PRINTED: 11/26/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) BROWN SERVICES			OMB NO. 093
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVE COMPLETED
	34G341	B. WING		R
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/18/202
WOODING PLACE GROUP HOM	-		112 WOODING PLACE	
	-		KINGS MOUNTAIN, NC 28086	
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES	ID		
PREFIX (EACH DEFICIEN TAG REGULATORY OR	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D.BE COMPI
W 000 INITIAL COMMENTS	S	W 00	0	
for all previous defici 2024. A total of 6 of 3 as the facility did not documentation as de correction (POC) sub	cted on November 18, 2024 encies cited on July 31, 7 deficiencies were re-cited provide supporting escribed in the plan of emitted. The facility remains			
out of compliance. (W 159) QIDP				
CFR(s): 483.430(a)		{W 159]		
qualified intellectual of This STANDARD is r Based on interview a facility failed to ensure disabilities profession, integrated, and monite	ed and monitored by a lisability professional who- not met as evidenced by: and record verification, the the qualified intellectual al (QIDP) coordinated, bred the changing health tranent of 1 of 3 sampled ag is:		Pm will in-service QP on properly document individuals care and properly document hospital stays, critical incidents and chin health status. PM will monitor month and other documentation to ensure that site is provided	anges
survey from 7/30/24-7. have five hospitalization Continued review reve hospitalizations and/or (ED) visits on the follor	emergency department		Со	mpleted by 12/18/2
review of the record re	vealed client #5 to have the		RECEIVED	
following diagnoses: u	rinary tract infection (UTI),			
to LITI with hematuria	rulent drainage, sepsis due colostomy due to bowel		DEC 9 2024	
obstruction, acute kidn anemia, hyponatremia, deficiency. Review of	ey injury, dehydration, and vitamin B12 the record did not reveal confirm monitoring, follow		DHSR-MH Licensure Se	ect
ATORY DIRECTORIS OF PROVIDENCE	PPLIER REPRESENTATIVE'S SIGNATURE		TITLE	

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 pian 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.

