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		MEDICAID SERVICES	1		OMB N	NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		34G018	B. WNG_			R
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	4/15/2021
SPRINGD	ALE LANE GROUP HOM	E		934 SPRINGDALE LANE		
	THE PART OR OUT THOM	_		GASTONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD RE	(X5) COMPLETION DATE
{W 249}	PROGRAM IMPLEME CFR(s): 483.440(d)(1)		{W 24!	9}		
	each client must receive treatment program cor interventions and serventions.	dividual program plan, we a continuous active asisting of needed ices in sufficient number ort the achievement of the				
	Based on observations interviews, the facility fasampled clients (#1) retreatment program con-	ailed to ensure 1 of 3 ceived a continuous active sisting of needed ed in the individual support ansitions and				
r s	elative to transitions wa	upport the need of client		A. The interdisciplinary team for Springdale Group Ho all individuals are receiving a continuous active treatm consisting of needed interventions and services in a st and frequency to support the achievement of the objectin each individual's program plan. QIDP will be responsed staff on the goals of each individual. In addition, monitor the implementation of each individual's goals, the program plan as it relates to communicating transit reponsible for completing observations and monitoring a quarterly basis.	ent program ufficient number ctives as identified sible for inservicing the QIDP will including following	May 1, 2021
to s	2/10-11/21 survey revea o various activities to in	aled client #1 to transition clude leisure activities, e, meal participation and		DHSR - Mental He	alth	
o re e	bservation during the 2 evealed staff to verbally ach transition while inte	7/10-11/21 survey or prompt client #1 with permittently utilizing cue		MAY 3 2021		
S	ards to support commu ubsequent observation ontinue to walk off from ne group home when ve	revealed client #1 would staff or wander through		Lic. & Cert. Section	1	

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

OSSISTANT DIRECTOR

1. W. 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.

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STATEMENT OF DEFICIENCIES		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI		(VO) MILLER TO THE STATE OF THE		OMB	OMB NO. 0938-039	
AND PLAN OF CORRECTION			IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING		OATE SURVEY OMPLETED	
ŀ			34G018	B. WING				R	
		PROVIDER OR SUPPLIER PALE LANE GROUP HOMI	E		934	REET ADDRESS, CITY, STATE, ZIP CODE S SPRINGDALE LANE STONIA, NC 28052		04/15/2021	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RE	(X5) COMPLETION DATE	
	t to the control of t	options by staff. Review of records for or revealed an ISP dated of records for client #1 relative to transitions the follow a one object (pictonsecutive months with prompts at 80% of the steaching method for client #1 to refer to his spicture of the next active Continued review of the revealed step #2 to inclipate presented with one objective that will place the occupient #1 with the facility disabilities professional revealed client #1's schettransitions remains curre with the QIDP verified a utilized during survey obclient #1 with transitions are among staff with support ransitions was needed. A follow-up survey was considered the survey on 4/15/10 place the group of the	client #1 on 2/11/21 8/11/20. Continued review revealed an objective nat indicated client #1 will sture) cue schedule for 12 th 5 or less verbal/gestural time. Review of the ent #1's transition ach transition staff will ask schedule and take off the ity and put it in the box. It teaching method ude client #1 will be ect (picture) at a time by that activity is completed, object (picture) in a and move to the next task. If qualified intellectual (QIDP) on 2/11/21 edule objective to support ent. Continued interview schedule board was not servations to support. Further interview with as unsure if client #1 had not increased consistency ring client #1 with If you will be extended to do not serve a consistency in grant in the conducted 4/15/21. It is phome during the your phome observations revealed to door of the group home observations revealed various activities of	{W 2	49}				

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) 141 II TIS	I CONSTRUCTION	OMB I	RM APPRO NO. 0938-0
IND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		34G018	B. WING			R
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS	0	4/15/2021
SPRINGE	ALE LANE GROUP HO			STREET ADDRESS, CITY, STATE, ZIP CODE 934 SPRINGDALE LANE	=	
		SWIE .		GASTONIA, NC 28052		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
W 249}	Continued From pag	ge 2	2442424			
		was further observed to be	{W 249}			
	verbally prompted to	was his hands and to be				
	verbally prompted by	y staff with participating in the				
	lunch meal Addition	nal observations revealed				
	client #1 to complete	e all activity transitions with				
	only verbal promots	by staff and requiring multiple				
	verbal prompts of rec	direction at various times to				
	verbal prompts of redirection at various times to complete transitions.					
	The state of the s					
	Review of internal documents on 4/15/21 relative					
	to the plan of correction with a 4/1/20 completion					
	date from the 2/11/21 recertification survey					
	revealed no evidence of a revision to client #1's		1			
	communication goal t	to support transitions.				
(Continued document	review revealed no				
6	evidence of observati	ons or assessments by the				
0	clinical team to ensure	e client #1's communication				
r	program was impleme	ented as prescribed since				
t	he recertification surv	ey. Subsequent review of				
ii	nternal documents re	vealed evidence of an				
ir	n-service training with	staff dated 2/23/21.				
F	Review of the in-service	ce training revealed no				
s	pecific details as to w	hat staff were trained on				
re	elative to client #1's communication goal for					
tr	ansitions.	godi ioi				
In	itanziow with the Fee 11	7. 7				
4/	15/21 royagled all acili	ty home manager on				
Cli	15/21 revealed all communication goals for all					
ar	ients were in process of revision by the OIDP					
wi	nd were not currently implemented. Interview					
00	ith the QIDP revealed client #1's communication pal relative to transitions had remained a current aining objective with no revision since the					
tra						
2/	11/21 recertification a	up revision since the	1			
int	11/21 recertification s	urvey. Continued				
clie	ent #1 should be are	verified transitions for				
scl	hedule and picture	ported with the use of a				
the	OIDP revealed alice	ies. Further interview with				
sho	QIDP revealed clien	# 1 S transition goal				
0.10	and have been imple	mented as prescribed				- 1

