PRINTED: 02/18/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES (X		(X1) PROVIDED CURRILIED CO.	T		OMB NO. 0938-039		
	D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		34G018	B. WNG			2/44/2024	
	PROVIDER OR SUPPLIER DALE LANE GROUP HOM	E		STREET ADDRESS, CITY, STATE, ZIP CODE 934 SPRINGDALE LANE GASTONIA, NC 28052	1 02	2/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
W 227	CFR(s): 483.440(c)(4) The individual program objectives necessary t	n plan states the specific o meet the client's needs.	W 22	7			
	as identified by the cor required by paragraph	nprehensive assessment (c)(3) of this section.		DHSR - Mental Health			
	Based on observation, interview the individual to have sufficient training	support plan (ISP) failed		Lic. & Cert. Section			
	to address rate of eating to address rate of eating meal on 2/10/21 reveals in the meal and staff to Continued observation is multiple verbal prompts rate of eating. Further of to physically prompt clie eating with touching the prompting "wait" until the food he had in his mouth bites.	p home during the dinner ed client #1 to participate stand near the client. revealed staff to provide for client #1 to slow his bservation revealed staff nt #1 to slow his rate of clients arm and verbally e client had swallowed in before taking additional		A. The interdisciplinary team for Springdale Gill Home will assure safety at meal times for individual as evidenced by development and implementate a program to address #1's rate of eating. QIDF develop and inservice staff on the goal to ensuth is in maintained at every opportunity for eating addition, QIDF will monitor implementation of the on a consistent basis. The QIDF is responsible completing observations and monitoring data of this goal monthly for the first six months and quarterly thereafter. QIDF and House Manage also review with staff techniques for reminding providing supportive counseling on the importations of the provided of the importation of the importa	vidual #1 ation of will ure that ng. In this goal e for collection	April 1, 2021	
	Observation in the group breakfast meal for client observations consistent dinner meal on 2/10/21. staff to sit next to the clies upervision with verbal a the client's rate of eating of client #1 at the breakfast	#1 on 2/11/21 revealed with observations at the Observations revealed ent and to provide nd physical ques to slow Continued observation					

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

USSISTANT DIRECTOR

(X6) DATE

3.1.202

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		I DELIVIOLS					OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		34G018	34G018 B. WNG			00/44/0004			
W. AND DATE OF THE STOCKER, LINES	PROVIDER OR SUPPLIER DALE LANE GROUP HOM	E	Ì	9:	TREET ADDRESS, CITY, STATE, ZIP CODE 34 SPRINGDALE LANE 6ASTONIA, NC 28052	1	02/11/2021		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE		ON	
	client to take large bite in the client to begin cobserved to stop the colient had stopped cours food in his mouth. Review of records for revealed a nutritional at 12/21/20. Review of the assessment for client are recommended regular. Continued review of the assessment for client and the need stand by assistant interview with the facility disabilities professional revealed client #1 has a depending on environmenterview with the QIDF but thought client #1's compassessment referenced assistance during meal of stealing food. Further verified client #1 did no program despite the idea. B. The ISP for client #2 to address exercise. For Review of records for client #1.	es of a waffle that resulted oughing. Staff was dient from eating until the aghing and had no other client #1 on 2/11/21 assessment dated are 12/2020 nutritional #1 revealed a consistency, bite size diet. e current nutritional #1 revealed client #1 to ace from staff. Ety qualified intellectual I (QIDP) on 2/11/21 open known to eat fast mental triggers. Continued Prevealed he was unsure current nutritional I the need for stand by so due to the client's history er interview with the QIDP to thave a rate of eating entified need. Et failed to include training or example: I failed to include training or example:	W	BHH boda a fifth of the damment of t	3. The interdisciplinary team for Springdale Grown will work to assist #2 with reaching his dody weight (DBW) and incorporating exercise aily routine. QIDP will develop and inservice s goal that addresses daily exercise and physiciness. In addition, QIDP will monitor implement fithis goal on a consistent basis. The QIDP is esponsible for completing observations and mata collection of this goal monthly for the first sonths and quarterly thereafter. QIDP and Hou anager will also review with staff techniques for couragement in order to engage #2 in exercise refuses.	esired into his taff on eal itation onitoring six se		1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 - 1	FIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
34G018		B. WING_			02/11/2021	
	PROVIDER OR SUPPLIER DALE LANE GROUP HOM	E		STREET ADDRESS, CITY, STATE, ZIP CODE 934 SPRINGDALE LANE GASTONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 227	Continued review of rean ISP dated 1/9/20. revealed current traini	ecords for client #2 revealed Review of the 1/2020 ISP ng objectives relative to	W 2	27		
	dental hygiene, laundry, handwashing and shower. Subsequent review of records for client #2 revealed no training or program objectives relative to exercise. Interview with the QIDP on 2/11/21 verified client					
W 249	#2 had no current train exercise. Continued in revealed a exercise ob implemented for client behavior. Further inteclient #2 should have a	ning objective relative to nterview with the QIDP pjective had not been #2 due to non-compliance rview with the QIDP verified a exercise program to as identified in the client's essment.	W 24	19		
		dividual program plan, e a continuous active sisting of needed ces in sufficient number ort the achievement of the				
	treatment program cons	s, record review and ailed to ensure 1 of 3 beived a continuous active				