Chris Childers

**Program Manager** 

12/4/2024

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB	NO. 0938-039
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION		OMPLETED
		34G341	B. WING _			R
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	11/18/2024
WOODI	NG PLACE GROUP HON	IE.		112 WOODING PLACE	0002	
				KINGS MOUNTAIN, NC 28086		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID			
PREFIX TAG	(EACH DEFICIE!	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{W 159	Continued From page	ge 1	{W 159	O)		
	training, or core tea	m meetings to discuss the	(** 10.	9)		
	client's medical state	us change.				
	Interview with the Pr	rogram Manager (PM) on				
	7/31/24 revealed the	at the facility has not had a full				
	time QIDP for at least	st four months. Continued				
	interview with the PI	M indicated that he was filling				
	in as the interim QID	P for this facility along with				
	other facilities. Furth	her interview with the PM				
	verified that there ha	eve been no team meetings				
	change in health stor	an relative to client #5's				
	the PM verified that i	tus. Additional interview with QIDP documentation relative				
		ng health needs were not				
	completed relative to	the client's multiple				
	hospitalizations. Inter	rview with the PM also				
	revealed that there w	as no documented QIDP				
	follow-up for any hos	pital discharge				
	recommendations for	r services, program				
	implementation, in-se	ervice training, or receiving				
	appropriate personal	care in a timely manner				FEE .
	relative to the client's	changing medical needs.				
	A revisit was complete	ed on 11/18/24 to review the				
	plan of correction (PC	OC) and supporting				
	documentation. It is in	mportant to mention that the				
	client is currently in th	ne hospital on 11/18/24 for a				
	UTI. There was no ev	ridence of QIDP follow up for				
	the client's changing					
		ess the client's change in				
141040	health status.					
W 210}	INDIVIDUAL PROGRACER(s): 483.440(c)(3)		{W 210}			
	Within 30 days after a	dmission, the				
	interdisciplinary team	must perform accurate				
	assessments or reass	essments as needed to				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES	THE TOTAL OF THE STATE OF THE S			OMB NO. 0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G341	B. WING		R
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/18/2024
WOODIN				112 WOODING PLACE	
WOODIN	G PLACE GROUP HON	1E			
(VA) ID	CHRARADV	OTATEMENT OF THE PARTY OF THE P		KINGS MOUNTAIN, NC 28086	
PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D RE COMPLETION
(W 210)	Continued From pa	ne 2	041.040		
		liminary evaluation conducted	{W 210]	}	
	prior to admission.	innitiary evaluation conducted			
		s not met as evidenced by:			
	Based on record re	view and interview, the facility		Die OD LIG III	
	failed to ensure nee	ded assessments for 1		PM, QP, HS will ensure that all appointme	ents and
		were completed within 30		assessments for new individuals are comin a 30 day time period after admission. P	Deted
	days after admission	n. The findings are:		monitor all new admissions to ensure that	IIIW IVI
				assessments are completed within the 30	
		of client #3's record revealed			any poned
	an individual suppor	t plan (ISP) dated 12/29/23			Completed by 12/18/24
		ate of 12/28/23. Continued			
	review revealed a di	agnosis to include			
	schizoaffective disor	der, bipolar type,			
	hobovioral disturbes	pecified dementia with			
		ce, unspecified urinary tial primary hypertension,			
	peripheral vascular o	discoss upspecified			
	intellectual disabilitie	e anviety disorder			
		lisorder, unspecified heart			
	failure.	and an appearance receive			
	Further review revea	led a behavior support plan			
	(BSP) consent for me	edications and targeted			
		hysical aggression, verbal			
		destruction, noncompliance			
		ts. Subsequent review			
		m dated 6/19/24, nursing			
		ted 1/5/24, labs completed			
	2/21/24, physical con	dated 7/29/24. Additional			
		a BSP or guidelines, a			
		one scheduled for 11/14/24,			
	physical therapy (PT)	, or occupational therapy			
	(OT) evaluations.	, and any			
	Interview on 7/31/24	with the interim qualified			
		professional (QIDP) and			
1	home manager (HM)	verified that current			
	assessments for clien	t #3 which includes a BSP,			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	<u> 139</u>
		34G341	B. WING _		R	
	PROVIDER OR SUPPLIER  IG PLACE GROUP HOMI	E .		STREET ADDRESS, CITY, STATE, ZIP CODE 112 WOODING PLACE KINGS MOUNTAIN, NC 28086	11/18/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE	ION
{W 210}	during survey for rev revealed that all asso completed within 30 clients.	evaluation were not available riew. Further interview essments should be days after admission for all	{W 210	0}		
{W 218}	plan of correction (Podocumentation. Then	e was no supporting ded according to the POC				
	CFR(s): 483.440(c)(3 The comprehensive finclude sensorimotor This STANDARD is r The facility failed to a assessment for 2 of 4 #5) was obtained as a record verification. Th A. The facility failed to assessments were co Review of client #4's i dated 8/15/23 reveale IDD, Spastic quadriple disorder and in turned	unctional assessment must development. not met as evidenced by: assure a prescribed sampled clients (#4 and evidenced by interview and er findings are: assure OT and PT mpleted for client #4. Individual support plan (ISP) d a diagnosis of severe egic cerebral palsy, anxiety right foot. Continued	{W 218	PM Nurse, QP, HS will ensure that all PT/OT are completed for each individual in the home a 30 day time frame after admission or on a ybasis. PM, Nurse, and QP will monitor PT/OT to ensure that PT/OT needs are met for each	e within yearly Fevaluations	
	four wheeled walker w and eyeglasses. Furth referral note dated 7/8 have an annual physic (PT)/occupational ther Subsequent review rev	/14 the need for client #5 to cal therapy app (OT) assessment. //ealed the last PT //ealed 1/13/15 and an OT				

