

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

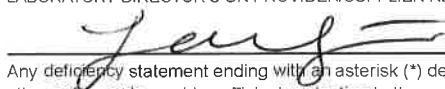
PRINTED: 07/09/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>WILHELM PLACE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>630 WILHELM PLACE CONCORD, NC 28026</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 249	<p><b>PROGRAM IMPLEMENTATION</b> CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure clients received a continuous active treatment program consisting of needed interventions as identified in the plan of care (POC) for 2 of 3 sampled clients (#2, # 3). The findings are:</p> <p>A. The facility failed to utilize the hand splint guidelines for client #3 as prescribed. For example:</p> <p>Afternoon observations throughout the group home on 6/30/21 from 4:30pm to 6:00pm revealed client #3 to participate in various activities including games and outdoor activities. Client #3 was not observed to wear a hand splint on either the right or left hand during survey observations. Subsequent observation in the group home on 7/1/21 from 7:00 AM to 9:00 AM revealed client #3 to participate in various activities without wearing a splint on either the right or left hand.</p>	W 249	<p>A. Staff to be re-inserviced on all adaptive equipment wearing schedules.</p> <p>Monitoring of equipment schedules by: GHD Weekly QA Monthly QIDP Quareterly</p>	9/1/2021

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

TITLE

(X6) DATE



**QIDP**

**7/15/21**

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: 07/09/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>WILHELM PLACE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>630 WILHELM PLACE CONCORD, NC 28026</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 249	Continued From page 1  Review of records on 7/1/21 for client #3 revealed a plan of care (POC) dated 2/19/21 which indicated that client #3 has the following adaptive equipment: elbow splint, hand splints, wheel chair, tech talk, lpad, and a marissa electric lift. Further review of the record for client #3 revealed hand splint guidelines dated 6/6/14, which indicated that client #3 should wear both splints at the same time, during all waking hours and between meals and baths. Review of the occupational therapy evaluation dated 12/22/20 indicated that client #3 should continue to use bilateral forearm-based splints with hand and thumb support with the current wearing schedule of all waking hours between meals and baths.  Interview with the facility nurse on 7/1/21 verified that client #3 should consistently wear prescribed hand splints according to the hand splint guidelines and doctor's orders. Interview with the Home Manager (HM) on 7/1/21 verified that client #3 does not like to wear the prescribed hand splints. Continued interview with the HM confirmed that staff should follow the hand splint guidelines according to guidelines as directed by the physician.  Interview with the qualified intellectual disabilities professional (QIDP) on 7/1/21 verified that client #3 should be wearing her hand splints according to medical orders. Continued interview with the QIDP verified that all of client #3's goals and interventions are current. Further interview with the QIDP confirmed that client #3 should wear her hand splints as prescribed to assist with hand and thumb support.	W 249			

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

PRINTED: 07/09/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>WILHELM PLACE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>630 WILHELM PLACE CONCORD, NC 28026</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 249	<p>Continued From page 2</p> <p>B. The facility failed to provide adequate active treatment to engage client #2 during large amounts of unstructured time. For example:</p> <p>Afternoon observations throughout the group home on 6/30/21 at 4:30 PM revealed client #2 to remain in his bedroom with the door closed for 50 minutes of observations. Continued observation of client #2 at 5:23 PM revealed the client to walk into the dining room with the assistance of a walker. Further observation of client #2 at 5:30 PM revealed the client to enter the kitchen, pour his beverages, microwave his dinner and take all meal items to the dining room table using a bin on the walker. At no point during the observation period was staff observed to offer client #2 activities outside of his room.</p> <p>Morning observations throughout the group home on 7/1/21 at 6:50 AM revealed client #2 to remain in his bedroom with the door closed for 60 minutes of observations. Continued observation of client #2 at 7:54 AM revealed the client to walk in the dining room dressed for the day. Further observation at 8:00 AM revealed the client to prepare and eat his breakfast meal. Subsequent observations at 8:29 AM revealed client #2 to go to the medication room for medication administration. At no point during the observation period was staff observed to offer client #2 activities outside of his room.</p> <p>Review of records for client #2 on 7/1/21 revealed a POC dated 6/19/20. Review of the ISP dated 6/19/20 revealed client #2 to have program goals for group exercise, to sit up straight/tall in the wheel chair (WC) while looking into a mirror to strengthen core muscles and posture, to use a</p>	W 249	<p>B. Staff to be re-inserviced on engaging clients in activities that support the client connecting with peers and staff.</p> <p>Quality Assurance checks done by: GHD Weekly QA Monthly QIDP Quarterly</p>	9/1/2021	

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

PRINTED: 07/09/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>WILHELM PLACE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>630 WILHELM PLACE CONCORD, NC 28026</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 249	Continued From page 3 calculator, improve social skills, to complete 3 personal hygiene tasks, and a communication goal. Continued review of record for client #2 revealed a Behavior Support Program (BSP) dated 5/1/21. Review of the BSP dated 5/2021 revealed client #2's target behaviors of inappropriate use of electronics and inappropriate use of social media. Further review of records for client #2 on 7/1/21 revealed interventions for the target behaviors to indicate the need to encourage the client to spend time out of his bedroom, engaged in non-computer activities to support the client connecting with his peers and staff.  Interview with the QIDP on 7/1/21 revealed client #2 has a history of posting sexually inappropriate pictures on social media and talking to scammers through the computer. Continued interview with the QIDP verified client #2 can participate in meaningful activities in the home and can have access to a computer in other areas of the home. Further interview with the QIDP confirmed client #2's BSP is current and should be followed as prescribed.	W 249			