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	DHSR - Mental Health JUN 14 2021 Lic. & Cert. Section	

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

Program Mgr | 6/7/21

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.

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

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W 249	Continued From page 1 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.	W 249	1. RN will inservice all staff on the proper way to give medications (Name of medicine purpose of medicine, and side effect of medicine) 6/11/21 2. Clinical Supervisor will inservice all staff on medication administration programs (how to run & document) 6/11/21 3. Home Supervisor and Clinical Supervisor will complete observations on a weekly basis to ensure programs are being ran, name of medicines, purpose of medicine, and side effects of medicines are being given. 6/11/21 & ongoing	

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	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		

Community Alternatives of NC

301 10th Street NW, Suite B101
Conover NC 28163
Phone: 828/466-6023 Fax: 828/466-6025

June 7, 2021

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

Dear Ms. Holder-Hansen

Please find the enclosed Plan of Correction for the deficiencies cited during the annual survey at Wooding Place in Kings Mountain NC. Hopefully our corrections will be acceptable. Please accept our invitation to return to our facility on July 24, 2021 to follow up and ensure compliance. If you have any questions please contact me either via email at tfinger@rescare.com or office phone 828-466-6023 or by cell phone at 704-349-2376. Thank you

Sincerely,

Tracey Norris, QIDP
Program Manager

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

June 4, 2021

Mr. Mike Penland, Facility Administrator
Community Alternatives of North Carolina
301 10th Street NW, Suite B 101
Conover, NC 28613

Re: Recertification Completed 5/25/2021
Wooding Place Group Home 112 Wooding Place, Kings Mountain NC 28086
Provider Number #34G341
MHL# 023-150
E-mail Address: mpenland@rescare.com

Dear Mr. Penland:

Thank you for the cooperation and courtesy extended during the recertification survey completed May 25, 2021. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is July 24, 2021.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- 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) via email.***

Send the original 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

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

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) 750-2702.

Sincerely,

Shyluer Holder-Hansen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: QM@partnersbhm.org