The second secon		NIEDICAID SERVICES			OMB N	O. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY PLETED	
NAME OF		34G341	B. WING	-	11	R /18/2024
NAME OF	PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZIP COL	DE	7.07.02.4
WOODIN	IG PLACE GROUP HOMI	=		112 WOODING PLACE		
				KINGS MOUNTAIN, NC 28086		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
(W 218)	Continued From pag	e 4	{W 21	B}		
	developmental profemanager (HM) verifiefor client #4 had not 7/31/24 survey.  B. The facility failed trassessments were control disorder, professor in the professor in the control disorder, professor in the professor in the control disorder, professor in the control disorder.	individual support plan (ISP) sled a diagnosis of impulsive bund IDD, neurogenic				
	bladder NOS, infantili- spastic quadreplegia, and seizure disorder. adaptive equipment to high sided dish, whee chair, communication Further review reveal	e TP, hyperthyroidism, dysphasia, mild cataracts, Continued review revealed o include built up utensils, elchair, hoyer lift, shower board, and hospital bed. ed the last PT assessment			Completed by	12/18/24
	needed assessments completed as of the 7.  A revisit was complete plan of correction (PO documentation. It is in client #5 is currently in	ed on 11/18/24 to review the IC) and supporting apportant to mention that a the hospital on 11/18/24 documentation was not				
(W 288)	MGMT OF INAPPROF BEHAVIOR CFR(s): 483.450(b)(3)	PRIATE CLIENT	(W 288)			
	Techniques to manage	inappropriate client				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/26/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 34G341 B. WING 11/18/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 112 WOODING PLACE **WOODING PLACE GROUP HOME** KINGS MOUNTAIN, NC 28086 SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {W 288} Continued From page 5 (W 288) behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on record review and interviews, the PM, QP, will ensure that all Behavior Support Plans for each facility failed to ensure that all interventions to individual are completed, reviewed, and signed in an appropriate and timely manner. PM and QP will monitor each BSP to ensure manage inappropriate behavior were that they are signed and remain appropriate for each individual incorporated into a behavior support plan (BSP) for 6 of 6 clients (#1, #2, #3, #4, #5, #6). The findings are: Completed by 12/18/24 A. Review of records on 7/31/24 for client #3 revealed an informed consent signed by the legal guardian and human rights committee dated 12/29/23. Continued review revealed client #3's BSP consent to address behavior management and prescribed medications; Divalproex 500mg, Divalproex 100mg, Fanapt 4mg, Quetiapine 50mg, Trazodone 100mg, and Hydroxyn 25mg. Further review did not reveal a BSP to address targeted behaviors of physical aggression, verbal aggression, property destruction, non compliance, and untrue statements. Interview on 7/31/24 with the interim qualified intellectual developmental professional (QIDP) revealed that client #3 did not have a BSP. Continued interview revealed that the team had not started the process to complete a BSP for client #3. Further interview with the QIDP also revealed that client #3 is in need of a BSP for interventions and prescribed medications relative to behavior management. B. Review of records on 7/31/24 for client #1 PM, QP, will ensure that all Behavior Support Plans for each revealed a BSP dated 1/15/23. Continued review individual are completed, reviewed, and signed in an appropriate did not reveal an updated BSP to address and timely manner. PM and QP will monitor each BSP to ensure

interventions and prescribed medications relative

to client's behavior management.

