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

PRINTED: 06/24/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G245	B. WING			06/	24/2025
	PROVIDER OR SUPPLIER DOD GROUP HOME			1	TREET ADDRESS, CITY, STATE, ZIP CODE 507 ROBINHOOD RD VILMINGTON, NC 28401	•	
(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 APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
W 249	formulated a client' each client must re treatment program interventions and s and frequency to so objectives identified plan. This STANDARD is Based on observation interviews, the facili received a continuous consisting of needed as identified in the in the area of prograffected 2 of 3 audifindings are: A. During observation of the service of the should receive service of the should receive service of the	erdisciplinary team has a individual program plan, ceive a continuous active consisting of needed ervices in sufficient number apport the achievement of the d in the individual program. Is not met as evidenced by: tions, record reviews and ity failed to ensure each client ous active treatment program ed interventions and services and interventions and services and interventions. This it clients (#1 and #6). The ions in the home throughout 5, client #1 did not gitated behaviors. Staff did not such as Goldfish, and praise or reinforcement. In client #1's behavior and services are reinforcement. In client #1's behavior and praise or reinforcement. In client #1's behavior and praise or reinforcement. In client #1's behavior and praise for anour during waking hours he displays no agitated behaviors. In with Staff A revealed client but he will eat small crunchy affish and should still receive	W 2	249			
LABORATOR)	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		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.

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		34G245	B. WING		06	/24/2025		
NAME OF PROVIDER OR SUPPLIER ROBINHOOD GROUP HOME				STREET ADDRESS, CITY, STATE, 2 1507 ROBINHOOD RD WILMINGTON, NC 28401				
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W 249	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 2	249				

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W 249	Interview on 6/24/2 client #6 should be	ge 2 5 with the QIDP revealed prompted to use the bathroom cause she can get busy and	W 2	49			