STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G087	A. BUILDING _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNY LANE #1	**2840 HWY 70 EAST CLAREMONT, NC 28610**

(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 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and facility document review, the facility failed to ensure sufficient training was provided to staff related to effectively applying the transport vehicle wheelchair securement system for 1 of 1 client (#3) in the home who uses a wheelchair. The finding is: Observations at the group home on 4/22/19 at 4:20 PM revealed staff members A, B, and the home manager assisting all clients with loading onto the facility van for a dinner outing. Staff A and B were observed applying the wheelchair safety system for client #3 which included attaching the four tie-down straps to the wheelchair frame and the lap belt. The staff members were not observed applying a shoulder belt/strap. Further observations at 4:25 PM revealed the home manager getting into the drivers seat and preparing to leave the group home. When asked about the the shoulder strap, the home manager attempted to apply it and the strap would not release from the retractor. Interview with the home manager on 4/22/19 revealed she was not aware the retractor was not working and indicated the last time she had secured it was 3 to 4 weeks prior and it was working correctly. Interview with staff B on 4/22/19 indicated the retractor had been working correctly earlier the same day. Continued	W 189		

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.

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W 189	Continued From page 1 observations at 4:35 PM revealed all clients except client #3 leaving the group home on the van to get a carry out meal to bring back to the group home for dinner. Review of facility staff training documentation on 4/23/19 revealed staff A and B had been trained on how to apply transport vehicle wheelchair safety restraints on 2/7/19 and 3/29/19 respectively. Interview with the qualified intellectual disabilities professional on 4/23/19 confirmed that Staff A and B should have made the home manager aware the shoulder strap retractor was not working correctly, prior to transport on 4/22/19. Therefore, though Staff A and B had been previously trained related to wheelchair vehicle transport securement and safety, the facility failed to ensure staff were adequately trained to assure effective use of the wheelchair tie down system.	W 189		