STATEMENT OF DECICIENCIES		DETAILS SELVINGES			OMB N	OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		TE SURVEY MPLETED	
	34G018 B. WING			2/11/2021			
NAME OF PROVIDER OR SUPPLIER SPRINGDALE LANE GROUP HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	934 SPRINGDALE LANE GASTONIA, NC 28052 PROVIDER'S PLAN OF	CODE		
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 249	relative to transitions v	ransitions and dings are: ensure a program objective	W2	A. The interdisciplinary team for Home will assure that all individu continuous active treatment progneeded interventions and servic number and frequency to support	uals are receiving a gram consisting of ses in a sufficient	April 1, 2021	
	to various activities to i setting the table, hygie medication administrat observation during the revealed staff to verbal each transition while in cards to support comm Subsequent observatio	ealed client #1 to transition include leisure activities, ne, meal participation and ion. Continued 2/10-11/21 survey ly prompt client #1 with termittently utilizing cue unication with client #1. In revealed client #1 would m staff or wander through		the objectives as identified in ea plan. QIDP and House Manager individual's goals to determine if Once the appropriate revisions (and House Manager are respons staff on the goals of each individ House Manager will monitor the individual's goals daily, including plan as it relates to communicati individual #1. QIDP will assist the monitoring the implementation of goals on a consistent basis. The for completing observations and collection monthly for the first six thereafter.	ich individual's progran rewill review each revisions are needed. (if any) are made, QIDF sible for inservicing earlual. In addition, the implementation of eac refollowing the program ing transitions with e House Manager in feach individual's QIDP is responsible monitoring data.	ch h	
	of records for client #1 relative to transitions the follow a one object (pict consecutive months with prompts at 80% of the titeaching method for clie objective revealed at eaclient #1 to refer to his spicture of the next activitions. Continued review of revealed step #2 to inclupresented with one objection #1 will place the old client #1 will place the old follows.	8/11/20. Continued review revealed an objective at indicated client #1 will rure) cue schedule for 12 h 5 or less verbal/gestural rime. Review of the ent #1's transition ch transition staff will ask schedule and take off the ty and and put it in the of the teaching method rude client #1 will be ct (picture) at a time by that activity is completed,					

