CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	· · ·	E SURVEY PLETED
		34G018	B. WING			04	/09/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		_		93	34 SPRINGDALE LANE		
SPRINGD	ALE LANE GROUP HOM	E		G	ASTONIA, NC 28052		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	EP Testing Requirem: CFR(s): 483.475(d)(2 §416.54(d)(2), §418.7 §460.84(d)(2), §482.1 §483.475(d)(2), §484 §485.542(d)(2), §485 §485.920(d)(2), §485 §485.920(d)(2), §491 *[For ASCs at §416.5 at §485.542, OPO, "C §485.727, CMHCs at §491.12, and ESRD F (2) Testing. The [facilit to test the emergency must do all of the follo (i) Participate in a full- community-based even (A) When a commun accessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the emer exempt from engagin community-based or if functional exercise for actual event. (ii) Conduct an addition years, opposite the year functional exercise un this section is conduct	ents (1) (1) (1) (1) (1) (1) (1) (1)	TAG		CROSS-REFERENCED TO THE APPRO		DATE
	functional exercise; o (B) A mock disaster d	e exercise that is individual, facility-based r					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	?F		TITLE		(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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.

PRINTED: 04/11/2025 FORM APPROVED

TITLE

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/11/2025 1 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G018	B. WING		_	04/0	09/2025
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SPRINGD	ALE LANE GROUP HOM	E		934 SPRINGDALE LANE GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	a facilitator and include a narrated, clinically-r scenario, and a set of directed messages, o designed to challenge (iii) Analyze the [faciliti maintain documentati exercises, and emerg [facility's] emergency *[For Hospices at 418 (2) Testing for hospic patient's home. The f exercises to test the e annually. The hospic (i) Participate in a full community based eve (A) When a communit accessible, conduct a functional exercise ev (B) If the hospice exp man-made emergenc the emergency plan, t engaging in its next re community-based function onset of the emergen (ii) Conduct an additi opposite the year the exercise under parag is conducted, that ma to the following: (A) A second full-sca community-based or a exercise; or (B) A mock disaster o (C) A tabletop exercise	des a group discussion using relevant emergency f problem statements, or prepared questions e an emergency plan. ty's] response to and ion of all drills, tabletop gency events, and revise the plan, as needed. 3.113(d):] tes that provide care in the hospice must conduct emergency plan at least e must do the following: I-scale exercise that is ery 2 years; or ty based exercise is not in individual facility based very 2 years; or eriences a natural or ey that requires activation of the hospital is exempt from equired full scale ercise or individual hal exercise following the cy event. onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section by include, but is not limited le exercise that is a facility based functional	E 039				

Facility ID: 945217

If continuation sheet Page 2 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/11/2025 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE	
		34G018	B. WING			04/	09/2025
NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGD	ALE LANE GROUP HOM	E			934 SPRINGDALE LANE GASTONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	a narrated, clinically-r scenario, and a set of directed messages, o designed to challenge (3) Testing for hospice care directly. The hos exercises to test the e year. The hospice m (i) Participate in an a is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the hospice exp man-made emergency the emergency plan, f engaging in its next re based or facility-base following the onset of (ii) Conduct an additi may include, but is no (A) A second full-sca community-based or exercise; or (B) A mock disaster of (C) A tabletop exercis facilitator that include narrated, clinically-rel and a set of problem messages, or prepare challenge an emerger (iii) Analyze the hosp maintain documentati	relevant emergency f problem statements, or prepared questions e an emergency plan. es that provide inpatient spice must conduct emergency plan twice per ust do the following: innual full-scale exercise that or ty-based exercise is not an annual individual nal exercise; or eriences a natural or cy that requires activation of the hospice is exempt from equired full-scale community d functional exercise the emergency event. ional annual exercise that ot limited to the following: ile exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ed questions designed to ncy plan. bice's response to and ion of all drills, tabletop gency events and revise the	E	039			

