							M APPROVED
	STOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COMF	SURVEY PLETED
		34G132	B. WING _			05/	07/2019
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHRISTY	WOODS GROUP HOME			1	0100 MT. OLIVE ROAD		
				N	IOUNT PLEASANT, NC 28124		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 189	CFR(s): 483.430(e)(1 The facility must prov		W -	189			
		his or her duties effectively,					
	Based on observatio facility failed to provid						
	revealed all 5 clients is seated at the dining ta wheelchairs. On-goin revealed clients #2 and themselves the support fed the supper meal to fed by staff A. Contin supper meal revealed #5 were eating their sis seated at the dining ta unoccupied until all of completed their meal Further observations	er meal while client #3 was by staff C and client #5 was bued observations during the d while clients #2, #3, #4 and supper meal, client #1 was able, without her meal and f the other clients had and left the dining area. at 6:32 PM revealed staff A oper meal in the microwave					
	staff A and staff C rev receives her meal after eaten due to having 2 shift and 3 clients nee Interviews conducted intellectual disabilities	on 5/6/19 at 6:30 PM with realed client #1 usually er the other clients have 2 staff scheduled on second eding to be fed by staff. on 5/7/19 with the qualified is professional and the group	_		TITLE		(X6) DATE

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

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.

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(V2) DA	E SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	· /			IPLETED		
		34G132	B. WING		0	05/07/2019		
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD	θE			
CHRISTY	WOODS GROUP HOME			100 MT. OLIVE ROAD DUNT PLEASANT, NC 28124				
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE		
W 189	Continued From page	e 1	W 189					
		led the expectation that all 5 home should receive their						
W 227	INDIVIDUAL PROGR CFR(s): 483.440(c)(4		W 227					
	objectives necessary as identified by the co	m plan states the specific to meet the client's needs, omprehensive assessment h (c)(3) of this section.						
	Based on observatio interview, the individu as the plan of care (F objectives necessary	ual program plan, referred to POC), failed to include to meet the needs of 1 of 3 and 1 non-sampled client						
		o include objectives in the e-vocation/vocation for client						
	during the recertificat 5/6/19 and 5/7/19, re cooperative with verb and performed tasks	al and physical prompting related to activities of daily stance from staff including						
	administration, self-at transferring himself to	mbulating in his wheelchair, o the couch and back to his pulating various objects in						

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		MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
· · · ·		IDENTIFICATION NUMBER:	` <i>'</i>	G	· · · ·	IPLETED	
		34G132	B. WING		05/07/2019		
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CHRISTY	WOODS GROUP HOME			10100 MT. OLIVE ROAD MOUNT PLEASANT, NC 28124			
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
W 227	which included current verbalize a choice of sitting on the sofa wit position, tolerate have put his deodorant on, tolerate his daily routing rates of target behaving the 4/19/19 POC for of educational/pre-vocating were included. Furth client #2 revealed a F dated 4/20/18 which of in the area of educating include partial independ following skills, with w prompts: attend to tar group for at least 30 m appropriately to instru- produces at least som one- and two-step dimenoity motivated to work and Interview conducted of intellectual disabilities verified client #2 did m acquisition objectives education/pre-vocations B. The POC failed to area of self-care and education/pre-vocations Observations conducted during the recertificat 5/6/19 and 5/7/19, rev	realed a POC dated 4/19/19 Int objectives for client #2 to a leisure item, tolerate h his feet reclined in neutral d-over hand assistance to and improve his ability to ine in order to decrease his iors. Continued review of client #2 revealed no tional/vocational objectives er review of the POC for Functional Skills Assessment documented client #2's skills on/pre-vocation/vocation endence in performing the verbal and/or physical task, complete task, attend a minutes, responds uction/verbal prompts, ne acceptable work, follows rections and is highly d produce. on 5/7/19 with the qualified is professional (QIDP) not have any current skill in the area of on. a include objectives in the on/vocation for client #4. ted in the group home ion survey conducted on vealed client #4 to be bal prompting. Additional	W 2	27			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G132				(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		B. WING		05/07/2019		
NAME OF PI	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE		0/01/2013
CHRISTY	WOODS GROUP HOME	E Contraction of the second		100 MT. OLIVE ROAD DUNT PLEASANT, NC 28124		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
W 227	Y WOODS GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 the environment, consuming meals, discarding used food items/dishes/spoons/clothing protectors, and propelling herself in a wheelchair throughout the group home. Review of the record for client #4 on 5/6/19 and 5/7/19 revealed a POC dated 1/11/19. Review of the POC revealed formal objectives to use signing abilities daily and to tolerate her daily routine to reduce target behaviors. Further review revealed additional needs identified in her POC as "NEEDS PRIORITIZED" which includes increase communication skills, maintain/improve social skill abilities, and maintain gross motor functional abilities. Subsequent review of client #4's POC revealed a Functional Skills Assessment (CFA) dated 1/11/19. Review of the CFA indicated the following "Training Potential" needs: "Turn water on/off" and "Combs, brushes hair" and "Communicates socially-uses please, thank you, hi etc." and "Follows three step directives." Subsequent review of client #4's CFA in the area of vocational needs revealed partial independence and verbal and physical prompting needs for tasks such as "Attends learned task to its completion" and "Grasps concept of tool usage." Interview conducted on 5/7/19 with the home manager and the qualified intellectual disabilities professional (QIDP) verified client #4 could use more formal programs.		W 227			