		T CENTRE CENTRICE			ONB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 2.0/	PLE CONSTRUCTION IG		E SURVEY MPLETED	
		34G018	B. WING _		0:	2/11/2021	
	PROVIDER OR SUPPLIER PALE LANE GROUP HOM	E		STREET ADDRESS, CITY, STATE, ZIP CODE 934 SPRINGDALE LANE GASTONIA, NC 28052			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	Interview with the faci disabilities profession revealed client #1's so transitions remains cu with the QIDP verified utilized during survey client #1 with transition the QIDP revealed he a board for transitions among staff with supp transitions was neede B. The team failed to objective relative to ha implemented in sufficienced of client #1. For Observations in the gr 2/10-11/21 survey reversions times. Continued observations times would projective cue coupled with address handwashing revealed client #1 wou his hands with physical Review of records for circle and ISP dated of records for client #1 relative to handwashing will perform the steps in or less verbal prompts time for 6 consecutive teaching method for cliobjective revealed staff the picture steps for was	lity qualified intellectual al (QIDP) on 2/11/21 chedule objective to support a schedule board was not observations to support ins. Further interview with was unsure if client #1 had and increased consistency orting client #1 with d. ensure a program andwashing was ent frequency to support the example: oup home during the ealed staff to verbally sh his hands at various ervations revealed staff at the a verbal prompt to Subsequent observation ld walk with staff and wash I guidance from staff. client #1 on 2/11/21 8/11/20. Continued review revealed an objective g that indicated client #1 in washing his hands with 2 for each step 100% of the months. Review of the ent #1's handwashing f will review with client #1	W 24	B. The interdisciplinary team for Springdale Home will assure that all individuals are recontinuous active treatment program consineeded interventions and services in a sufnumber and frequency to support the achie the objectives as identified in each individuplan. QIDP and House Manager will review individual's goals to determine if revisions once the appropriate revisions (if any) are and House Manager are responsible for instaff on the goals of each individual. In add House Manager will monitor the implement individual's goals daily, including following plan as it relates to handwashing for indivicualDP will assist the House Manager in monimplementation of each individual's goals of consistent basis. The QIDP is responsible to completing observations and monitoring discollection monthly for the first six months at the reafter.	ceiving a sting of ficient syement of lal's program veach are needed. made, QIDF servicing earlition, the ation of each the program lual #1. hitoring the nafata	ch	

