PRINTED: 08/30/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		34G248	B. WING _			08/	18/2021
	ROVIDER OR SUPPLIER SWOOD GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP COL 214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677)E		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
W 104	This STANDARD is represented by the sampled clients (continued by the facility vanually place. Further verified that at times terms of the submitted submitt	nust exercise general policy, g direction over the facility. not met as evidenced by: n, record review and failed to exercise general fer the facility by failing to fail and #3). The finding is: roup home on 8/18/21 at ff D to transfer client #3 into find the van lift. Further for the van lift raised client #3 quent observation at 9:00 and D to transfer client #1 sing the van lift. Further for the safety strap could not be client as the attachment to foken. Continued staff D to manually hold the finding the van lift raised client on 8/18/21 verified that the finder had been broken for at interview with staff D he van lift will stall and staff lift and lower the van lift in itew with staff D verified that several calls and emails to the security strap and van lift	W 1	04			

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.

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	34G248	B. WING			08/	18/2021	
		•	2	14 HOLLINGSWOOD DRIVE			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	I				(X5) COMPLETION DATE	
Continued From page	e 1	w	104				
professional (QIDP) of was aware that the various QIDP and facility admits a facility would make susafety strap fastener adate was available as serviced. It should be noted on and initial interviews, reported to the survey been repaired and that are able to be safely are able to be safely are able to be safely the PROTECTION OF CICFR(s): 483.420(a)(7). The facility must ensure the facility treatment and care of the survey of the same and care of the safely are the safely streament and care of the facility during client care for the finding is: Morning observations 8/18/21 at 7:30 AM results and the safely are observation at 7:55 A the bathroom and entitle aving the bathroom	on 8/18/21 verified that she can lift needed to be serviced, but locate the work order at the control of the co	W	130				
	Continued From page Interview with the quaprofessional (QIDP) of was aware that the valowever she could not the time of the survey QIDP and facility administration facility would make subserviced. It should be noted on and initial interviews, reported to the survey been repaired and the are able to be safely PROTECTION OF CICFR(s): 483.420(a)(7). The facility must ensurate the facility treatment and care of the facility treatment and care of the facility during client care for the finding is: Morning observations 8/18/21 at 7:30 AM rebathroom with staff a observation at 7:55 A the bathroom and encleaving the bathroom	AGOVIDER OR SUPPLIER SWOOD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Interview with the qualified intellectual disabilities professional (QIDP) on 8/18/21 verified that she was aware that the van lift needed to be serviced, however she could not locate the work order at the time of the survey. Further interview with the QIDP and facility administrator verified that the facility would make sure that the van lift and safety strap fastener were repaired, however, no date was available as to when the items would be serviced. It should be noted on 8/18/21, after observations and initial interviews, the facility administrator reported to the survey team the facility van had been repaired and that moving forward all clients are able to be safely transported. PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure privacy during client care for 1 of 4 sampled clients (#4).	ROVIDER OR SUPPLIER SWOOD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 W Interview with the qualified intellectual disabilities professional (QIDP) on 8/18/21 verified that she was aware that the van lift needed to be serviced, however she could not locate the work order at the time of the survey. Further interview with the QIDP and facility administrator verified that the facility would make sure that the van lift and safety strap fastener were repaired, however, no date was available as to when the items would be serviced. It should be noted on 8/18/21, after observations and initial interviews, the facility administrator reported to the survey team the facility van had been repaired and that moving forward all clients are able to be safely transported. PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. 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Further observation at 7:55 AM revealed staff B to exit the bathroom and enter into client #4's bedroom leaving the bathroom door ajar. Observations	A BUILDING 34G248 BYONDER OR SUPPLIER SHOOD GROUP HOME SUMMARY STATEMENT OF DEPICIENCIES (EACH CORRECTIVALIST BE PRECEDED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) Continued From page 1 Interview with the qualified intellectual disabilities professional (QIDP) on 8/18/21 verified that she was aware that the van lift needed to be serviced, however she could not locate the work order at the time of the survey. Further interview with the facility would make sure that the van lift and safety strap fastener were repaired, however, no date was available as to when the items would be serviced. It should be noted on 8/18/21, after observations and initial interviews, the facility administrator reported to the survey team the facility van had been repaired and that moving forward all clients are able to be safely transported. 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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G248	B. WING _			08/	18/2021	