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CENTER: STATEMENT C	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		FORM OMB NO (X3) DATE	D: 05/10/2019 MAPPROVED D: 0938-0391 SURVEY LETED
		34G132	B. WING	_		_	05/	07/2019
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	1 00/	011/2013
					10100 MT. OLIVE ROAD	,		
CHRISTY	WOODS GROUP HOME				MOUNT PLEASANT, NO	28124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 475	Continued From page	24	w	475	5			
	Based on observation interview, the facility f settings during suppe included appropriate e sampled clients (#2) a (#4). The findings are A. The facility failed t included appropriate e supper and breakfast	Failed to ensure place r and breakfast meals eating utensils for 1 of 3 and 1 non-sampled client e: to ensure place settings eating utensils during meals for client #2.						
	revealed client #2 arri where he was assiste beefaroni casserole a staff into bite-sized pir setting for the supper include a high-sided s a spoon. Observation 7:40 AM revealed clied dining table where he serve himself his brea sausage biscuit pre-c pieces. Client #2's pla	ted on 5/6/19 at 5:30 PM ived at the dining table ad by staff to serve himself and tossed salad pre-cut by eces. Client #2's place meal was observed to scoop dish, regular cups and hs conducted on 5/7/19 at ent #2 was sitting at the was assisted by staff to akfast meal consisting of a but by staff into bite-sized ace setting for the breakfast o include a high-sided scoop d a spoon.						
	5/6/19 and 5/7/19, rev dated 5/2/19 prescribi consistency for client record for client #2 re dated 4/19/19 which i Assessment (CFA) da CFA revealed docume skills stating client #2	for client #2, conducted on vealed a physician's order ing a bite-sized diet #2. Continued review of the vealed a plan of care (POC) ncluded a Functional Skills ated 4/20/18. Review of the entation in the area of dining uses mealtime adaptive ently. Further review of the						

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		MEDICAID SERVICES	(X2) MI U 7		ISTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			· · ·	MPLETED
		34G132				05/07/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
CHRISTY	WOODS GROUP HOME				MT. OLIVE ROAD NT PLEASANT, NC 28124		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
W 475	documenting client #2 active movements an be within functional lin release and pinching to bring objects to his mouth etc Interview conducted y disabilities profession revealed client #2 has spoon for eating, how for client #2 not to be use a fork, spoon and food served. B. The facility failed to included appropriate supper and breakfast Dinner observations i at 5:30 PM revealed of table consuming her and chopped salad w	At #2 revealed an y Evaluation dated 12/19/18 2's bilateral upper extremity id coordination continue to mits with functional grasp, abilities as well as the ability a face for eating, wiping his with the qualified intellectual hal (QIDP) on 5/7/19 is always utilized only a vever, no reason is known afforded the opportunity to d knife as indicated by the to ensure place settings eating utensils during : meals for client #4. In the group home on 5/6/19 client #4 sitting at the dining meal consisting of Beefaroni vith a regular spoon. Further d client #4's place setting to	W	475			
	Breakfast observation 5/7/19 at 7:40 AM rev dining table consumir sausage biscuit with g a regular spoon. Fur client #4's place settin	ular drinking containers. Ins in the group home on vealed client #4 sitting at the ing her meal consisting of a gravy (cut into quarters) with ther observations revealed ing to include only a regular divided dish, and regular					
		client #4's POC dated bods needing utensils cut sandwiches quartered,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/10/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G132	B. WING		_	05/	07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CHRISTY	WOODS GROUP HOME			10100 MT. OLIVE ROAD MOUNT PLEASANT, NC	28124		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 475	regular liquids" Con for client #4 revealed documenting indeper mealtime skills to incl and "Feeds self with s sufficiently for introdu utensils/food/beverag #4's CFA revealed no acquisition identified a Interview conducted w revealed client #4 has spoon for eating, how for client #4 not to be	ntinued review of the record a CFA dated 1/11/19 Indence in the area of ude "Self feeds once set up" spoon" and "Opens mouth cing je." Further review of client a areas of mealtime skill	W 475				

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