

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

PRINTED: 04/20/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/13/2022</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>DAL-WAN HEIGHTS GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>748 SHARON DR. STATESVILLE, NC 28677</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, interviews and record reviews, the facility failed to ensure 3 of 4 sampled clients (#2, #4 and #6) received a continuous active treatment program consisting of needed interventions as identified in their person centered plans (PCPs) relative to communication. The findings are:</p> <p>A. The team failed to ensure a program objective relative to communication was implemented in sufficient frequency to support the need of client #2. For example:</p> <p>Observation in the group home throughout the 4/12/22 - 4/13/22 survey revealed client #2 to participate in various activities in the group home to include leisure activities, participating in meal preparation and medication administration. At various times during survey observations on 4/12-13/2022 client #2 was observed to verbally make loud verbal gestures at staff to which staff would verbally respond.</p> <p>Review of records for client #2 on 4/13/22 revealed a PCP dated 7/8/21. Review of current</p>	W 249		
-------	---	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/13/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>DAL-WAN HEIGHTS GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>748 SHARON DR. STATESVILLE, NC 28677</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 1</p> <p>training objectives of the 7/21 PCP for client #2 revealed a communication program implemented 10/11/21. Review of client #2's communication program revealed the client will after a model will utilize her communication picture book an average of 90% of opportunities for 2 consecutive months.</p> <p>Continued review of the communication program for client #2 revealed the program was to be implemented during the client's daily routine and to target choices for mealtime and leisure. Review of program directions revealed staff will provide the opportunity to use the communication book to allow client #2 to expressively request items or activities; they will gesture towards or hand the client the book when appropriate. Further review revealed the trainer will involve the client in an interaction and open the book to an appropriate page.</p> <p>Interview with the qualified intellectual developmental professional QIDP on 4/13/22 verified client #2 has a current communication program. Continued interview with the QIDP verified client #2's communication program should have been implemented as written to support the client's communication needs.</p> <p>B. The team failed to ensure a program objective relative to communication was implemented in sufficient frequency to support the need of client #4. For example:</p> <p>Observation in the group home throughout the 4/12/22 - 4/13/22 survey revealed client #4 to participate in various activities in the group home to include leisure activities, exercise, participating in setting the table, eating meals, chores, laundry</p>	W 249			

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

PRINTED: 04/20/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/13/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>DAL-WAN HEIGHTS GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>748 SHARON DR. STATESVILLE, NC 28677</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 and medication administration. At various times during survey observations on 4/12-13/2022 client #4 was observed to complete tasks following verbal request from staff.</p> <p>Review of records for client #4 on 4/13/22 revealed a PCP dated 10/26/21. Review of current training objectives of the 10/21 PCP for client #4 revealed a communication program implemented 1/20/21. Review of client #4's communication program revealed the client will complete the TEACCH schedule with 95% accuracy for 2 consecutive months.</p> <p>Continued review of the communication program for client #4 revealed staff should encourage the client to utilize the communication book across all settings. Staff should also respond to and reinforce the use of manual signing, utilize symbols in the communication picture book and provide the TEACCH schedule during the daily routine.</p> <p>Interview with the QIDP on 4/13/22 verified client #4 has a current communication program. Continued interview with the QIDP verified client #4's communication program should have been implemented as written to support the client's communication needs.</p> <p>C. The team failed to ensure a program objective relative to communication was implemented in sufficient frequency to support the need of client #6. For example:</p> <p>Observation in the group home throughout the 4/12/22 - 4/13/22 survey revealed client #6 to participate in various activities in the group home</p>	W 249			

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

PRINTED: 04/20/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G086</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/13/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>DAL-WAN HEIGHTS GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>748 SHARON DR. STATESVILLE, NC 28677</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 3</p> <p>to include leisure activities, eating meals, taking dishes to the kitchen and medication administration. At various times during survey observations on 4/12-13/2022 client #4 was observed to verbally scream or make loud verbal gestures at staff to which staff would verbally respond "It's okay and calm down" followed by verbal request to complete tasks.</p> <p>Review of records for client #6 on 4/13/22 revealed a PCP dated 7/19/21. Review of current training objectives of the 7/21 PCP for client #4 revealed a communication program implemented 1/20/21. Review of client #4's communication program revealed the client will go to the designated activity/location when presented with a picture paired with a gesture prompt with 90% accuracy for 2 consecutive months.</p> <p>Continued review of the communication program for client #4 revealed the program was to be implemented during appropriate times throughout the client's schedules. Review of program directions revealed staff will carry the book containing the pictures and provide the client the opportunity for transition from one activity to the next by giving the client a cue in the form of a picture paired with a gestured cue.</p> <p>Interview with the QIDP on 4/13/22 verified client #6 communication program is current. Continued interview with the QIDP verified client #6's communication program should have been implemented as written to support the client's communication needs.</p>	W 249			