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

PRINTED: 05/29/2018 FORMAPPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION		E SURVEY PLETED
		34G293	B. WING			1	R-C
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		860	EETADDRESS, CITY, STATE, ZIP CODE 9 STONEGATE DR LEIGH, NC 27615		/25/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
W 000	"As a result of the foldetermined that W10: April 6, 2018 were costandard level deficie STAFF TREATMENT CFR(s): 483.420(d)(1) The facility must developolicies and procedur mistreatment, neglect This STANDARD is represent neglect of clients (#4) in the facility Management intended to prevent neglect of clients (#4) in the facility. Review on 5/25/18 of	clow-up survey, it was 2, W104, W122 from the rected. In addition, repeat ncies are cited." OF CLIENTS) elop and implement written es that prohibit or abuse of the client. not met as evidenced by: ew and staff interviews, the ment policies intended to ents. This affected 1 of 6 lity. The finding is:	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		The deficiencies will be corrected by the follow actions: A. Management personnel, including all person responsible for investigations, will be re-tral on Rescare's policy and definitions of abusing lect. B. Once investigations have been concluded, be reviewed by a team consisting of, but no to, Program Managers, Executive Director & Resources personnel. Review committe will responsible for ensuring that findings are cowift the agencies policies. Recommendation provided by this committee. C. An investigation checklist will be implement assist investigators to complete thorough investigations that consider all support need individual and to ensure that all relevant per are interviewed. Once developed, managen personnel will be trained prior to its implement. D. Once an investigation has been initiated, P Managers and Executive Director will moniprogress of the investigation daily until complete to the control of the con	ns ined e and they will be ined & Human I be ined to dis of an insons enert entation.	08/24/18
	was contacted by pho around 3:20pm. Staff staff #2 had arrived at pick up the clients and not at the workshop. If #2 was at home restin had been given to staff work around 3pm. The contacted the qualified professional (QIDP) at QIDP drove to the faciliassisted clients #1, #3 and arrived at the faciliaround 3:20pm.	ne by staff #1 on 5/1/18 #1 told the RM that he and the vocational workshop to I discovered client #2 was The RM told staff #1 client g and that this information If #2 when she arrived at			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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GHY512

Facility ID: 955748

If continuation sheet Page 1 of 6

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

PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		IVAL DESIGNATION OF THE PROPERTY OF THE PROPER			No transfer and the second of	OMR L	<u>vo. 0938-0391</u>
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED
		34G293	B. WING		,	1	R-C 5/25/2018
NAME OF P	ROVIDER OR SUPPLIER	•		s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	0/20/2010
STONEGA	\TE] B(609 STONEGATE DR		
0.0,1207				R	RALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
	QIDP and RM arrived 3:45pm, client #4 was sleeping. Additional re investigation estimated the facility around 40-4 lnterviews on 5/25/18 #2 had only been work weeks. He stated he whad been left at the fact are to visually check o minutes. He also state the phone client #2 was remembered leaving c #1 stated staff #2 was she had forgotten about facility. He stated whe facility around 3:50pm, the facility. He stated be relieved from their shift he stated they clocked the investigation was c Review on 5/24/18 of che is verbal and has dis Intellectual Disabilities (Undifferentiated type). plan (IPP) indicated client #2 physical aggression, eledestruction. These behalter investigation the person appointed to review revealed client #2 physical aggression, eledestruction. These behalter investigation is the person appointed to review revealed client #2 physical aggression, eledestruction. These behalter investigation is the person appointed to review revealed client #2 physical aggression, eledestruction.	at the facility around found in his bedroom view of the facility's d client #2 was left alone at 50 minutes. with staff #1 revealed staff king at the facility about 3 //as unaware that client #2 cility. He confirmed staff in client #2 every 15 d when the RM told him on as at home, staff #2 lient #2 at the facility. Staff scared and very upset that ut leaving client #2 at the in the van arrived at the the QIDP and RM were at both he and staff #2 were by the QIDP and the RM. out and went home until ompleted. client #2's record revealed agnoses of Moderate and Schizophrenia The individual program ent #2 had been int and had a guardian of o act on his behalf. Further f2 has target behaviors of	₹W 1	49)	Please see page 1.		
	Review on 5/25/18 of th Neglect # C.4.5 reveale	ne facility's policy on ed, "Defined in 10A NCAC					

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

PRINTED: 05/29/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SU	
		34G293	B. WING		R-C	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				STREET ADDRESS, CITY, STATE, ZIP CODE 8609 STONEGATE DR RALEIGH, NC 27615	05/25	5/2018
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE I	(X5) COMPLETION DATE
(W 149)	27c.0102 as failure to necessary to maintain health and well-being Review on 5/25/18 of investigation dated 5/1	provide care or services the mental health, physical of the client." the conclusions from the /18 revealed, "Based on	{W 14	Please see page 1.		
{W 154}	of willful neglect has be However, it was determined to the effective manner." Interview on 5/25/18 where acknowledged the neglect manner acknowledged the neglect. He further of this investigation dain neglect was not substated STAFF TREATMENT CCFR(s): 483.420(d)(3) The facility must have a	een unsubstantiated. mined all employee properly documented in an ith the Executive Director lect of supervision of client met the facility's definition acknowledged the findings ted 5/1/18 concluded intiated. DE CLIENTS evidence that all alleged	{W 154	4} Please see page 4.		
·	Based on record review and interviews, the acility 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			·		·

