STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G341	A. BUILDING _____ B. WING _____	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the interdisciplinary team failed to assure consistent interventions to support needs identified in the individual service plans (ISPs) for 2 of 4 sampled clients (#3 and #4) relative to participation during medication administration. The findings are: A. The team failed to ensure training objectives were implemented as prescribed for client #3. For example: Observations in the group home on 5/25/21 at 6:45 AM revealed staff D to prompt client #3 to the medication room to receive morning medications. Continued observations revealed staff D to get the medication bin, punch medications out of the blister pack, to place in a medication cup and then assist client with taking his medications by mouth followed with a cup of water. Further observations revealed staff D to throw empty medication cup in the trash can. At no time during observations did staff D provide opportunities for client to participate in medication administration. Additional observations revealed	W 249		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G341	A. BUILDING _____ B. WING _____	05/25/2021

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W 249	Continued From page 1	W 249		

staff D did not educate client on the name or purpose of medications.

Review of medical record for client #3 on 5/21/21 revealed an individual service plan (ISP) dated 6/15/20. Continued review revealed a medication administration training objective to include; client will get the bin, take medications, throw away the medication cup.

Interview with the qualified intellectual disabilities professional (QIDP) and the home manager on 5/25/21 confirmed all training objectives for client #3 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.

B. The team failed to ensure training objectives were implemented as prescribed for client #4. For example:

Observations in the group home on 5/25/21 at 7:00 AM revealed staff D to prompt client #4 to the medication room to receive morning medications. Continued observations revealed staff D to get the medication bin, punch medications out of the blister pack to place in a medication cup then give to client #4 to take followed by a cup of water. Further observations revealed staff D to throw away medication cup in the trash can as client exit the med room. At no time during observations did staff D provide opportunities for client to participate in medication administration or educate client on the name or purpose of medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G341	A. BUILDING _____ B. WING _____	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 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.	W 249		