STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G167	A. BUILDING _____ B. WING _____	05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDLEWOOD GROUP HOME	103 WOOD GLENN ROAD ROANOKE RAPIDS, NC 27870

(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 126	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(4) The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 audit clients (#4) was considered for training in the area of money management skills to the extent of his capabilities. The finding is: Review on 5/3/21 of client #4's individual program plan (IPP) dated 11/23/20 revealed he was admitted to the facility on 10/30/20. Review of the IPP revealed that client #4 has limited money management skills and that he needs assistance in this area. Review on 5/4/20 of his skills assessment dated 11/1/20 revealed client #4 needs assistance when presenting money to the cashier during purchases, he requires assistance waiting for a receipt and waiting for change after a purchase. Further review on 5/3/21 of client #4's IPP dated 11/23/20 revealed he has formal training on writing his last name, washing clothing, writing his address and brushing his teeth. He does any not have any training identified in the area of money management. Interview on 5/4/21 with the habilitation specialist and the qualified intellectual disabilities professional (QIDP) confirmed the team had not identified training in the area of money	W 126		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 126	Continued From page 1 management after a need was identified on client #4's skill assessment that he needed assistance with managing money and making purchases.	W 126		