PRINTED: 05/29/2018 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	
		34G293	B. WING _		,	R-C 05/25/2018	
NAME OF PROVIDER OR SUPPLIER STONEGATE				STREET ADDRESS, CITY, STATE, Z 8609 STONEGATE DR RALEIGH, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS	S	W	000			
{W 149}	"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 1	49}			
	professional (QIDP) a QIDP drove to the far assisted clients #1, #	ed intellectual disabilities and both the RM and the cility. Staff #1 and staff #2 3, #5 and #6 onto the van cility around 3:50pm. Further					

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G293	B. WING _				-C 25/2018
NAME OF PROVIDER OR SUPPLIER STONEGATE				STREET ADDRESS, CITY, STATE, ZIP CO 8609 STONEGATE DR RALEIGH, NC 27615	DDE	1 03/	23/2010
(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 ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
{W 149}	QIDP and RM arrived 3:45pm, client #4 was sleeping. Additional rinvestigation estimate the facility around 40 Interviews on 5/25/18 #2 had only been wo weeks. He stated he had been left at the fare to visually check minutes. He also stat the phone client #2 w remembered leaving #1 stated staff #2 was he had forgotten abfacility. He stated whe facility around 3:50pm the facility. He stated relieved from their she stated they clocked the investigation was Review on 5/24/18 of he is verbal and has Intellectual Disabilitie (Undifferentiated type plan (IPP) indicated cadjudicated incompet the person appointed review revealed clien physical aggression, destruction. These be a behavior support pl 5/18/18. Review on 5/25/18 of	ation revealed when the lat the facility around is found in his bedroom eview of the facility's ed client #2 was left alone at 4-50 minutes. With staff #1 revealed staff rking at the facility about 3 was unaware that client #2 acility. He confirmed staff on client #2 every 15 ed when the RM told him on the reast at home, staff #2 client #2 at the facility. Staff is scared and very upset that but leaving client #2 at the en the van arrived at the enthe van arrived at the hoth he and staff #2 were wift by the QIDP and RM were at both he and staff #2 were wift by the QIDP and the RM. It dout and went home until completed. I client #2's record revealed diagnoses of Moderate is and Schizophrenia etc. The individual program stient #2 had been tent and had a guardian of to act on his behalf. Further it #2 has target behaviors of	{W 14	49}			

PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				R-C			
		34G293	B. WING			05/	25/2018
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
STONEGA	TE				8609 STONEGATE DR		
0.0.1207					RALEIGH, NC 27615		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{W 149}	necessary to maintain health and well-being Review on 5/25/18 or investigation dated 5/ statement and docum of willful neglect has the However, it was deter communication is not effective manner." Interview on 5/25/18 or acknowledged the ne #2 in this investigation for neglect. He further of this investigation of this investigation danglect was not substraction of the facility must have violations are thorough. This STANDARD is represented to ensure was thoroughly investigation of neglect was not substractions are thoroughly investigation of neglect was not substractions. The facility failed to ensure was thoroughly investigation of neglect not neglect	a provide care or services in the mental health, physical of the client." If the conclusions from the 1/18 revealed, "Based on identation review allegations been unsubstantiated. Imined all employee properly documented in an with the Executive Director glect of supervision of client in met the facility's definition or acknowledged the findings ated 5/1/18 concluded tantiated. OF CLIENTS) If the conclusions from the 1/18 revealed, "Based on 1/18 entitions from the 1/18 entition	{W 1		}		
	5/1/18 revealed the R was contacted by pho	-					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				R-C				
		34G293	B. WING			05/	25/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·		
				86	609 STONEGATE DR			
STONEGA	ATE			R	ALEIGH, NC 27615			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE	
{W 154}	Continued From pag	ge 3	{W 1	54}				
	staff #2 had arrived	at the vocational workshop to	,	-				
		nd discovered client #2 was						
	1 .	. The RM told staff #1 client						
		ting and that this information						
		taff #2 when she arrived at						
	work around 3pm. T	he RM immediately						
	contacted the qualifi	ied intellectual disabilities						
		and both the RM and the						
		acility. Staff #1 and staff #2						
		#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							
		as found in his bedroom review of the facility's						
		ted client #2 was left alone at						
	the facility around 40							
		8 with staff #1 revealed staff						
	_	orking at the facility about 3						
		e was unaware that client #2						
	I .	facility. He confirmed client						
		y checked every 15 minutes.						
	phone client #2 was	n the RM told him on the						
		g client #2 at the facility. Staff						
		as scared and very upset that						
		bout leaving client #2 at the						
		then the van arrived at the						
	1	om, the QIDP and RM were at						
		d both he and staff #2 were						
		hift and they clocked out and						
	I .	investigation was completed.						
		of client #2's record revealed						
	I .	diagnoses of Moderate						
	I .	es and Schizophrenia						
		pe). The individual program						
	plan (IPP) indicated	client #2 had been						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	CO	(X3) DATE SURVEY COMPLETED		
		34G293	B. WING			R-C 5/25/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 8609 STONEGATE DR RALEIGH, NC 27615	•	5/25/2016	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{W 154}	the person appoints review revealed clie physical aggression destruction. These behavior support pl 5/18/18. Review on 5/25/18 Neglect # C.4.5 rev 27c.0102 as failure	etent and had a guardian of ed to act on his behalf. Further ent #2 has target behaviors of a, elopement and property behaviors are addressed by a ean (BSP) which was dated of the facility's policy on ealed, "Defined in 10A NCAC to provide care or services	{W 1	54}			
	health and well-being Additional review on investigation on 5/2 interviews with the including client #2. with the vocational investigation. Client of elopement and herequirements were The conclusions from "Based on statement allegations of willful unsubstantiated. However, we will be added to the statement of t	n 5/25/18 of the internal 5/18 revealed there were no clients from the facility There were also no interviews staff in the internal #2's inappropriate behaviors is specific supervision also not included in the BSP. m the investigation revealed, nt and documentation review neglect has been owever, it was determined all cation is not properly					
	revealed interviews clients at the facility workshop in conjun investigation. He alsabout client #2's tar requirements were investigation was but the Executive Direction in the facility of t	8 with the Executive Director were not conducted with the or staff at the vocational ction with the this so confirmed information get behaviors and supervision not considered when the eing completed. In addition, tor acknowledged the neglect lient #2 at the facility on 5/1/18					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION G	(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
34G293		B. WING		R-C			
NAME OF P	ROVIDER OR SUPPLIER	040233		STREET ADDRESS, CITY, STATE, ZIP CODE	05	5/25/2018	
NAME OF T	NOVIDEN ON 301 1 EIEN			8609 STONEGATE DR			
STONEGA	TE			RALEIGH, NC 27615			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
{W 154}	{W 154} Continued From page 5		{W 15	54}			
(W 134)		nition for neglect, although	{***)4 }			