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 _____	R-C 05/25/2018

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 000	INITIAL COMMENTS "As a result of the follow-up survey, it was determined that W102, W104, W122 from the April 6, 2018 were corrected. In addition, repeat standard level deficiencies are cited."	W 000		
{W 149}	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit 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 prevent neglect of clients. This affected 1 of 6 clients (#4) in the facility. The finding is: Facility Management failed to implement policies intended to prevent neglect of clients in the facility. Review on 5/25/18 of an investigation dated 5/1/18 revealed the Residential Manager (RM) was contacted by phone by staff #1 on 5/1/18 around 3:20pm. Staff #1 told the RM that he and staff #2 had arrived at the vocational workshop to pick up the clients and discovered client #2 was not at the workshop. The RM told staff #1 client #2 was at home resting and that this information had been given to staff #2 when she arrived at work around 3pm. The RM immediately contacted the qualified intellectual disabilities professional (QIDP) and both the RM and the QIDP drove to the facility. Staff #1 and staff #2 assisted clients #1, #3, #5 and #6 onto the van and arrived at the facility around 3:50pm. Further	{W 149}		

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

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{W 149}	Continued From page 1	{W 149}		

review of the investigation revealed when the QIDP and RM arrived at the facility around 3:45pm, client #4 was found in his bedroom sleeping. Additional review of the facility's investigation estimated client #2 was left alone at the facility around 40-50 minutes.

Interviews on 5/25/18 with staff #1 revealed staff #2 had only been working at the facility about 3 weeks. He stated he was unaware that client #2 had been left at the facility. He confirmed staff are to visually check on client #2 every 15 minutes. He also stated when the RM told him on the phone client #2 was at home, staff #2 remembered leaving client #2 at the facility. Staff #1 stated staff #2 was scared and very upset that she had forgotten about leaving client #2 at the facility . He stated when the van arrived at the facility around 3:50pm, the QIDP and RM were at the facility. He stated both he and staff #2 were relieved from their shift by the QIDP and the RM. he stated they clocked out and went home until the investigation was completed.

Review on 5/24/18 of client #2's record revealed he is verbal and has diagnoses of Moderate Intellectual Disabilities and Schizophrenia (Undifferentiated type). The individual program plan (IPP) indicated client #2 had been adjudicated incompetent and had a guardian of the person appointed to act on his behalf. Further review revealed client #2 has target behaviors of physical aggression, elopement, property destruction. These behaviors were addressed by a behavior support plan (BSP) which was dated 5/18/18.

Review on 5/25/18 of the facility's policy on Neglect # C.4.5 revealed, "Defined in 10A NCAC

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{W 149}	Continued From page 2 27c.0102 as failure to provide care or services necessary to maintain the mental health, physical health and well-being of the client." Review on 5/25/18 of the conclusions from the investigation dated 5/1/18 revealed, "Based on statement and documentation review allegations of willful neglect has been unsubstantiated. However, it was determined all employee communication is not properly documented in an effective manner." Interview on 5/25/18 with the Executive Director acknowledged the neglect of supervision of client #2 in this investigation met the facility's definition for neglect. He further acknowledged the findings of this investigation dated 5/1/18 concluded neglect was not substantiated.	{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 record review and interviews, the facility failed to ensure an allegation of neglect was thoroughly investigated. This affected 1 of 6 audit clients (#2). The finding is: An allegation of neglect involving client #2 was not thoroughly investigated. Review on 5/25/18 of an investigation dated 5/1/18 revealed the Residential Manager (RM) was contacted by phone by staff #1 on 5/1/18 around 3:20pm. Staff #1 told the RM that he and	{W 154}		

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{W 154}	Continued From page 3	{W 154}		

staff #2 had arrived at the vocational workshop to pick up the clients and discovered client #2 was not at the workshop. The RM told staff #1 client #2 was at home resting and that this information had been given to staff #2 when she arrived at work around 3pm. The RM immediately contacted the qualified intellectual disabilities professional (QIDP) and both the RM and the QIDP drove to the facility. Staff #1 and staff #2 assisted clients #1, #3, #5 and #6 onto the van and arrived at the facility around 3:50pm. Further review of the investigation revealed when the QIDP and RM arrived at the facility around 3:45pm, client #4 was found in his bedroom sleeping. Additional review of the facility's investigation estimated client #2 was left alone at the facility around 40-50 minutes.

Interviews on 5/25/18 with staff #1 revealed staff #2 had only been working at the facility about 3 weeks. He stated he was unaware that client #2 had been left at the facility. He confirmed client #2 was to be visually checked every 15 minutes. He also stated when the RM told him on the phone client #2 was at home, staff #2 remembered leaving client #2 at the facility. Staff #1 stated staff #2 was scared and very upset that she had forgotten about leaving client #2 at the facility . He stated when the van arrived at the facility around 3:50pm, the QIDP and RM were at the facility. He stated both he and staff #2 were relieved from their shift and they clocked out and went home until the investigation was completed.

Review on 5/24/18 of client #2's record revealed he is verbal and has diagnoses of Moderate Intellectual Disabilities and Schizophrenia (Undifferentiated type). The individual program plan (IPP) indicated client #2 had been

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{W 154}	Continued From page 4	{W 154}		

adjudicated incompetent and had a guardian of the person appointed to act on his behalf. Further review revealed client #2 has target behaviors of physical aggression, elopement and property destruction. These behaviors are addressed by a behavior support plan (BSP) which was dated 5/18/18.

Review on 5/25/18 of the facility's policy on Neglect # C.4.5 revealed, "Defined in 10A NCAC 27c.0102 as failure to provide care or services necessary to maintain the mental health, physical health and well-being of the client."

Additional review on 5/25/18 of the internal investigation on 5/25/18 revealed there were no interviews with the clients from the facility including client #2. There were also no interviews with the vocational staff in the internal investigation. Client #2's inappropriate behaviors of elopement and his specific supervision requirements were also not included in the BSP. The conclusions from the investigation revealed, "Based on statement and documentation review allegations of willful neglect has been unsubstantiated. However, it was determined all employee communication is not properly documented in an effective manner."

Interview on 5/25/18 with the Executive Director revealed interviews were not conducted with the clients at the facility or staff at the vocational workshop in conjunction with the this investigation. He also confirmed information about client #2's target behaviors and supervision requirements were not considered when the investigation was being completed. In addition, the Executive Director acknowledged the neglect of staff #2 leaving client #2 at the facility on 5/1/18

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{W 154}	Continued From page 5 met the facility's definition for neglect, although the findings indicated neglect was not substantiated.	{W 154}		