that they are signed and remain appropriate for each individual

Completed by 12/18/24

STATEMENT	OF DEFICIENCIES	AND PROPERTY OF THE PROPERTY O			OMB NO. 0938-03
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		34G341	B. WING		R
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/18/2024
WOODING	0.00 4.00 000			112 WOODING PLACE	
MOODING	G PLACE GROUP HON	IE .			
(X4) ID	SUMMARY	OTATELERIT OF SETIMENT		KINGS MOUNTAIN, NC 28086	
PREFIX	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OUR DRE COMPLETIO
(W 288)	Continued From page	ge 6	{W 288		
		4 with the QIDP revealed	{VV ZOC	2)	
	client #1's BSP have	e not been updated due to the			
	absence of a behav	ior specialist and contractor to			
	complete or update	client's BSP.			
	C. Review of record	s on 7/31/24 for client #2			
	revealed a BSP date	ed 6/15/22. Continued review		PM, QP, will ensure that all Behavior Suppo	et Plans for each
	did not reveal an uni	dated BSP to address		individual are completed, reviewed, and sign	ned in an appropriate
	interventions and pro	escribed medications relative		and timely manner. PM and QP will monitor	each BSP to ensure
	to client's behavior n			that they are signed and remain appropriate	for each individual
		<b>3</b>			Completed by 12/18/24
	Interview on 7/31/24	with the QIDP revealed			
	client #2's BSP have	not been updated due to the			
	absence of a behavior	or specialist and contractor to			
	complete or update of	client's BSP.			
	D. Review of records	on 7/31/24 for client #4			
	revealed a BSP date	d 8/15/22. Continued review		PM, QP, will ensure that all Behavior Support	Diameters
	did not reveal an upd	lated BSP to address		individual are completed, reviewed, and signe	r Hans for each
	interventions and pre	escribed medications relative		and timely manner. PM and QP will monitor e	ach BSP to ensure
	to client's behavior m	nanagement.		that they are signed and remain appropriate f	or each individual
	Interview on 7/31/24	with the QIDP revealed			Completed by 12/18/24
	client #4's BSP have	not been updated due to the			
	absence of a behavio	or specialist and contractor to			
	complete or update c	lient's BSP.			
1	E. Review of records	on 7/31/24 for client #5			
		12/14/22. Continued		PM, QP, will ensure that all Behavior Support	Plans for each
		an updated BSP to address		individual are completed, reviewed, and signe-	d in an appropriate
i	nterventions and pres	scribed medications relative		and timely manner. PM and QP will monitor ea that they are signed and remain appropriate for	ach BSP to ensure
t	o client's behavior ma	anagement.			A COULTIGUESI
1	nterview on 7/31/24 v	with the QIDP revealed		Co	ompleted by 12/18/24
		not been updated due to the			
8	bsence of a behavior	r specialist and contractor to			
	omplete or update cli				
	Boulow of specials	on 7/31/24 for alignt #6			

ATATEL		L MEDIOAID GERVICES			OMB NO. 093	38-0391
AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVE COMPLETED	
		34G341	B. WING		R	
NAME OF	PROVIDER OR SUPPLIER	340341	D. WING		11/18/20	124
				STREET ADDRESS, CITY, STATE, ZIP CO	DE	
WOODIN	G PLACE GROUP HOM	E		112 WOODING PLACE		
				KINGS MOUNTAIN, NC 28086		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMP EAPPROPRIATE D	(X5) PLETION DATE
(W 288)	Continued From pag	ne 7	044.004			
		ed 1/15/23. Continued review	{W 288	3}		
	did not reveal an un	dated BSP to address		PM, QP, will ensure that all Behavior S	Support Plans for each	
	interventions and or	escribed medications relative		individual are completed, reviewed, an	d signed in an appropriate	
	to client's behavior r	nanagement.		and timely manner. PM and QP will me that they are signed and remain appro-	initor each BSP to ensure priate for each individual	
	Interview on 7/31/24	with the QIDP revealed				
		not been updated due to the			Completed by 12	2/18/24
	absence of a behavi	or specialist and contractor to				
	complete or update	client's BSP.				
	A revisit was comple	ted on 11/18/24 to review the				
	plan of correction (POC) and supporting documentation. It is important to mention that					
	documentation. It is i	important to mention that				
	for a LITI Supporting	in the hospital on 11/18/24				
		documentation was not to the POC submitted.				
(W 331)	NURSING SERVICE					
(44 00 1)	CFR(s): 483.460(c)	5	(W 331)			
		ride clients with nursing				
	Services in accordance					
		not met as evidenced by: and record verification,		PM, Nurse, QP, and HS will in-service all staff of medical med		
		d to provide staff training to		of medical needs of individuals in the home as changes and how to properly document each in	cident. PM, Nurse,	
	address the clients of	nanging medical needs for 1		and QP will monitor documentation and provide		1
	of 3 sampled clients (			to ensure that any medical changes are properl and care is provided	/ documented	
	Review of the record	on 7/31/24 for client #5			Completed by 12/18/24	
	revealed several hosp	oitalizations from				
		inued review of the medical				
		rified the following ED visits				
	and/or hospitalization	s: 1/10/24, 1/26/24, 3/22/24,				
		Further review of the				
		ed client #5 to have the				
		uring the hospitalizations:				
		(UTI), pressure sores with				
	purulent drainage, ser					
	nematuria, colostomy	due to bowel obstruction,				

