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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G345	A. BUILDING ______ B. WING ______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUSE'S GROUP HOME #6	5820 NC HIGHWAY 135 STONEVILLE, NC 27048

(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 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interview the facility failed to assure the individual program plan (IPP) for 1 of 5 sampled clients (#4) included objective training to meet the client's behavioral needs. The finding is: Staff did not provide training to client #4 to address his behavioral needs after he attempted to elope from the facility. Review on 3/14/18 of client #4's individual program plan (IPP) dated 2/23/18 revealed he has a priority training need to decrease his verbal aggression, physical aggression and property destruction. Further review revealed a behavior support plan (BSP) dated 1/18/18 which specifically addressed : decreasing the frequency of verbally aggressive behavior to 2 or less episodes per month for 6 months and decreasing his physically aggressive behaviors to 0 per month for 6 consecutive months. This BSP did not address elopement. Review on 3/14/18 of client #4's behavioral data from December -March revealed the following: December 2018: Property Destruction: 0, Elopement: 0, Verbal Aggression: 4 January 2018: Property Destruction: 1,	W 227	APR 2 0 2018 Lic. & Cert. Section Rouse's Interdisciplinary Team (QP, ED, Psychologist, Med Tech, Program Coordinator, and Habilitation Assistant) will have a core team meeting to discuss clients' behavioral needs.	04/02/18
			Clients identified with behavioral needs will have a behavioral support plan written by the psychologist to address identified behavior. Clients with existing behavioral support plans will have their behavioral support plans modified to address identified behavior.	04/12/18
			The psychologist will modify client #4's behavior support plan to include elopement.	04/10/18
			The QP will obtain consents from the guardian and the human rights committee member for the new behavioral support plans and/or modified support.	04/20/18
			The Psychologist and QP will provide training on new and/or modified behavioral support plans	04/26/18
			Weekly, the QP will do observations in the home and day program, review BSP plan documentation and talk receive status reports on bsps to ensure clients' behavioral needs are meet.	05/08/18
			Monthly the QP, Psychologist and the Interdisciplinary team will monitor BSPs to ensurebehavioral training needs are addressed for all clients served.	05/09/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamyra Caple	QIDP	04/10/2018

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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W 227	Continued From page 1 Elopement: 7, Verbal Aggression: 4 February 2018: 0 March: 0 Observations on 3/14/18 of client #4 at the vocational program and at the facility revealed he was in the continuous supervision of staff . Interview on 3/14/18 with direct care staff revealed client #4 had attempted to elope in January 2018 but that staff kept him in their visual supervision in the yard until they could get him back into the facility. Staff confirmed client #4 requires visual supervision at least every 15 minutes inside the facility and continuous visual supervision outside the facility. Interview on 3/14/18 with facility management staff revealed direct care staff had been tracking elopement behaviors although it was not addressed in client #4's BSP. Further interview revealed client #4 requires visual supervision at least every 15 minutes in the facility and continuous supervision outside the facility. Management staff stated client #4 had attempted to elope 7 times in January 2018 but had been in staff's visual supervision with staff right behind him in the yard before he was taken back inside the facility. Management staff stated the Psychologist had removed elopement behaviors from his BSP because prior to January, he had no attempts to leave the facility. Additional interview revealed there had been no further elopement attempts since January 2018 and the Psychologist had not been notified so revisions could be made in his BSP.	W 227		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)	W 322		

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W 322	Continued From page 2 The facility must provide or obtain preventive and general medical care.	W 322		
	This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 4 audit clients (#5) received a complete annual physical examination. The finding is: Client #5 did not have a complete physical. Review on 3/15/18 of client #5's physical assessment dated 1/10/18 revealed genitals and rectum not done. During an interview on 3/15/18, the qualified intellectual disabilities professional (QIDP) confirmed the the genitals and rectum were not assessed as indicated by the physician. Further interview revealed she did not know exactly when client #5's genitals will be assessed.		RN and clinical team will review all client's physicals to ensure that each client's physical is complete. Clients identified with incomplete physicals will have appointments scheduled with his/her physician to address any assessments that was not completed during the client's physical. The interdisciplinary team will review completed assessments to ensure that all clients receive complete annual physical examination. RN will review all new annual physicals to ensure all assessments are completed for every client.	04/06/18 04/12/18 04/19/18 05/12/18
W 350	DENTAL SERVICES CFR(s): 483.460(e)(3) The facility must provide education and training in the maintenance of oral health.	W 350		
	This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to provide effective training in maintenance of oral hygiene to staff who are responsible for carrying out this activity for 2 of 5 audit clients (#2, #4). The finding is:		The interdisciplinary team reviewed all clients' oral health records during monthly clinicals. Team will brainstorm on protocols to ensure client tooth brushing training is consistent throughout all shifts. The QP and Associate QP will perform program validations to access each client that has oral hygiene needs identified.	04/02/18 04/17/18