Facility ID: 945217

If continuation sheet Page 3 of 14

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/11/2025 APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	
		34G018	B. WING			_	04/	09/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		_		93	34 SPRINGDALE LANE			
SPRINGDA	ALE LANE GROUP HOM	E		G	ASTONIA, NC 28052			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S	PLAN OF CORRECTION		(X5)
PREFIX	·	Y MUST BE PRECEDED BY FULL	PREF			CTIVE ACTION SHOULD BI		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG			NCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
						DEI ICIENCI)		
E 039	Continued From page	93	E	039				
	*[For PRFTs at §441.7	184(d), Hospitals at						
	§482.15(d), CAHs at §	§485.625(d):]						
	(2) Testing. The [PRT	F, Hospital, CAH] must						
	conduct exercises to f	test the emergency plan						
	twice per year. The [I	PRTF, Hospital, CAH] must						
	do the following:							
		nnual full-scale exercise that						
	is community-based;	or						
		ty-based exercise is not						
	accessible, conduct a							
	facility-based function							
		pital, CAH] experiences an						
		-made emergency that						
	-	the emergency plan, the						
	[facility] is exempt from							
		nmunity based or individual,						
	-	al exercise following the						
	onset of the emergen							
		additional] annual exercise or						
	-	but is not limited to the						
	following: (A) A second full-scal	le evercise that is						
	. ,	ndividual, a facility-based						
	functional exercise; or	-						
		lisaster drill; or						
		ercise or workshop that is						
	led by a facilitator and	•						
		arrated, clinically-relevant						
	emergency scenario,							
		nessages, or prepared						
		challenge an emergency						
	plan.							
	(iii) Analyze the [1	facility's] response to and						
		on of all drills, tabletop						
		ency events and revise the						
	[facility's] emergency	-						
	*[For PACE at §460.8	4(d):]						

Facility ID: 945217

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/11/2025 APPROVED D. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G018	B. WING				04/	09/2025	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP	CODE			
		-		93	34 SPRINGDALE LANE				
SPRINGDA	ALE LANE GROUP HOM	E		G	ASTONIA, NC 28052				
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
E 039	exercises to test the e annually. The PACE of following: (i) Participate in an an is community-based; of (A) When a communit accessible, conduct a facility-based function (B) If the PACE exper man-made emergency the emergency plan, the engaging in its next re- based or individual, far exercise following the event. (ii) Conduct an active years opposite the year exercise under paragri is conducted that may the following: (A) A second full-scal community-based or i functional exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and includ using a narrated, clinic scenario, and a set of directed messages, on designed to challenge (iii) Analyze the PACE maintain documentative exercises, and emerg PACE's emergency platices at	E organization must conduct emergency plan at least organization must do the nnual full-scale exercise that or ty-based exercise is not in annual individual, hal exercise; or iences an actual natural or y that requires activation of the PACE is exempt from equired full-scale community acility-based functional e onset of the emergency dditional exercise every 2 ar the full-scale or functional raph (d)(2)(i) of this section y include, but is not limited to le exercise that is individual, a facility based r drill; or se or workshop that is led by des a group discussion, cally-relevant emergency f problem statements, r prepared questions e an emergency plan. E's response to and on of all drills, tabletop lency events and revise the lan, as needed.	E	039					

Facility ID: 945217

If continuation sheet Page 5 of 14

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 04/11/2025 APPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE	
		34G018	B. WING			_	04/	09/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
0000000		_		9	34 SPRINGDALE LANE			
SPRINGD	ALE LANE GROUP HOM	=		G	GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	including unannounce emergency procedure ICF/IID] must do the f (i) Participate in an aris is community-based; ((A) When a communit accessible, conduct a facility-based function (B) If the [LTC facility] actual natural or man- requires activation of LTC facility is exempt required a full-scale c individual, facility-base following the onset of (ii) Conduct an addition may include, but is not (A) A second full-scale community-based or a functional exercise; on (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-rele and a set of problem s messages, or prepare challenge an emerger (iii) Analyze the [LTC and maintain docume exercises, and emerger [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/II to test the emergency The ICF/IID must do t	an at least twice per year, d staff drills using the s. The [LTC facility, ollowing: nnual full-scale exercise that or y-based exercise is not n annual individual, al exercise. facility experiences an made emergency that the emergency plan, the from engaging its next ommunity-based or ed functional exercise the emergency event. onal annual exercise that t limited to the following: e exercise that is an individual, facility based Irill; or se or workshop that is led by group discussion, using a evant emergency scenario, statements, directed d questions designed to ncy plan. facility] facility's response to ntation of all drills, tabletop ency events, and revise the emergency plan, as needed.	E	039				