		MEDICAID SERVICES			OMB	NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER  WOODING PLACE GROUP HOME		I WITH THE THE PARTY OF THE PAR		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G341	B. WING		R 11/18/2024	
			STREET ADDRESS, CITY, STATE, ZIP CO 112 WOODING PLACE KINGS MOUNTAIN, NC 28086	DE	11/10/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
(W 331)	acute kidney injury, s malnutrition, dehydra and vitamin b12 defid	severe protein-calorie tion, anemia, hyponatremia, ciency.	{W 331	)		
	discharge summary of following recommend two hours to eliminate face assessment of client's return to the face assessment and treatment nursing assessment. Client #5 did not reveal interventions, vital sig staff upon discharge the record also did not not the staff upon discharge the record also did not the staff upon discharge the record also did not the staff upon discharge the record also did not the staff upon discharge the record also did not the staff upon discharge the staff upon disch	of the most current hospital dated 6/13/24 revealed the dations: repositioning every a pressure sores, face to consumer within 24 hours of acility, review of discharge plan, post-inpatient stay Review of the record for all repositioning guidelines, ns, or in-service training for from the hospital. Review of the reveal core team meetings changing medical needs.				
	has not been docume client's record. Contir and program manage that staff have not rec	staff have been every two hours however, it nted or recorded in the nued interview with the HM r (PM) on 7/31/24 verified eived in-service training relative to monitoring vital				
t i	there have been no checilient #5 since he has status. Continued intervevealed that there is relient's #5 vital signs, repecial instructions from the client's changing therview with the PM recilient with the PM recilient with the PM recilient #5 since he client's changing the public than the pm recilient with the pm recilient #5 since he client's changing the pm recilient #5 since he client's changing the pm recilient #5 since he client's changing the pm recilient #5 since he client #	on 7/31/24 revealed that anges in personal care for had a change in medical view with the PM also to evidence of monitoring epositioning guidelines, or m nursing services relative to eveled nursing services				