	ROVIDER OR SUPPLIER SWOOD GROUP HOME			21	TREET ADDRESS, CITY, STATE, ZIP CODE 4 HOLLINGSWOOD DRIVE TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 130	Continued observation to the bathroom with a door behind her. Interview with the quaprofessional (QIDP) of #4 should not have be bathroom, unclothed, interview with the QIE should be offered private treatment. STAFF TRAINING PE	d be seen from the hallway. In revealed staff B to return client #4 and to close the alified intellectual disabilities on 8/18/21 verified that client een left alone in the with the door ajar. Further OP confirmed that all clients racy during care and	w					
	must focus on skills a toward clients' behaving This STANDARD is in Based on observation interview, the facility for adequately trained spoupport client safety for The finding is: Observation at the grows at the vecation of the vocation of the vocation of the vecation	vork with clients, training and competencies directed oral needs. Not met as evidenced by: n, record review and sailed to ensure staff were secific to supervision to or 3 of 4 clients (#2, #3, #4.) The pup home on 8/18/21 at clients to be outside the mpting to load the van for ional program. Continued M revealed clients #2, #3 incility van, with staff F, with further observation revealed clients van, while the vehicle to to her personal car leaving						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		34G248	B. WING		0	8/18/2021	
	ROVIDER OR SUPPLIER SWOOD GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP 214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 191	and #4 revealed behat for close supervision. 8/18/21 verified client the facility van unsupervehicle is running. In administrator and quaprofessional (QIDP) consafety should be a prinever be left unattend INDIVIDUAL PROGR CFR(s): 483.440(c)(4). The individual program objectives necessary as identified by the conservation.	8/18/21 for clients #2, #3 avior programs with the need Interview with staff D on s should not ever be left on ervised, especially if the terview with the facility alified intellectual disabilities on 8/18/21 verified client ority and clients should led on a running vehicle. AM PLAN		227			
	Based on review of r person centered plan sufficient training or ir identified needs for 2 and #4). The findings A. The facility failed t address the safety of transportation guideling Afternoon observation 8/17/21 at 4:30 PM regroup home from a value and no shoes. Further	of 4 sampled clients (#1 sare: o have a training program to client #4 relative to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		34G248	B. WING _		08/18/2021
	ROVIDER OR SUPPLIER SWOOD GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677	, 337.101221
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W 227	dinner meal and to essuch as crawling on the and throwing objects. Continued observation client #4 to the facility escalating behaviors revealed staff E to seattached to a seat on remain barefoot. Add staff E and the qualifity professional (QIDP) to clients #4 and #2 to the clients #4 and #2 to the clients #4 and #2 to the clients #4 to participate in various grooming and participate in the facility various grooming and participate in various grooming and pa	included participating in the whibit escalating behaviors the floor, screaming, crying at staff and peers. One revealed staff E to escort of van for a van ride due to a Subsequent observation occure client #4 to a harness the van and client #4 to ditional observation revealed ed intellectual disabilities to leave the facility with take a van ride. Is in the group home on the fact of the state of the stat	W 2	27	

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	34G248	B. WING _		08/18/2021
	,		STREET ADDRESS, CITY, STATE, ZIP COD 214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677	•
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guidelines for client # Interview with staff D client #4 has difficulti will exhibit head bang verified that client #4 difficulties and the clivest connected to a transfery during transposite with the QIDP verified getting client #4 to will lead to escalating believerified during the intreview with the QIDP verified getting client #4 to will lead to escalating believerified during the intreview with the QIDP verified during the could be neglit from ensure the client's sate. B. The facility failed address safety of client address safety of client transfers. For example, the could be delient #1 to wheelchair with no secont in the factor of the dining regait belt from her observation revealed bedroom, to access the return to the dining regulating her gait belt and client remained in her subsequent observation.	on 8/18/21 verified that es during transportation and ging. Interview with the QIDP has transportation ent is required to wear a gait ravel harness to ensure retation. Further interview de that staff have a hard time ear shoes, which can often haviors. The QIDP also erview that at times staff will ess client #4's behaviors. DP confirmed that all of client entions are current. DP also confirmed that client transportation guidelines to fety during transportation. It have guidelines to ent #1 relative to wheelchair ole: Cacility on 8/18/21 at 7:07 AM est at the kitchen table in her eatbelt or gait belt. On revealed client #1 to look at the staff to bring the client bedroom. Further staff A to walk to client #1's he client's gait belt and soom to assist client #1 with round her waist while the rewheelchair.	W2	227	