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STATEMENT AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION		IO. 0938-039 TE SURVEY
		DENTIFICATION NUMBER:	A. BUILDIN	G		MPLETED
		34G018	B. WING _			R
	PROVIDER OR SUPPLIER DALE LANE GROUP HOME	=		STREET ADDRESS, CITY, STATE, ZIP CODE 934 SPRINGDALE LANE GASTONIA, NC 28052	1 04	1/15/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
t t t t t t t t t t a in	during the follow-up sure. B. The team failed to objective relative to har implemented in sufficienced of client #1. For each of client #1. For each of client #1 to was times. Continued obsevarious times would prepicture cue coupled with address handwashing, revealed client #1 would his hands with physical Review of records for client #1 relative to handwashing will perform the steps in or less verbal prompts for the picture steps for was continued review revealed staff with physical prompts for the picture steps for was continued review revealed opoint to the first picture ell the client the steps, curtil all steps for handwashing objective with the QIDP of the picture with the quality with the QIDP of the picture with the quality with the qua	ensure a program andwashing was ant frequency to support the example: Sup home during the aled staff to verbally his hands at various revealed staff at esent client #1 with a an a verbal prompt to Subsequent observation di walk with staff and wash guidance from staff. Supplementation of the staff and wash guidance from staff. Supplementation of the staff and wash guidance from staff. Supplementation of the staff and wash guidance from staff. Supplementation of the staff and wash guidance from staff. Supplementation of the staff and washing his hands with 2 or each step 100% of the staff will review with client #1 washing his hands. Supplementation of the staff will verbally ontinuing the process shing are complete. Supplementation of the staff will revealed client we remains current. The QIDP revealed client we was not implemented observations. Further certified client #1 was in	{W 24\$		p Home will assure that eatment program 1 a sufficient number objectives as identified sponsible for inservicing ion, the QIDP will pals, including following the QIDP is oring data collection on	May 1, 2021

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1	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/Y2\ MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF CORRECTION		F CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING		
				The Boile Billion		0	MPLETED
L			34G018	B. WING			R
l	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	4/15/2021
l	SPRINGE	ALE LANE GROUP HOMI	-		34 SPRINGDALE LANE		
L	OI MINOD	ALE LANE GROUP HOMI	=		GASTONIA, NC 28052		
Г	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
	PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DRE	(X5) COMPLETION DATE
		survey on 4/15/21 at 13 to open the front door of	programs should be a. conducted 4/15/21. pup during the follow-up 1:25 AM revealed client #1 of the group home to	{W 249}			
	1	verbally prompted by st to be physically directed bathroom after client #1 prompts by staff for han observation revealed cli prompted by staff with p	n various activities of loring and watching as further observed to be aff to wash his hands and d by another client to the would not follow verbal dwashing. Subsequent ent #1 to be verbally articipating in the lunch rations revealed client #1				
	t c s # h h re a te c c in of in R. sp re	o the plan of correction completion date from the	e 2/11/21 recertification ence of a revision to client to support didocument review observations or o home by the clinical tion survey to ensure program was ed. Subsequent review realed evidence of an eaff dated 2/23/21, raining revealed no estaff were trained on dwashing objective.				
_	CMS-2567/02		ione manager on				1

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLET	DI E CONOTE I IOTICA	OMB N	O. 0938-0
LAI4	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DAT	E SURVEY PLETED
		34G018	B. WING_			R
PRINGE	PROVIDER OR SUPPLIER DALE LANE GROUP HOM			STREET ADDRESS, CITY, STATE, ZIP CODE 934 SPRINGDALE LANE GASTONIA, NC 28052	04	/15/2021
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	CHOULD DE	(X5) COMPLETIC DATE
;	4/15/21 revealed all coclients were in process and were not currently with the QIDP revealed goal relative to handwa current training objective 2/11/21 survey. Coc QIDP verified handwas be supported with the LE Further interview with the #1's handwashing goal	ommunication goals for all soft revision by the QIDP implemented. Interview dictient #1's communication asking had remained a we with no revision since ontinued interview with the shing for client #1 should use of picture cues.	{W 249			

Indicate how often the monitoring will take place.

Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. *Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information)*

Send the <u>original</u> completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call me at (828) 750-2664.

Sincerely,

Kaila Mitchell

Facility Compliance Consultant II

Mental Health Licensure & Certification Section

Enclosures

Cc:

QM@partnersbhm.org dhhs@vayahealth.com

DHSR - Mental Health

MAY 3 2021

Lic. & Cert. Section