Facility ID: 945217

If continuation sheet Page 6 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/11/2025 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G018	B. WING			_	04/	09/2025
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SPRINGD	ALE LANE GROUP HOM	E			34 SPRINGDALE LANE GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	is community-based; (A) When a community- accessible, conduct a facility-based function (B) If the ICF/IID experiman-made emergency the emergency plan, the engaging in its next recommunity-based or if functional exercise following exercise following exercise; or (A) A second full-scale community-based or a functional exercise; or (B) A mock disaster d (C) A tabletop exercise a facilitator and includuing a narrated, clini scenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/II maintain documentati exercises, and emergi ICF/IID's emergency for the emergency for the emergency for (A) When a community-based; or (A) When a community-based; or (A) When a commander the emergency for (A) When a commander the emergency for (A) When a commander the community-based; or (A) When a commander the emergency for (A) When a commander the emergency for (A) When a commander the community-based; or (A) When a commander the comm	or ty-based exercise is not in annual individual, nal exercise; or. eriences an actual natural or by that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based llowing the onset of the onal annual exercise that bit limited to the following: e exercise that is an individual, facility-based r ritil; or se or workshop that is led by des a group discussion, cally-relevant emergency f problem statements, r prepared questions e an emergency plan. ID's response to and on of all drills, tabletop uency events, and revise the plan, as needed. 02] HA must conduct exercises r plan at HA must do the following: -scale exercise that is munity-based exercise is not	E	039				

Facility ID: 945217

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/11/2025 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G018	B. WING				04/	09/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
		_		9	34 SPRINGDALE LANE			
SPRINGD	ALE LANE GROUP HOM	E		G	GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	 (B) If the HHA exor man-made emerge of the emergency plar engaging in its next recommunity-based or if functional exercise following is conducted, an addition opposite the year the exercise under parager is conducted, that limited to the following (A) A second full-community-based or a functional exercise; or (B) A mock disass (C) A tabletop exercise (B) A mock disass (C) A tabletop exercise under parager of the discussion, using a nate emergency scenario, statements, directed receives designed to plan. (iii) Analyze the HHA's documentation of all common emergency events, are emergency plan, as nate emergency scenario, state the emergency following: (i) Conduct a paper-based or a functional exact and the emergency scenario of all common emergency plan, as nate emergency scenario, and the emergency scenario of all common emergency plan, as nate emergency plan, as nate emergency scenario, and the emergency scenario of a state emergency following: (ii) Conduct a paper-based or a facilitator and the emergency scenario, the emergency s	experiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based llowing the onset of the onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section t may include, but is not g: -scale exercise that is an individual, facility-based r ter drill; or ercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency s response to and maintain drills, tabletop exercises, and nd revise the HHA's needed.	E	039				

Facility ID: 945217

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	-						FORM	D: 04/11/2025
STATEMENT	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION		(X3) DATE). 0938-0391 SURVEY LETED
		34G018	B. WING _			_	04/	09/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SPRINGD	ALE LANE GROUP HOM	E			34 SPRINGDALE LANE ASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	questions designed to plan. If the OPO exper man-made emergency the emergency plan, the engaging in its next refollowing the onset of (ii) Analyze the OPO's documentation of all the emergency events, are OPO's] emergency plan. *[RNCHIs at §403.74 (d)(2) Testing. The RM exercises to test the exercises to test thexercises to test the exercises to test	 b challenge an emergency priences an actual natural or y that requires activation of the OPO is exempt from equired testing exercise the emergency event. a response to and maintain abletop exercises, and nd revise the [RNHCI's and an, as needed. a.8]: NHCI must conduct emergency plan. The RNHCI cased, tabletop exercise at etop exercise is a group cilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an CI's response to and on of all tabletop exercises, ts, and revise the RNHCI's eeded. atot met as evidenced by: ew and interview, the facility nial testing of the facility's ness plan (EPP). The finding 	E	039				