	ROVIDER OR SUPPLIER SWOOD GROUP HOME SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page guidelines for client # Interview with staff D client #4 has difficulti will exhibit head bang verified that client #4 difficulties and the cli vest connected to a t safety during transpo with the QIDP verified getting client #4 to we lead to escalating be verified during the int stop the van to addre Interview with the QII #4's goals and interve Interview with the QII #4 could benefit from ensure the client's sa B. The facility failed address safety of clie transfers. For examp Observations in the fi revealed client #1 to wheelchair with no se Continued observatio at staff A and request her gait belt from her observation revealed bedroom, to access t return to the dining re putting her gait belt a client remained in he Subsequent observat 8/18/21 at 8:35 AM re	TORRECTION IDENTIFICATION NUMBER: 34G248 ROVIDER OR SUPPLIER	ROVIDER OR SUPPLIER SWOOD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 guidelines for client #4. Interview with staff D on 8/18/21 verified that client #4 has difficulties during transportation and will exhibit head banging. Interview with the QIDP verified that client #4 has transportation difficulties and the client is required to wear a gait vest connected to a travel harness to ensure safety during transportation. Further interview with the QIDP verified that staff have a hard time getting client #4 to wear shoes, which can often lead to escalating behaviors. The QIDP also verified during the interview that at times staff will stop the van to address client #4's behaviors. Interview with the QIDP confirmed that all of client #4's goals and interventions are current. Interview with the QIDP also confirmed that client #4 could benefit from transportation guidelines to ensure the client's safety during transportation. B. The facility failed to have guidelines to address safety of client #1 relative to wheelchair transfers. For example: Observations in the facility on 8/18/21 at 7:07 AM revealed client #1 to sit at the kitchen table in her wheelchair with no seatbelt or gait belt. Continued observation revealed client #1 to look at staff A and request the staff to bring the client her gait belt from her bedroom. Further observation revealed staff A to walk to client #1's bedroom, to access the client's gait belt and return to the dining room to assist client #1 with putting her gait belt around her waist while the client remained in her wheelchair. Subsequent observation at the group home on 8/18/21 at 8:35 AM revealed all clients to exit the	ROUDER OR SUPPLIER SWOOD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 5 guidelines for client #4. Interview with staff D on 8/18/21 verified that client #4 has difficulties during transportation and will exhibit head banging. Interview with the QIDP verified that client #4 has transportation difficulties and the client is required to wear a gait vest onnected to a travel harness to ensure safety during transportation. Further interview with the QIDP verified that staff have a hard time getting client #4 to wear shoes, which can often lead to escalating behaviors. The QIDP also verified during the interview that at times staff will stop the van to address client #4's behaviors. Interview with the QIDP palso confirmed that all of client #4's goals and interventions are current. Interview with the QIDP also confirmed that client #4's spals and interventions are current. Interview with the QIDP also confirmed that client #4's goals and interventions are current. Subsequent observation revealed staff A to walk to client #1 to look at staff A and request the staff to bring the client her gait belt from her bedroom. Further observation revealed staff A to walk to client #1's bedroom, to access the client's gait belt and return to the dining room to assist client #1 with putting her gait belt around her waist while the client remained in her wheelchair the client part belt and return to the dining room to assist client #1 with putting her gait belt around her waist while the client remained in her wheelchair the client part and the part belt and return to the dining room to assist client #1's bedroom, to access the client's gait belt and return to the dining room to assist client #1 with putting her gait belt around her waist while the client hereafted.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY OMPLETED	
		34G248	B. WING _			08/18/2021	
	ROVIDER OR SUPPLIER SWOOD GROUP HOME		•	STREET ADDRESS, CITY, STATE, ZIP CODE 214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677			
