

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

PRINTED: 05/28/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2019
NAME OF PROVIDER OR SUPPLIER CREST ROAD GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 114 GREENHOUSE LANE SOUTHERN PINES, NC 28387		
(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 000	INITIAL COMMENTS	W 000			
W 159	<p>On this date, 5/16/19 a follow up survey was completed with all deficiencies corrected and a complaint survey was done for complaint intake NC00150884 and NC00150131. Both of the complaint allegations were substantiated with a corresponding deficiency cited.</p> <p>QIDP CFR(s): 483.430(a)</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations record reviews and interviews, the facility failed to assure the qualified intellectual disabilities professional (QIDP) coordinated services and supports for 1 of 1 audit client (#1). The finding is:</p> <p>Client #1's therapy services were not coordinated by the QIDP.</p> <p>Review of client #1's record on 5/16/19 revealed he was receiving therapy from a therapist. The therapy appointments suddenly stopped.</p> <p>Interview with the management on 5/16/19 revealed the guardian had been scheduling appointments with the therapist and they suddenly stopped. The qualified intellectual disabilities professional (QIDP) confirmed that she did not follow up with the therapist to ascertain future appointment dates. She confirmed that she had not coordinated these services.</p>	W 159			

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.