DEPARTMENT OF HEALTH AND HUMAN SERVICES									
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u> 0938-0391</u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED		
		34G341	B. WING			05	05/25/2021		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
WOODING					112 WOODING PLACE				
WOODING	S PLACE GROUP HOME			KINGS MOUNTAIN, NC 28086					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP		COMPLETION DATE		
IAG					DEFICIENCY)				
W 249				249	<u>م</u>				
VV 2+3	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)			270					
	As soon as the interd	isciplinary team bas							
		ndividual program plan,							
		ive a continuous active							
	treatment program co								
		vices in sufficient number							
	and frequency to sup	port the achievement of the							
	objectives identified in	n the individual program							
	plan.								
		not met as evidenced by:							
	Based on observation, interview and record								
	consistent interventio	olinary team failed to assure							
		dual service plans (ISPs) for							
		s (#3 and #4) relative to							
	participation during medication administration. The findings are:								
	5								
		ensure training objectives							
	were implemented as	prescribed for client #3. For							
	example:								
	Observations in the g	roup home on E/2E/21 of							
		roup home on 5/25/21 at ff D to prompt client #3 to							
	the medication room	• •							
		led observations revealed							
	staff D to get the med								
	•	e blister pack, to place in a							
		nen assist client with taking							
	-	outh followed with a cup of							
		ations revealed staff D to							
		on cup in the trash can. At							
		vations did staff D provide							
		t to participate in medication							
	administration. Addition	onal observations revealed							
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			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.

PRINTED: 06/03/2021

CENTER STATEMENT C AND PLAN OF	MENT OF HEALTH AN S FOR MEDICARE & M DF DEFICIENCIES CORRECTION	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G341	A. BUILDING B. WINGS	CONSTRUCTION		PRINTED: 06/03/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 05/25/2021		
WOODING PLACE GROUP HOME				12 WOODING PLACE KINGS MOUNTAIN, NC	28086			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 249	staff D did not educate purpose of medical rec revealed an individual 6/15/20. Continued re administration training will get the bin, take m medication cup. Interview with the qua professional (QIDP) a 5/25/21 confirmed all #3 are current. Contin and HR verified staff st the name and purpose administered. Further HM confirmed staff sh objectives as written. B. The team failed to a were implemented as example: Observations in the gu 7:00 AM revealed staff the medication room t medications. Continu staff D to get the med medication cup then g followed by a cup of w revealed staff D to thr the trash can as client time during observatio opportunities for client	e client on the name or ns. cord for client #3 on 5/21/21 I service plan (ISP) dated eview revealed a medication g objective to include; client nedications, throw away the alified intellectual disabilities and the home manager on training objectives for client nued interview with the QIDP should educate all clients on e of medications interview with the QIDP and hould follow training ensure training objectives prescribed for client #4. For roup home on 5/25/21 at ff D to prompt client #4 to to receive morning ued observations revealed lication bin, punch e blister pack to place in a give to client #4 to take vater. Further observations row away medication cup in t exit the med room. At no ons did staff D provide t to participate in medication cate client on the name or	W 249					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 06/03/2021 APPROVED ). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
34G341		34G341	B. WING				05/25/2021		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	TE, ZIP CODE			
WOODING	PLACE GROUP HOME		112 WOODING PLACE KINGS MOUNTAIN, NC 28086						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ix S	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
W 249	Continued From page 2		w	249					
	Continued From page 2 Review of client #4 record on 5/21/21 revealed an individual service plan (ISP) dated 8/12/20. Continued review revealed a medication administration training objective to include; take medications, throw medication cup in trash and exit medication room. Interview with the qualified intellectual disabilities professional (QIDP) and the home manager on 5/25/21 confirmed all training objectives for client #4 are current. Continued interview with the QIDP and HR verified staff should educate all clients on the name and purpose of medications administered. Further interview with the QIDP and HM confirmed staff should follow training objectives as written.								

FORM CMS-2567(02-99) Previous Versions Obsolete

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