STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Governing Body and Management failed to: exercise general policy, budget, and operating direction over the facility (W104). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services.	W 102		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Governing body and management failed to exercise general policy, budget, and operating direction over the facility by failing to ensure allegations of abuse were thoroughly investigated, direct care staff reported inappropriate behavior by clients and unauthorized absences by staff providing coverage were reported to management in the facility. The findings are: 1. Direct Care Staff failed to consistently report to management inappropriate behavior by consumers for whom they were responsible.	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 104	Continued From page 1	W 104		

Review on 4/9/18 of an investigation dated 2/10/18 revealed a direct care staff reported to management staff that client #2 reported to him that former client #4 inappropriately touched clients #2 and #1 in the genital area. Statements were taken from several staff in the facility and clients #1, #2 and #4 were interviewed. After reviewing the statements the investigative team determined these allegations were unsubstantiated as client #4 was hospitalized during the time frame client #2 alleged that these events took place.

Interview on 4/6/18 with the Residential Manager via phone indicated after this investigation she instructed direct care staff to be aware of client #4's location every 15 minutes when he was in the home. She also instructed staff to be certain the door alarms above former client #4 and client #2's bedroom doors were operational. She additionally stated she told direct care staff to report any interactions between clients that was inappropriate. She stated during the last week in March 2018 (uncertain of specific date) a direct care staff reported to her client #2 reported former client #4 had inappropriately touched him. She stated former client #4 had been hospitalized and the time frame client #2 provided to direct care staff did not seem possible, so she chose not to investigate these allegations.

Interview on 4/6/18 with staff #1 revealed he had witnessed former client #4 going into client #2's bedroom and on one occasion, he had shut the bedroom door. He did not report this inappropriate interaction to management staff.

Interview on 4/6/18 with staff #2 revealed he had seen former client #4 go into client #1's bedroom

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

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W 104	Continued From page 2	W 104		

and touch his face and ears. He stated this was not reported to management staff.

Additional interview on 4/9/18 with the Residential Manager revealed she was not aware of former client #4 entering client #1 or #2's bedrooms. She stated direct care staff had not reported this to her. She stated on at least one occasion in March 2018 she had entered the facility and observed the door alarms over clients #2 and former client #4's bedroom doors had been disabled. She stated when asked, direct care staff reported they had not disabled these door alarms. She stated former client #4 was tall in stature and would have been able to deactivate these alarms. The Residential Manager stated she did not report this to management. She did instruct staff to be aware of these door alarms and to be certain during their assigned shifts the alarms were operational.

Interview on 4/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware of allegations involving former client #4 and client #2 that were given to the Residential Manager in March 2018. He stated he was also unaware of allegations of former client #4 entering the bedroom areas of clients #1, #2. He was also unaware the door alarms over the bedroom doors of client #2 and former client #4 had been de-activated.

2. Direct Care staff failed to consistently notify management staff when they did not report to work as scheduled.

Interview on 4/9/18 with a direct care staff revealed she had been told by a coworker that on a Monday in February 2018 on second shift one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

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W 104	Continued From page 3 of two assigned direct care staff did not report to work as scheduled. She stated direct care staff reported he had driven to the vocational center, picked up the clients and taken them back to the facility. He stated he worked alone for the entire second shift without notifying management staff. Direct care staff stated this was not the only incident when staff did not report to work as scheduled without notifying management staff. Interview on 4/9/18 with the Qualified Professional (QP) and Residential Manager (RM) revealed they were not aware of any incident when staff did not report to work as scheduled and did not notify management staff.	W 104		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to: implement policies intended to prohibit possible abuse of clients (W149) and thoroughly investigate allegations of abuse that affected 1 of 6 clients in the home (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 149	Continued From page 4 mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement policies intended to prohibit mistreatment or abuse of clients. This affected 3 of 6 clients in the home (#1, #2, #4). The finding is: Facility Management neglected to implement policies intended to prevent abuse of clients in the home. Review on 4/6/18 of client #2's record revealed an individual program plan (IPP) dated 5/18/17. Further review of his record revealed he is verbal and has diagnoses of Moderate Intellectual Disabilities and Schizophrenia (Undifferentiated type). The IPP indicated client #2 had been adjudicated incompetent and had a guardian of the person appointed to act on his behalf. Additional review of his IPP revealed "Will have a privacy goal implemented as needed. He has no issues with maintaining his privacy or the privacy of others at this time." Review on 4/6/18 of former client #4's record revealed an IPP dated 1/30/18. Further review of his record revealed he is verbal and has diagnoses of Moderate Intellectual Disability, Attention Deficit Hyperactivity Disorder, Impulse Control Disorder, Episodic Mood Disorder, Pervasive Developmental Disorder. Further review of this IPP revealed a behavior support plan dated 3/19/18 to address target behaviors of Physical Aggression and Property Destruction. Review on 4/9/18 of an investigation dated	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