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W 227	observation revealed client #1 with loading attempt a (1) person wheelchair to a seat observation, after int staff C to assist staff of client #1 from her van. Review of records or revealed a nursing not revealed client #1 was emergency room after pelvis and referred to review of nursing not client #1 is using a wassist from wheelchair ecord review for client eport dated 4/7/21 the discussion client #1's cut has decompensated to be wheelchair bous ince pelvic fractures remove her seatbelt wheelchair putting he fracturing a bone. Interview with staff C #1 is a (2) staff trans Interview with the fact disabilities profession revealed client #1 should be wheelchair. Con QIDP verified client with a recent health of with a recent health of the staff of	tional program. Continued I staff C and staff F to assist I the van and staff F to transfer of client #1 from her on the facility van. Further erview with staff C, revealed F with a (2) person transfer wheelchair to a seat in the	W2	227			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G248	B. WING			08/	18/2021
	ROVIDER OR SUPPLIER SWOOD GROUP HOME			STREET ADDRESS, 214 HOLLINGSWO STATESVILLE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 227	#1 is a (2) staff transf	with the QIDP verified client er and client #1 should have transfers although no developed. AM PLAN	W				
	Based on observation failed to assure that of and self-management activity choice and co 4 clients (#1 #2, #3 and Observations in the group of the facility control of the vocations of the vocation	not met as evidenced by: ns and interviews, the facility pportunities for client choice t were offered relative to mmunity integration for 4 of nd #4). The finding is: roup home on 8/18/21 from revealed staff to secure ne facility van to prepare for ional program. Continued staff to assist client #3 into er observation revealed staff client #1 in the facility van via taff identified client #1 did tached to her wheelchair. ealed staff to remove client ir van lift to address ne client's wheelchair. ion revealed staff to have safety strap for client #3 uiring staff to unload client n.					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIAT	5.475
W 247	van. Ongoing observed #2, and #4 to leave the #3 was assisted back to be transported dues strap of the van. At a approximate 2 hour of clients offered the open group home with leist until it was time to be vocational program. Interview with the quaprofessional (QIDP) of clients should not have over an hour and a has seatbelt issues of clief further confirmed that provided the opporture self-management with facility van as staff and client #1's wheelchair PROGRAM IMPLEMI CFR(s): 483.440(d)(1). As soon as the interd formulated a client's it each client must recent reatment program continuous and servand frequency to suppobjectives identified in plan.	wheelchair into a seat on the ration revealed clients #1, he group home while client into the group home unable to issues with the safety ho point during the bservation period were portunity to remain in the are or program engagement transported to the salified intellectual disabilities on 8/18/21 verified that we remained on the van for all while staff addressed and #1 and #3. The QIDP is all clients should have been hity for choice and in regard to staying on the didressed concerns relative to and client #3's safety strap. ENTATION) isciplinary team has individual program plan, ive a continuous active ensisting of needed vices in sufficient number port the achievement of the in the individual program	W:			
	Based on observatio	ns, record review and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, , ,	(X3) DATE SURVEY COMPLETED	
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W 249	sampled clients (#4) treatment program or interventions as identically plan (PCP). The finding Afternoon observations (PCP). The finding Afternoon observations (PCP). The finding Afternoon observations (PCP) are to participate in various period such as crawling others' rooms, tantruing objects at staff and period was client (PCP) and (PCP) are to period was client (PCP) are to period was client (PCP) are to period was client (PCP) are to period was a client (PCP) and (PCP) are to period was a client (PCP). The finding is to period was a client (PCP) are to period was a client (PCP) are to period was a client (PCP) are to period was a client (PCP). The finding is to period was a client (PCP) are to period was a client (PCP) are to period was a client (PCP). The finding is to period was a client (PCP) are to period was a client (PCP) are to period was a client (PCP). The finding is to period was a client (PCP) are to period was a client (PCP). The finding is to period was a client (PCP) are to period was a client (PCP). The finding is to period was a client (PCP) are to period was a client (PCP). The finding is to period was a client (PCP) are to period was a client (PCP). The finding is to period was a client (PCP) are to period was a client (PCP). The finding is to period was a client (PCP) are to period was a client (PCP) are to period was a client (PCP). The finding is to period was a client (PCP) are to period was a client (PCP) are to period was a client (PCP) are to period was a client (P	failed to ensure 1 of 3 received a continuous active onsisting of needed tified in the person centered ng is: Ins in the group home on If to 5:30 PM revealed client arious activities such as cipate in the dinner meal. If the dinner meal is revealed client #4 to exhibit throughout the observation ing on the floor, going into im behaviors and throwing eers. Observations at 5:25 to assist client #4 onto the ride due to escalating int during the observation offered a transition schedule, If objects to help the client activities or to assist with Institute of the group home on If to 8:45 AM revealed client arious activities such as icipate in the breakfast meal. If the group home on If to 8:45 AM revealed client arious activities such as icipate in the breakfast meal. If the group home on If the group home on If to 8:45 AM revealed client arious activities such as icipate in the breakfast meal. If the group home on If to 8:45 AM revealed client arious activities on the group home on If to 8:45 AM revealed client arious activities on the group home on If to 8:45 AM revealed client arious activities on the group home on If to 8:45 AM revealed client arious activities on the group home on If the group home on the group home on If the group home on the group home	W 2-	49			