Facility ID: 945217

If continuation sheet Page 9 of 14

	S FOR MEDICARE &		0.00			10.0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
		34G018	B. WING		0	4/09/2025
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGD	ALE LANE GROUP HOM	E		4 SPRINGDALE LANE ASTONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
E 039	or facility-based traini	e 9 ing. Continued interview with hat the facility will schedule	E 039			
W 436	-		W 436			
	and teach clients to u choices about the use hearing and other con and other devices ide interdisciplinary team This STANDARD is n Based on observatio interviews, the facility prescribed adaptive e	The facility must furnish, maintain in good repair, nd teach clients to use and to make informed hoices about the use of dentures, eyeglasses, earing and other communications aids, braces, nd other devices identified by the nterdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and nterviews, the facility failed to assure that rescribed adaptive equipment was furnished for ampled client #4. The finding is:				
	client #4 to consume breakfast meal. Conti client #4 was provide straw during mealtime	survey 4/8-4/9/25 revealed the entire dinner meal and inued observations revealed d with a cup with a lid and a es. At no time during the as was client #4 provided				
	revealed an individua 7/25/24. Review of th assessment dated 7/2 client drinks from a pureview revealed a sport	on 4/9/25 for client #4 I personal plan (IPP) dated e IPP revealed a nutrition 23/24 that revealed that the rovale cup. Continued eech pathology assessment client to use a provale cup speed of liquid bolus				
		ith the qualified intellectual I (QIDP) verified that client				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/11/2025 1 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY
		34G018	B. WING			04/0	09/2025
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SPRINGD	ALE LANE GROUP HOM	E		934 SPRINGDALE LANE GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 436	#4's IPP was current. the QIDP revealed that	e 10 Continued interview with at the staff should have th his prescribed provale	W 43	6			
W 474	- ·)(iii)	W 47	4			
	developmental level of This STANDARD is in Based on observation interviews, the facility form consistent with th of 5 clients (#1, #2, #4	not met as evidenced by: ns, record reviews, and failed to serve food in a he developmental level of 4 4, and #5). The findings are: o follow client #1's diet as					
	PM revealed the dinner dinner waffles, scram strawberries, and whi observations at 4:41 F client #1's waffles into bacon into large slices revealed the client to At no time during the	PM revealed staff to cut o quarters and the turkey s. Further observations consume her dinner meal. dinner meal was staff ent #1 to provide the meal in					
	AM revealed the break whole wheat toast and observations at 6:50 A consume her breakfast consistency with the t during the breakfast n	roup home on 4/9/25 at 6:41 kfast meal consisted of d cheese omelet. Continued AM revealed client #1 to st meal in whole toast cut in half. At no time meal was staff observed to ovide the meal in a bite size					