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W 149	Continued From page 5	W 149		

2/10/18 revealed a direct care staff reported to management staff that client #2 reported to him that former client #4 inappropriately touched clients #2 and #1 in the genital area. Statements were taken from several staff in the facility and clients #1, #2 and #4 were interviewed. After reviewing the statements the investigative team determined these allegations were unsubstantiated as client #4 was hospitalized during the time frame client #2 alleged that these events took place.

Review on 4/9/18 of a note by staff revealed former client #4 was physically aggressive towards staff and exhibited suicidal ideations on 3/27/18. Direct Care staff contacted the Police Department and former client #4 was hospitalized on 3/27/18.

Interview on 4/6/18 with the Residential Manager via phone indicated after this investigation dated 2/10/18 she instructed direct care staff to be aware of client #4's location every 15 minutes when he was in the home. She also instructed staff to be certain the door alarms above former client #2 and client #4's bedroom doors were operational. She explained that she told direct care staff to report any interaction between clients that was inappropriate. She stated during the last week in March 2018 (uncertain of specific date) a direct care staff reported to her client #2 told him former client #4 had inappropriately touched him. She stated former client #4 had been hospitalized on 3/27/18 and the time frame client #2 provided to direct care staff did not seem possible, so she chose not to investigate these allegations.

Interview on 4/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed former

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

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W 149	Continued From page 6	W 149		

client #4 was hospitalized and probably would not be re admitted to the facility when he is discharged. Alternative placement is being pursued by the hospital.

Interview on 4/6/18 at the vocational center with client #2 revealed former client #4 had inappropriately touched him in the genital area with his mouth about two weeks ago. He stated former client #4 came into his bedroom at night, shut the door, pulled down his pants and kissed his genital area with his mouth. He stated former client #4 then left his bedroom, shutting the door behind him. When asked if this was witnessed by his roommate (who is not interviewable) or by the 2 direct care staff working in the facility, he stated, "No." It should be noted client #2 was crying during this interview and afterwards he vomited into a trash can in the room where he was being interviewed. This interview was also witnessed by the vocational staff who works with him as a Qualified Professional (QP).

Additional interviews on 4/6/18 with client #5 and #6 revealed no inappropriate touching by other clients or staff. Clients #1 and #3 were not interviewable.

Interview on 4/6/18 with former client #4 at the hospital revealed he had no knowledge of any clients entering other clients bedrooms without their consent. He stated he had never entered clients #1 and #2's bedrooms. He stated client #2 had come to his bedroom after he invited him to come and play a video game with him. He stated client #2 sat on his bed and watched him play a video game. He denied ever touching any of the clients in the facility. He asked this surveyor, "Who would tell you I went into their bedrooms?"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

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W 149	Continued From page 7	W 149		

This interview was witnessed by former client #4's therapist at the hospital.

Interview on 4/6/18 with staff #A revealed he had witnessed former client #4 going into client #2's bedroom and on one occasion, he had shut the bedroom door. He did not report this inappropriate interaction to management staff.

Interview on 4/6/18 with staff #B revealed he had seen former client #4 go into client #1's bedroom and touch his face and ears. He stated this was not reported to management staff. He also stated when he was working in March, he was in the hallway bathroom assisting client #1 with undressing when former client #4 walked into the bathroom. He stated when former client #4 realized staff #B was in the bathroom with client #1, former client #4 quickly exited the hallway bathroom. Staff #B did not report this to management.