	period was client #4	offered hand held objects, sition schedule to aid in					

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	ROVIDER OR SUPPLIER SWOOD GROUP HOME			21	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HOLLINGSWOOD DRIVE TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
W 249	revealed a person ce 5/21/21 which include use a TEACCH object routine and follow the Further review of the support plan (BSP) distaff should use object assist client #4 with trearry the objects and Review of the BSP all offer hand held items and to allow for approshould also use a zor safe and signs should client #4 is not allowed communication evaluation.	for client #4 on 8/18/21 Intered plan (PCP) dated and the following programs: to at schedule, tolerate daily a client's assigned schedule. Intered plan (PCP) dated are cord revealed a behavior ated 6/2/21 which indicated ats, pictures and words to ansitions. Staff should also pictures in an apron. Intered plan (PCP) dated Intered plan (PCP)	W	249			
W 287	during transitions. Interview with the quaprofessional (QIDP) of should have utilized at TEACCH object scheet to assist client #4 with deescalating behavior the QIDP verified that and interventions are interview with the QIDS should use client #4's prescribed to maintain behaviors and aid in the MGMT OF INAPPROBEHAVIOR CFR(s): 483.450(b)(3)	dule, pictures and/or words in transitions and irs. Further interview with all of client #4's programs current. Continued DP confirmed that staff a training objectives as in structure, decrease target transition between activities. PRIATE CLIENT	W	287			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G248	B. WING			08/18/2021	
	ROVIDER OR SUPPLIER SWOOD GROUP HOME			2	STREET ADDRESS, CITY, STATE, ZIP CODE 214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 287	Continued From page of staff.	: 11	W	287			
	Based on observation interviews the facility technique to manage not used for the convocients (#1, #2, #3 and Observations in the group home to have (leisure items that included observation to have a personalize "Client #4's leisure clothroughout the 8/17-1 revealed at no time wor unlocked for client Review of records on #3 and #4 revealed conorestriction of imple closets or the restricte Further review of the and #4 did not reveal restricted use of leisure closets of the client #1 and #4 will go "mess with" items in each the qualified intellecture (QIDP) on 8/18/21 verified to all client support redirection with facility QIDP control of the control of the control of the facility QIDP control of the control	roup home revealed the 2) locked closets with uded games and books. n revealed (1) leisure closet d sign on the door that read oset". Further observation 8/21 survey observations ere the leisure closets used use. 8/18/21 for clients #1, #2, urrent habilitation plans with menting a lock on leisure ed use of leisure items. record for clients #1, #2, #3 consents relative to the					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	34G248	B. WING	B. WING		08/18/2021	
NAME OF PROVIDER OR SUPPLIER HOLLINGSWOOD GROUP HOME		•	2	14 HOLLINGSWOOD DRIVE		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			*		(X5) COMPLETION DATE
CFR(s): 483.470(g)(2 The facility must furni and teach clients to u choices about the use hearing and other cor and other devices ide interdisciplinary team	sh, maintain in good repair, se and to make informed e of dentures, eyeglasses, mmunications aids, braces, entified by the as needed by the client.	W	436			
interview, the facility to equipment was furnis with client needs for 2 and #2). The findings A. The facility failed to client #1 had a seatbo	failed to ensure adaptive hed or used in accordance of 4 sampled clients (#1 s are: of ensure the wheelchair for elt or footrests to support the					
8/17-18/21 survey revaround the group hon wheelchair. Observarevealed client #1 to swheelchair with no se Observation of client left seatbelt strap to holient's wheelchair and missing. Subsequent throughout the mornin #1's feet to protrude of frames as the client winto different areas of Observation at the group wheelchair substitution of the seatbelt strap to holient's wheelchair and missing. Subsequent throughout the mornin #1's feet to protrude of the seatbelt strap to holient with the seatbelt substitution of the seatbelt strap to holient substitution of the seatbelt substitution of th	vealed client #1 to move ne with a manual tion on 8/18/21 at 7:07 AM sit at the kitchen table in her eatbelt or foot rests. #1's wheelchair revealed the tang to the back of the d the right strap to be t observation of client #1 ng of 8/18/21 revealed client but and to hit various door vas assisted with propelling the group home.					