STATEMENT	OF DEFICIENCIES	AND PROPERTY OF THE PROPERTY O			OMB N	NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G341	B. WING _			R
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	1/18/2024
WOODIN	G PLACE GROUP HOM			112 WOODING PLACE		
TTOODIN	O PLACE GROUP HOM	E		KINGS MOUNTAIN, NC 28086		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES				
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD RE	(X5) COMPLETION DATE
(W 331)	Continued From pag	ne 9	UW 33	1)		
	post-discharge care		{W 33	1)		
	A revisit was comple	eted on 11/18/24 to review the				
	plan of correction (P	OC) and supporting				
	documentation. It is	important to mention that the				
	client is currently in t	the hospital on 11/18/24 for a				
	Oli. Supporting doci	umentation was not available				
	evidence of document	C submitted. There was no nation relative to nursing				
	services oversight re	garding the client's changing				
	medical status.	garding the client's changing				
{W 340}	NURSING SERVICE	S	{W 340	1		
	CFR(s): 483.460(c)(5		/44 240			
	other members of the appropriate protective measures that include training clients and st health and hygiene m This STANDARD is r Based on interview a	not met as evidenced by: and record verification, the		PM, Nurse, QP, HS will in-service all staff on properly conditions and changes and properly documenting fine prevention of UTI's, pressure sores, etc. PM, Nurse, as	ding as well as	
	facility failed to provid	le nursing services in		monitoring to ensure that changes in medical condition	is are cared for,	
	changing medical stat	clients' needs relative to		treated, and documented in an appropriate manner.		
	clients (#5). The findir				Completed by 1	24974
					Completed by 12	LI 10124
		during the recertification				
		7/31/24 revealed client #5				
	has had five hospitaliz	zations over the last eight				
		eview of the record for client				
	infection (LITI) present	ving diagnoses: urinary tract ure sores with purulent				
		to UTI with hematuria,				
		el obstruction, acute kidney				
	injury, severe protein-	calorie malnutrition.				
	dehydration, anemia, I	hyponatremia, and vitamin				
1	B12 deficiency. Further	er review of the medical				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Committee of the Commit	The state of the s	MEDICAID SERVICES			OMB	NO. 0938-0391
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		34G341	B. WING _			R
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE ZIP CODE	11/18/2024
WOODING	G PLACE GROUP HOM			112 WOODING PLACE		
	STEASE GROUP HOM			KINGS MOUNTAIN, NC	28086	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION COTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(W 340)	Continued From pag	re 10	044.04	0		
,	record for client #5 v	rerified the following ED visits ns: 1/10/24, 1/26/24,	{W 34	0}		
	6/13/24 revealed cliediagnosis: Sepsis du acute kidney injury, of pressure sores with pure the nursing monthly shospital discharge survealed the following repositioning every to pressure sores, face consumer within 24 h facility, review of disciplan, post-inpatient single Review of the record	vo hours to eliminate to face assessment of lours of client's return to the charge orders and treatment tay nursing assessment. did not reveal a nursing son contact with client #5				
	client #5 indicated nu following dates: 3/10// 4/16/24, 4/20/24, 5/30 the medical record revinespitalization for clie 5/30/24-6/13/24. Revreveal nursing service since the client was dimedical record for clie assessments, follow unin-service training reladischarge recommendmedical needs. Reviewents and the service training reladischarge recommended and the service training relations and	o/24, and 5/31/24. Review of vealed the last nt #5 was from iew of the record did not es follow up or contact notes ischarged. Review of the ent #5 did not reveal nursing up care, in-person contact or titive to the client's hospital				
	Interview with the Prog	gram Manager (PM) on				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/CURRINGUE	T		OMB NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF F	PROVIDER OR SUPPLIER	34G341	B. WING		R 11/18/2024
	G PLACE GROUP HON	AE.		STREET ADDRESS, CITY, STATE, ZIP CO 112 WOODING PLACE KINGS MOUNTAIN, NC 28086	DE
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE
	7/31/24 revealed th full-time nurse since with the PM verified including nursing se discuss client #5 ch Further interview with health provider has services to client #5 interview with the Pl services has not corror in-person contact changing medical net A revisit was comple plan of correction (P documentation. It is client is currently in the plan of correction of the plan of th	e facility has not had a a 1/2024. Continued interview I that the interdisciplinary team ervices has not met to further ange in medical status. Ith the PM revealed a home been providing wound care two times a week. Additional M verified facility nursing mpleted nursing assessments with client #5 to assess his seeds.  Interded on 11/18/24 to review the OC) and supporting important to mention that the the hospital on 11/18/24 for a furner training assessments and the training training training to mention that the the hospital on 11/18/24 for a furner training traini	{W 34	0}	