STATEMENT OF DEFICIENCIES		(V4) DROVIDED GUIDEU FRIGUE			OMB NO. 0938-039		
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		ATE SURVEY OMPLETED	
		34G018	B. WNG_			2/44/2024	
	PROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 934 SPRINGDALE LANE GASTONIA, NC 28052		2/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	tell the client the steps until all steps for hand Interview with the QID #1's handwashing obje Continued interview w #1's handwashing obje as written during surve	ure and staff will verbally and continuing the process washing are complete. P on 2/11/21 revealed client ective remains current. If the QIDP revealed client ective was not implemented by observations. Further everified client #1 was in the implementation of programs should be an expression of the implementation of programs should be an expression of the implementation of programs should be an expression of the implementation of programs should be an expression of the implementation of programs should be an expression of the implementation of programs should be an expression of the implementation of programs and in the implementation of programs and interpretation of programs and interpretation of programs	W 24				
	for client #5. For example of client #5. For example of the ground AM revealed client #5 to be creakfast preparation in cold cereal. Continued to access a bag of cereal and pour cereal for clients.	provide a prescribed diet cle: provide a prescribed diet cle:		A & B. The interdisciplinary team for S Home will ensure that all individuals a following his/her prescribed diet. QID Manager are responsible for inservicir each staff on each individual's prescriincluding but not limited to specificatio intake, cholestrol, sugar, sodium, and QIDP will assist House Manager in moin implementation of each individual's propared consistent basis. The QIDP is responder completing observations and monit collection monthly for the first six mont diet is implemented or when revisions quarterly thereafter.	re assisted in Pand House ng and reviewing bed diet, ins for caloric portion sizes, etconitoring the escribed diet on nsible oring data this (when a new the same the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G018			(X2) MULTIPLE CONSTRUCTION A. BUILDING			B) DATE SURVEY COMPLETED
		B. WING			02/44/0204	
	F PROVIDER OR SUPPLIER FDALE LANE GROUP HOM	E		STREET ADDRESS, CITY, STA 934 SPRINGDALE LANE GASTONIA, NC 28052	ATE, ZIP CODE	02/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
W 466	#5's cereal revealed the based cereal with no concent continued review of the assessment for client with weigh 228 lbs with a decorate of 135-166 lbs. Subsective current nutritional assessing has gained 7 lbs over the above his DBW. Diet not closely. Glucose level will indications of diabetes controlled and diet must be controlled and diet must be controlled and with the facility disabilities professional verified the menu in the followed at all meals. Of the QIDP verified staff's amount of cereal for each amount specified on the interview with the QIDP recommended diet for cereal with the unmeasured cereal selection of a suggestion. The facility failed to prove the cereal selection of a suggestion of the procession of the cereal selection of a suggestion.	st menu for the group home e menu to consist of a ereal, a fruit muffin and 1 ew of records for client #5 mutritional assessment cified a 1800 calorie, low trated sweets diet. e 4/2020 nutritional 55 revealed the client to esired body weight (DBW) quent review of client #5 is esment revealed: Client #5 is epast year and is 62 lbs eeds to be followed was greatly elevated. and this should be to be followed closely. If qualified intellectual (QIDP) on 2/11/21 group home should be ontinued interview with hould have measured the chicken and provided the breakfast menu. Further verified the itent #5 was not followed real amount provided all and with the specific ar based cereal.	W	460		
	for client #2. For examp	IG.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			NO. 0938-0391 ATE SURVEY MPLETED	
			34G018	B. WNG			2/11/2021
	SPRINGD	PROVIDER OR SUPPLIER ALE LANE GROUP HOMI			STREET ADDRESS, CITY, STATE, ZIP CODE 934 SPRINGDALE LANE GASTONIA, NC 28052	:	72/11/2021
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(SHOULD BE	(X5) COMPLETION DATE
	i control of the cont	Observation in the gro 8:35 AM revealed clier breakfast preparation is cold cereal. Continued to pour cereal for client without measuring the to the client. Subseque #2's cereal revealed the based cereal with no or #2. Review of the breakfas on 2/11/21 revealed the banana, 1 cup of dry ce cup of skim milk. Revie revealed a nutritional as 12/21/20. Review of the assessment for client # weigh 185 lbs with a DE Continued review of the assessment revealed: C DBW range and needs basis. Needs to improv achieve desirable body review of the 12/2020 no revealed a recommende cholesterol, 1800 calorie interview with the facility disabilities professional verified the menu in grou ollowed at all meals. Co he QIDP verified staff sla amount of cereal for each	bup home on 2/11/21 at an #2 to participate in his in the kitchen that included dobservation revealed staff the #2 into a large bowl amount of cereal provided ent observation of client ent ecreal to be a sugar ther option offered to client et menu for the group home emenu to consist of a ereal, a fruit muffin and 1 ew of records for client #2 seessment dated en 12/2020 nutritional en 12/	W	460		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	ATE SURVEY
		34G018	B. WNG)2/11/2021
	ROVIDER OR SUPPLIER ALE LANE GROUP HOMI	E		934 S	ET ADDRESS, CITY, STATE, ZIP CODE PRINGDALE LANE TONIA, NC 28052	1 0	2021
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	Continued From page C. The facility failed to for client #1. For exam Observation in the gro breakfast meal for client the client's meal to cor and a waffle that staff the while sitting next to the observation of client #7 revealed the client to to that resulted in the client was observed to stop to the client had stopped food in his mouth. Review of records for corevealed a nutritional and 12/21/20. Review of the assessment for client #7 recommended regular of Continued review of the assessment for client #7 need stand by assistant in the client #7 need stand	provide a prescribed diet inple: up home during the int #1 on 2/11/21 revealed insist of a chopped banana proke into large pieces in client. Continued if at the breakfast meal in ake large bites of the waffle into begin coughing. Staff the client from eating until coughing and had no other in the client #1 on 2/11/21 in the client #1 o	W	460		AIE	DATE
i i t	#1's current diet to be b tems should be cut up a nterview with QIDP ver the breakfast meal shou	ite sized and all food accordingly. Continued ified client #1's waffle at ıld have been cut into bite oken into large pieces to					