 went to the movies with all other group home residents and the client dropped to the floor after requesting popcorn that he was told he could not have. Interview with staff C revealed client #1 was given time and then voluntarily walked with staff C outside, dropped to the ground again and then after a few minutes decided to accept staff help with getting up and walked back into the theatre with no further incident. Staff C further reported no knowledge of any abuse to client #1. Interview with staff D on 3/14/19 revealed after client #1 had dropped to the floor in the theatre he head butted her. Staff D further reported staff C walked up on the situation and took over while staff D took all other clients into the movie theatre. Staff D reported she did not know what happened after she went into the theatre. Staff D further reported no knowledge of any abuse towards client #1 by any staff. Additional interview with staff C verified staff did not complete an incident report relative to the behavioral incident of client #1 due to other distractions and forgetting to complete the report. Interview with the facility administrator on 3/14/19 revealed all behavior incidents should be documented in an incident report. Further interview with the facility administrator revealed no knowledge of client #1's behavior incident in the community during a movie outing on 3/2/19.	W 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G247	A. BUILDING ______ B. WING ______	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINOAK GROUP HOME	**3175 BANK ROAD LINCOLNTON, NC 28092**

(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 253	Continued From page 2 Interview with the facility qualified intellectual disabilities professional further verified no knowledge of client #1's behavior incident on 3/2/19.	W 253		