

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/04/2021  
FORM APPROVED  
OMB NO. 0938-0391

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

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

(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	<p><b>PROTECTION OF CLIENTS RIGHTS</b> CFR(s): 483.420(a)(4)</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	W 126	<p>W 126</p> <p>Facility will ensure the rights of all clients and allow all individuals to manage their financial affairs by teaching them to do so to the extent of their capabilities. Each consumer will assessed for training in the area of money management if they have not done so. Based on the findings of these assessments, the team will meet to discuss training options. When deemed appropriate, training objectives will be implemented. Addendums to MLB will be completed. All staff will receive updated in-service specific to the strengths and needs of each client, including any new goals that may be completed. Monitoring will occur no less than 4 times monthly by facility managers as a part of their observations in the day programs, community outings and other opportunities. Skills will be updated annually on the skills assessment. Data collection will be reviewed monthly by the QP on the monthly data review.</p>	
-------	---	-------	--	--

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

TITLE

(X6) DATE

*Susan Papp* *Director of Compliance* *5/17/21*

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/04/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G167</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/04/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDLEWOOD GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>103 WOOD GLENN ROAD ROANOKE RAPIDS, NC 27870</b>		
(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	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			