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR IN SPACE AND EQUIPM CFR(s): 483.470(g)(2) The facility must furniand teach clients to use hearing and other corand other devices ide interdisciplinary teams. This STANDARD is represented by the service of the client of the service of the client. The service of the client of the service of the servic	SWOOD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ROVIDER OR SUPPLIER SWOOD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure adaptive equipment was furnished or used in accordance with client needs for 2 of 4 sampled clients (#1 and #2). The findings are: A. The facility failed to ensure the wheelchair for client #1 had a seatbelt or footrests to support the safety of the client. The finding is: Observations of client #1 throughout the 8/17-18/21 survey revealed client #1 to move around the group home with a manual wheelchair. Observation on 8/18/21 at 7:07 AM revealed client #1 to sit at the kitchen table in her wheelchair with no seatbelt or foot rests. Observation of client #1's wheelchair revealed the left seatbelt strap to hang to the back of the client's wheelchair and the right strap to be missing. Subsequent observation of client #1 throughout the morning of 8/18/21 revealed client #1's feet to protrude out and to hit various door frames as the client was assisted with propelling into different areas of the group home. Observation at the group home on 8/18/21 at	ROVIDER OR SUPPLIER SWOOD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure adaptive equipment was furnished or used in accordance with client needs for 2 of 4 sampled clients (#1 and #2). 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Observation at the group home on 8/18/21 at	ROWIDER OR SUPPLIER SWOOD GROUP HOME SUMMARY STATEMENT OF DETICIENCIES (RACH DEPOCINE) SUMMARY STATEMENT OF DETICIENCIES (RACH DEPOCINE) (RACH DEPOCINEY WILLST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure adaptive equipment was furnished or used in accordance with client needs for 2 of 4 sampled clients (#1 and #2). The findings are: A. The facility failed to ensure the wheelchair for client #1 thad a seatbel or footrests to support the safety of the client. Thindings is: Observations of client #1 throughout the 8/17-18/21 survey revealed client #1 to move around the group home with a manual wheelchair. Observation on 8/18/21 at 2.707 AM revealed client #1 to still at the kitchen table in her wheelchair with no seatbelt or foot rests. Observation of client #1 swheelchair revealed the left seatbelt strap to hang to the back of the client's wheelchair and the right strap to be missing. Subsequent observation of client #1 throughout the morning of 9/18/21 revealed client #1 for foot rests. Observation the morning of 9/18/21 revealed client #1 throughout the morning of 9/18/21 revealed client #1 for foot rests. Observation the morning of 9/18/21 revealed client #1 footrests. Observation the morning of 9/18/21 revealed client #1 footrests. Observation at the group home. Observation at the group home on 8/18/21 at	A BUILDING 346248 B. WING WASTREET ADDRESS, CITY, STATE, 2IP CODE 214 HOLLINGSWOOD DRIVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) SPACE AND EQUIPMENT CFR(s): 483 470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure adaptive equipment was furnished or used in accordance with client needs for 2 of 4 sampled clients (#1 and #2). The findings are: A. The facility failed to ensure the wheelchair for client #1 to a seatbelt or footrests to support the safety of the client. #1 throughout the B177-18/21 survey revealed client #1 to move around the group home with a manual wheelchair. Observation on 8/18/21 at 17.07 AM reveated client #1 to sharp to be missing. Subsequent observation of client #1 throughout the morning of 8/18/21 revealed client #1 th

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 08/18/2021	
		34G248 B. WI					
NAME OF PROVIDER OR SUPPLIER HOLLINGSWOOD GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677		00/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