Additional interview on 4/9/18 with the Residential Manager revealed she was not told by direct care staff of former client #4 entering the bedroom areas of client #1 and client #2. She stated sometime during the month of March 2018 she noted when she came into her shift in the facility that the door alarms over the bedroom doors of client #2 and former client #4 had been de-activated. She stated she did not report this but instructed direct care staff to be aware of these alarms while they were working in the facility.

Review on 4/9/18 of the facility policy regarding Abuse and Neglect page C.4.5 revealed "Any incidents of abuse or neglect are to be reported and investigated immediately, and according to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 149	Continued From page 8	W 149		

prescribed procedures." Sexual Abuse is defined as "Any physical or provocative advances, such as caressing, fondling, sexual contact , sexual intercourse, etc. Encouraging a person to participate in nonconsensual sexual activity. Encouraging or allowing a person to be in any form of undress or to participate in sexual activity for the gratification of staff or other persons."

Interview on 4/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware of allegations involving former client #4 and client #2 that were given to the Residential Manager in March 2018. He stated he was also unaware of allegations of former client #4 entering the bedroom areas of clients #1, #2. He was also unaware the door alarms over the bedroom doors of client #2 and former client #4 had been de-activated. Additional interview revealed the facility policy regarding Abuse and neglect is current and should be implemented.

Interview on 4/9/18 with the Operations Manager revealed all allegations of abuse should immediately be investigated. She stated the facility policy regarding abuse is current and should be followed.

The facility neglected to thoroughly investigate allegations of sexual abuse to client #2 by former client #4 once management staff were made aware of these allegations. The facility also did not thoroughly investigate the possibility former client #4 had disabled the bedroom door alarms. Direct care staff also failed to report to management incidences of former client #4 entering the bedroom areas of clients #1 and #2. The failure of management staff to detect, identify, investigate these allegations resulted in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

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W 149	Continued From page 9 their facility policies for reporting and investigating abuse not being consistently implemented. These failures resulted in the facility's systemic failure to provide statutorily mandated services of client protections to the clients residing in the facility.	W 149		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to conduct a thorough investigation of allegations of client to client abuse involving clients (#1, #2) by former client #4. The finding is: Management failed to thoroughly investigate allegations of client to client sexual abuse. Review on 4/6/18 of client #2's record revealed an individual program plan (IPP) dated 5/18/17. Further review of his record revealed he is verbal and has diagnoses of Moderate Intellectual Disabilities and Schizophrenia (Undifferentiated type). The IPP indicated client #2 had been adjudicated incompetent and had a guardian of the person appointed to act on his behalf. Additional review of his IPP revealed "Will have a privacy goal implemented as needed. He has no issues with maintaining his privacy or the privacy of others at this time." Review on 4/6/18 of former client #4's record revealed an IPP dated 1/30/18. Further review of his record revealed he is verbal and has diagnoses of Moderate Intellectual Disability,	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 154	Continued From page 10	W 154		

Attention Deficit Hyperactivity Disorder, Impulse Control Disorder, Episodic Mood Disorder, Pervasive Developmental Disorder. Further review of this IPP revealed a behavior support plan dated 3/19/18 to address target behaviors of Physical Aggression and Property Destruction.

Review on 4/9/18 of a note by staff revealed former client #4 was physically aggressive towards staff and exhibited suicidal ideations on 3/27/18. Direct Care staff contacted the Police Department and former client #4 was hospitalized on 3/27/18.

Interview on 4/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed former client #4 was hospitalized and probably would not be re admitted to the facility when he is discharged. Alternative placement is being pursued by the hospital.

Review on 4/9/18 of an investigation dated 2/10/18 revealed a direct care staff reported to management staff that client #2 reported to him that former client #4 inappropriately touched clients #2 and #1 in the genital area. Statements were taken from several staff in the facility and clients #1, #2 and #4 were interviewed. After reviewing the statements the investigative team determined these allegations were unsubstantiated as client #4 was hospitalized during the time frame client #2 alleged that these events took place.

Interview on 4/6/18 with the Residential Manager via phone indicated after this investigation dated 2/10/18 she instructed direct care staff to be aware of client #4's location every 15 minutes when he was in the home. She also instructed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

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W 154	Continued From page 11	W 154		

staff to be certain the door alarms above former client #2 and client #4's bedroom doors were operational. She explained that she told direct care staff to report any interaction between clients that was inappropriate. She stated during the last week in March 2018 (uncertain of specific date) a direct care staff reported to her client #2 told him former client #4 had inappropriately touched him. She stated former client #4 had been hospitalized on 3/27/18 and the time frame client #2 provided to direct care staff did not seem possible, so she chose not to investigate these allegations.

