STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G272	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST ROAD GROUP HOME	**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 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.	W 000		
W 159	QIDP CFR(s): 483.430(a) 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: Client #1's therapy services were not coordinated by the QIDP. Review of client #1's record on 5/16/19 revealed he was receiving therapy from a therapist. The therapy appointments suddenly stopped. 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.	W 159		

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