Facility ID: 945217

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/11/2025 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION		(X3) DATE	
		34G018	B. WING			_	04/	09/2025
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
SPRINCD		E		934	SPRINGDALE LANE			
SPRINGD	ALE LANE GROUP HOM	E		GA	STONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 474	Continued From page consistency.	9 11	W 47	74				
	an individual persona Review of the IPP rev assessment dated 11 prescribed a regular of Interview with the qua professional (QIDP) of #1's prescribed diet. F (QIDP) confirmed spe be followed as prescr B. The facility failed to prescribed. For exam Observations in the g PM revealed the dinn dinner waffles, scram strawberries, and whi observations at 4:39 I	/22/24 for client #1 to be diet, bites-sized, thin liquid. alified intellectual disability on 4/9/25 confirmed client Further interview with the ecially modified diets should ibed. o follow client #2's diet as ple: roup home on 4/8/25 at 4:35 er meal consisted of Belgian bled eggs, turkey bacon, p cream. Continued PM revealed client #2 to						
	staff observed to assi meal in a bite size con Observations in the g PM revealed the brea whole wheat toast an observations revealed breakfast meal in who toast cut in half. At no meal was staff observ provide his meal bite Review of client #2's a an IPP dated 10/24/2	the during the dinner was st client #2 to provide the insistency roup home on 4/9/25 at 4:35 kfast meal consisted of d cheese omelet. Continued d client #2 consumed the ole consistency with the o time during the breakfast yied to assist the client to sized. record on 4/9/25 revealed						

Facility ID: 945217

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	-	ID HUMAN SERVICES				FORM	0: 04/11/2025 APPROVED		
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 04/09/2025			
		34G018			_				
NAME OF PI	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, ST	TATE, ZIP CODE	-			
SPRINGD	ALE LANE GROUP HOM	E	934 SPRINGDALE LANE GASTONIA, NC 28052						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
W 474	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 for client #2 to be prescribed a regular diet, bites-sized, thin liquids. May have double portions on non-starchy vegetables. Interview with the QIDP on 4/9/25 confirmed client #2's prescribed diet. Further interview with the QIDP confirmed specially modified diets should be followed as prescribed. C. The facility failed to follow client #4's diet as prescribed. For example: Observations in the group home on 4/9/25 at 4:35 PM revealed the breakfast meal consisted of whole wheat toast and cheese omelet. Continued observations revealed client #4 consumed the breakfast meal in whole consistency with the toast cut in half. The QIDP prompted staff to cut the toast for client #4; however, the staff cut the toast into large slices. At no time during the breakfast meal was staff observed to assist client#4 to provide his meal bite sized. Review of client #4's record on 4/9/25 revealed an IPP dated 7/25/24. Review of the IPP revealed a nutritional assessment dated 7/23/24 for client #4 to be prescribed an 1800 calorie diet, bite-sized, thin liquids as tolerated. Interview with the QIDP on 4/9/25 confirmed client #4's prescribed diet. Further interview with the QIDP confirmed specially modified diets should be followed as prescribed. D. The facility failed to follow client #5's diet as prescribed. For example:		W 474						

Facility ID: 945217

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/11/2025 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G018	B. WING		_	04/09/2025	
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SPRINGD	ALE LANE GROUP HOM	E		34 SPRINGDALE LANE GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 474	ALE LANE GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 dinner waffles, scrambled eggs, turkey bacon, strawberries, and whip cream. Continued observations at 4:39 PM revealed staff to cut client #5's waffles into quarters. Further observations revealed the client to consume his dinner meal. At no time during the dinner meal was staff observed to assist client #5 to provide his meal in a bite size consistency. Observations in the group home on 4/9/25 at 7:21 AM revealed the breakfast meal consisted of whole wheat toast with jelly and cheese omelet. Continued observations at 7:23 AM revealed client #5 to consume his breakfast meal in whole consistency with the toast cut in half. At no time during the breakfast meal was staff observed to assist the client to provide the meal in a bite size consistency. Review of client #5's record on 4/9/25 revealed an IPP dated 3/13/25. Review of the IPP revealed a nutritional assessment dated 3/15/25 for client #5 to be prescribed a non-concentrated sweet, low cholesterol, no seconds, no caffeine, no grapefruit diet. Continued review revealed that the Speech and Language Pathologist (SLP) evaluated the client's right dysphasia on recommended that client #5 continues a regular diet with thin liquids and staff to cut foods into bite-sized pieces to improve safety with intake. Interview with the QIDP on 4/9/25 confirmed client #5's prescribed diet. Further interview with the QIDP confirmed specially modified diets should be followed as prescribed.		W 474				

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