Interview on 4/6/18 at the vocational center with client #2 revealed former client #4 had inappropriately touched him in the genital area with his mouth about two weeks ago. He stated former client #4 came into his bedroom at night, shut the door, pulled down his pants and kissed his genital area with his mouth. He stated former client #4 then left his bedroom, shutting the door behind him. When asked if this was witnessed by his roommate (who is not interviewable) or by the 2 direct care staff working in the facility, he stated, "No." It should be noted client #2 was crying during this interview and afterwards he vomited into a trash can in the room where he was being interviewed. This interview was also witnessed by the vocational staff who works with him as a Qualified Professional (QP).

Additional interviews on 4/6/18 with client #5 and #6 revealed no inappropriate touching by other clients or staff. Clients #1 and #3 were not interviewable.

Interview on 4/6/18 with former client #4 at the hospital revealed he had no knowledge of any clients entering other clients bedrooms without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

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STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 154	Continued From page 12	W 154		

their consent. He stated he had never entered clients #1 and #2's bedrooms. He stated client #2 had come to his bedroom after he invited him to come and play a video game with him. He stated client #2 sat on his bed and watched him play a video game. He denied ever touching any of the clients in the facility. He asked this surveyor, "Who would tell you I went into their bedrooms?" This interview was witnessed by former client #4's therapist at the hospital.

Interview on 4/6/18 with staff #A revealed he had witnessed former client #4 going into client #2's bedroom and on one occasion, he had shut the bedroom door. He did not report this inappropriate interaction to management staff.

Interview on 4/6/18 with staff #B revealed he had seen former client #4 go into client #1's bedroom and touch his face and ears. He stated this was not reported to management staff. He also stated when he was working in March, he was in the hallway bathroom assisting client #1 with undressing when former client #4 walked into the bathroom. He stated when former client #4 realized staff #B was in the bathroom with client #1, former client #4 quickly exited the hallway bathroom. Staff #B did not report this to management.

Additional interview on 4/9/18 with the Residential Manager revealed she was not told by direct care staff of former client #4 entering the bedroom areas of client #1 and client #2. She stated sometime during the month of March 2018 she noted when she came into her shift in the facility that the door alarms over the bedroom doors of client #2 and former client #4 had been de-activated. She stated she did not report this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 154	Continued From page 13	W 154		

but instructed direct care staff to be aware of these alarms while they were working in the facility.

Review on 4/9/18 of the facility policy regarding Abuse and Neglect page C.4.5 revealed "Any incidents of abuse or neglect are to be reported and investigated immediately, and according to prescribed procedures." Sexual Abuse is defined as "Any physical or provocative advances, such as caressing, fondling, sexual contact , sexual intercourse, etc. Encouraging a person to participate in nonconsensual sexual activity. Encouraging or allowing a person to be in any form of undress or to participate in sexual activity for the gratification of staff or other persons."

Interview on 4/9/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware of allegations involving former client #4 and client #2 that were given to the Residential Manager in March 2018. He stated he was also unaware of allegations of former client #4 entering the bedroom areas of clients #1, #2. He was also unaware the door alarms over the bedroom doors of client #2 and former client #4 had been de-activated. Additional interview revealed the facility policy regarding Abuse and neglect is current and should be implemented.

Interview on 4/9/18 with the Operations Manager revealed all allegations of abuse should immediately be investigated. She stated the facility policy regarding abuse is current and should be followed.

The facility failed to thoroughly investigate allegations of sexual abuse to client #2 by former client #4 once management staff were made

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	C 04/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 154	Continued From page 14 aware of these allegations. The facility also failed to investigate the possibility former client #4 had disabled the bedroom door alarms and failed to ensure direct care staff reported to management former client #4 entering the bedroom areas of clients #1 and #2. The failure of management staff at the facility to detect, identify, investigate these allegations and follow their own facility policy reporting and investigating abuse resulted in their systemic failure to ensure statutorily mandated services of client protections to the clients residing in the facility.	W 154		