W 436	transport to the voobservation reveal client #1 with loading the surveyor verified belt for her wheeled revealed staff C to lift and to report clievan lift without a season subsequent observation throughout the van lift to get on observation through the van lift t	ding the facility van for cational program. Continued ed staff C and staff F to assist ng the van lift until interview by ed client #1 did not have seat hair. Further observation remove client #1 from the van ent #1 was unable to use the eatbelt due to safety concerns. vation revealed nursing staff to ne and to add a seatbelt to ne are that allowed client #1 to use not the facility van. Additional shout the process of client #1 van revealed no footrests to be chair. for client #1 on 8/18/21 person centered plan (PCP) continued review of records for a nursing note dated 12/30/20 to #1 was sent to the local after a behavior; diagnosed with the review of nursing notes (20 client #1 is using a person assist from wheelchair Subsequent record review for a mini-team report dated 4/7/21 eam met to discuss client #1's	W	436			

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		34G248	B. WING _			08/	18/2021
NAME OF PROVIDER OR SUPPLIER HOLLINGSWOOD GROUP HOME			2	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HOLLINGSWOOD DRIVE TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE	
W 436	wheelchair due to a ri interview with the QIE be using footrests on loading the van or got support safety of the feet. Interview with the footrests for client #1 was unsure why they the survey period. B. The facility failed the equipment for client #5 For example: Observations through revealed client #2 to warm and and the with the use observations in the graph of the wash cloth to address. Review of records for revealed a PCP dated current PCP revealed moderate intellectual explosive disorder and adaptive equipment in a brace on arm during AFO's during awake I needed and a wheeld review of an occupation assessment for client left elbow splint is need contractures 2 times (Continued review of the contracture of the contract	It on when sitting in her sk of falls. Continued of verified client #1 should her wheelchair when ing out into the community to client with positioning of her ne QIDP further revealed had been furnished and she had not been used during o ensure adaptive 22 was used as prescribed. out the 8/17-18/21 survey wear bi-lateral AFO's and to se of a quad cane. Continued out home on 8/17/21 and to time did client #2 wear and splint or to hold a rolled as contractures. client #2 on 8/18/21 dr/9/21. A review of the a diagnosis history of disability, intermittent decrebral palsy with eeds for client #2 to include gawake hours, bilateral nours, a quad cane as hair for extended outings. A conal therapy (OT) #2 dated 8/3/20 revealed a eded to prevent further daily, 2 hours each day. The other was presented a set splint is needed 2 times	W	136			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G248	B. WING		0	8/18/2021	
NAME OF PROVIDER OR SUPPLIER HOLLINGSWOOD GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677			
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W 436	washcloth in her han Subsequent record rewars a brace on her Additional review of r 8/18/21 revealed a vi Review of the curren diagnosis of glaucomprescription for glass Interview with the QII client #2 has an arm wearing the brace as interview with the QII 8/18/21 verified it wa arm brace was locate the nursing office and it on the current surv with the QIDP verified and when client #2 is the client should be hin her left hand. Interview with the factient #2 was furnished wearing her eyeglass Continued interview revealed client #2 has broken (on the current was not verified and	the client keeps a rolled up d during waking hours. eview revealed client #2 rarm during the day. ecords for client #2 on sion consult dated 12/29/20. It vision consult revealed a rar, myopia and astigmatism; es provided. DP on 8/18/21 revealed brace and should be prescribed. Continued DP and facility nurse on s unknown where client #2's red as it could not be found in distaff were unable to locate rey date. Further interview dictient #2 has a hand splint is not wearing the hand splint, holding a rolled up washcloth cellity nurse on 8/18/21 verified red glasses and should be see as prescribed.	W 43				