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W 350	Continued From page 3 The facility did not provide education for staff in the area of toothbrushing for clients #2 and #4 after several dental visits when they had oral hygiene needs identified. 1) Review on 3/14/18 of #2's individual program plan (IPP) dated 7/13/17 revealed client #2 requires complete assistance with toothbrushing and grooming tasks. Further review revealed a training program dated 4/18/17 " Will brush teeth with 75% independence for 3 of 3 periods." Review on 3/14/18 of client #2's dental visits revealed the following: 12/13/16: Oral Hygiene Fair 6/30/17: Prophy, Oral Hygiene Heavy Plaque 1/4/18: Heavy Plaque and Moderate Calculus, "Needs to brush more." Interview with facility management staff on 3/14/18 revealed there had been no revisions to client #2's written program methodology for toothbrushing. Management staff stated they had purchased a sonic care toothbrush in December 2017 but there had been no changes and no additional training for client #2 or direct care staff since his dental visit on 1/4/18. 2) Review on 3/14/18 of client #4's IPP dated 2/23/18 revealed he can brush his teeth but needs assistance because it is difficult for him to open his mouth wide enough because of a previous broken jaw injury prior to his placement. Further review revealed a toothbrushing program will brush his teeth before going to bed with 100% accuracy for 2/3 reporting periods. Review on 3/14/18 of client #4's dental visits	W 350	New and or modified/revisions training objectives for tooth brushing will be implemented by QP for clients that are identified to need training in completing his/her oral hygiene. Staff training in the area of tooth brushing for clients will be performed globally. QPs, Associate QPs, Program Coordinator, Medical Staff and Lead Staff will monitor oral hygiene training weekly to ensure clients' oral hygiene needs are met. During monthly clinical reviews, the interdisciplinary team will review all clients' medical reviews and training objective progress, including oral hygiene training objectives. Program monitoring and/or validations will be conducted as needed per review. Following each client's dental visit, the Medical Staff will alert the QP on the status of each dental report. Core teams meeting will be held immediately for any dental finding rated less than good oral hygiene.	04/15/18 03/28/18 05/04/18 05/01/18 04/10/18

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W 350	Continued From page 4 revealed the following: 7/13/17: Prophy, Moderate plaque 7/29/17: Moderate Plaque 3/1/18: Moderate Plaque Interview on 3/14/18 with facility management staff revealed this toothbrushing program was implemented several months ago before client #4's IPP meeting in February 2018. Additional interview revealed client #4's guardian had purchased a sonic care toothbrush around December 2017. Further interview revealed no revisions to this program and no additional training for staff since client #2's last two dental visits on 7/29/17 and on 3/1/18.	W 350		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all medications were administered without error for 1 of 4 audit clients (#1). The finding is: Client #1's medication of Perigard was not administered without error. During observations of medication administration on 3/15/18 at approximately 7:10 am, staff poured between 25 ml and 30 ml of client #1's Perigard into a medication cup. Staff let client #1 pick the cup and the client poured it to his mouth, swished	W 369	The RN obtained the physician orders for client #1's Perigard to indicate the specific amount to be poured The Interdisciplinary Team (QPs, Associate QPs, Program Coordinator, Lead Staff, RN and Med Tech) will verify all medication labels to ensure it specifies the specific amount to be administered for each client. The Interdisciplinary Team (QP, Program Coordinator,Lead Staff, Med Tech and RN) will monitor medication administration to ensure medication is administered without error at least 2 times weekly.	03/15'18 03/28/18 05/10/18

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W 369	Continued From page 5 and spit in the sink.	W 369		
	Review on 3/15/18 of client #1's current physician's orders dated revealed, "Perigard 0.12% oral rinse: Swish 1-2 minutes and expectorate every morning and every night after brushing."		The Medical Staff and QP will in-service Direct Support Professionals and Habilitation Assistants to follow the 6 Medication Check verification. Including the protocol to follow if a medication is received that does meet the physician's order.	04/15/18
	During an interview on 3/15/18 with the staff involved revealed, staff pours a random amount of client #1's Perigard into a medication cup. Staff stated, "I always put enough amount for him to swish."		A medication error was completed by the medical department for administration of Perigard without the specific amount listed on the physician order.	03/15/18
	During an interview on 3/15/18, the nurse confirmed the current physician orders for client #1's Perigard does not have the specific amount to be poured.			
W 418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress.	W 418		
	This STANDARD is not met as evidenced by: Based on observation and interviews the facility failed to provide each client with a comfortable mattress. This affected 1 of 4 audit clients (#5). The finding is:		Maintenance replaced Client #4's with mattress was replaced.	03/15/18
			Maintenance will provide monthly check of clients' mattresses and replaced mattresses as needed	05/01/18
	Client #5 was not provided with a comfortable mattress.		QP will in-service Direct Support Professionals to ensure client mattresses and/or other items that need repair and/or replacement in the clients' common areas or bedrooms are in good repairs.	04/15/18
	During observations in the group home on 3/15/18, client #5's mattress had a large indentation/dip in the center of the mattress. This was noticeable from the hallway.			

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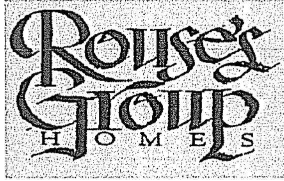
W 418	Continued From page 6 During an interview on 3/15/18, the qualified intellectual disabilities professional (QIDP) confirmed client #5's mattress is in need of a replacement.	W 418		



Post Office Box 16
Stoneville, North Carolina 27048
Office#: (336) 427-2562
Fax#: (336) 427-2798

"Serving Others So They May Better Serve Themselves"

Wambui Karanu
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

April 10, 2018

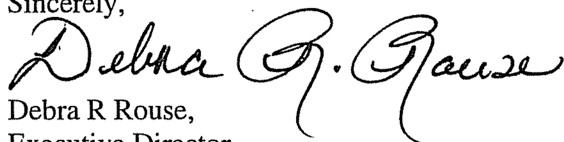
Re: Rouses Recertification Survey Completed March 14-15, 2018

Dear Ms. Karanu,

Enclosed is the POC for the recertification survey completed March 14 - 15, 2018, Rouse's Group Home #6. We have attached the list of members and an outline for documents provided.

If you have questions and/or need additional information, please contact me at (336) 339-8404 or via email at debra@rousesgroup home.com. You may also reach our QIDP, Myra Caple at (336) 932-0546 or via email at myra.c@rousesgrouphome.com. We look forward to seeing you in May.

Sincerely,



Debra R Rouse,
Executive Director