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

PRINTED: 05/29/2018 FORMAPPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROV IDENT		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) 241 II	TIDI	E CONSTRUCTION	OMB NO. 0938-0391		
		FCORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY		
				7. BUILL	A. BUILDING			COMPLETED	
34G293			B. WING		R-C				
ſ	NAME OF P	ROVIDER OR SUPPLIER				CTDECT ADDRESS OF A STATE OF A ST	05	/25/2018	
ĺ	STONEO	F admittee			•	STREET ADDRESS, CITY, STATE, ZIP CODE			
STONEGATE		NE.			ı	3609 STONEGATE DR			
ŀ	(X4) ID	SI IMMARY STA	TEMENT OF DEFIDIENCES		<u>'</u>	RALEIGH, NC 27615			
	PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	N
•	the second secon	pick up the clients and not at the workshop. The workshop. The workshop. The work around 3pm. The contacted the qualified professional (QIDP) and QIDP drove to the facilitiassisted clients #1, #3, and arrived at the facilitiate work around 3pm. The contacted the qualified professional (QIDP) and QIDP and RM arrived at 33.45pm, client #4 was fasteeping. Additional reviewes investigation estimated the facility around 40-50 and the facility around 40-50 and the state of the work work weeks. He stated he was to be visually chelled also stated when the whone client #2 was at he membered leaving client stated staff #2 was so the had forgotten about acility. He stated when acility around 3:50pm, the facility. He stated bot elieved from their shift a tent home until the investigation as the state of the investigation that is the facility. He stated bot elieved from their shift a tent home until the investigation at the state of the investigation at the state of the state of the investigation at the state of the state of the investigation at the state of the work work was at the facility. He stated bot elieved from their shift at the facility around 3:50pm, the facilit	the vocational workshop to discovered client #2 was he RM told staff #1 client and that this information #2 when she arrived at RM immediately intellectual disabilities d both the RM and the fity. Staff #1 and staff #2 #5 and #6 onto the van by around 3:50pm. Further ion revealed when the at the facility around ound in his bedroom liew of the facility's client #2 was left alone at minutes. With staff #1 revealed staffing at the facility about 3 is unaware that client #2 ity. He confirmed client ecked every 15 minutes. RM told him on the some, staff #2 in #2 at the facility. Stafficated and very upset that leaving client #2 at the the van arrived at the the van arrived at the ine QIDP and RM were at the he and staff #2 were and they clocked out and stigation was completed. Left #2's record revealed and Schizophrenia the individual program	{W.1	54}	The deficiencies will be corrected by the following actions: A. Qualified Professional (QP) will revise and/or add to all individual Support Plans to include supervisit requirements for all individuals. B. QP will re-train all staff on steep log documentation will include how and when to conduct sleep checks. C. QP will re-train all staff on room check documental Training will include how and when to conduct root. D. Residential Manager (RM) and QP will monitor and adherence to all corrective measures daily for a root Afterwards, they will each provide on-going monitor and safe all corrective measures weekly for a month. Afterward all corrective measures weekly for a month. Afterward Program Manager will provide on-going monitoring to the provide on-going monitoring to th	i. Training ion, in checks. document onth. rence to	06/24/18	

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

PRINTED: 05/29/2018 FORM APPROVED

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1			OMB NO. 0938-039 ⁻		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI		E CONSTRUCTION		TE SURVEY MPLETED	
		34G293	B. WNG	·		i	R-C	
NAME OF	PROVIDER OR SUPPLIER			T :	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	5/25/2018	
STONE	CATE			8609 STONEGATE DR				
J. O.V.	DAIL			RALEIGH, NC 27615				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES						
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF	ıv	PROVIDER'S PLAN OF CORRECTION		(X5)	コ
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	COMPLETION	١ ١
					DEFICIENCY)	116		- 1
201454								\dashv
{W 154	- Land		{W1	54}				
	adjudicated incompete	nt and had a guardian of		,				
	the person appointed to	o act on his behalf. Further			Please see page 4.			- 1
	review revealed client	#2 has target behaviors of						- [
	physical aggression, el	opement and property		ĺ				-
	destruction. These beh	aviors are addressed by a		Ì				- [
	behavior support plan (BSP) which was dated		1				
	5/18/18.							
		•		ĺ				İ
	Review on 5/25/18 of the	ne facility's policy on		1				
	Neglect # C.4.5 reveale	d, "Defined in 10A NCAC			•			
	27c.0102 as failure to p	rovide care or services						
	necessary to maintain t	he mental health, physical		- 1				
	health and well-being o	the client."						
	Additional review on 5/2)E/40 of the internal						
	investigation on 5/25/18	soverled the second						
	interviews with the clien	to from the facility						ı
	including client #2 Ther	e were also no interviews				1		1
	with the vocational staff	in the internal						
	investigation: Client #2's	inappropriate behaviors		-		1		1
	of elopement and his sp	ecific supervision						
	requirements were also	not included in the RSP				-		
	The conclusions from the	e investigation revealed		- 1				
-	"Based on statement and	d documentation review						
	allegations of willful negl	ect has been				1		
	unsubstantiated. However	er, it was determined all						1
	employee communication	n is not properly						
1	documented in an effecti	ve manner."						
	tt							
	Interview on 5/25/18 with the Executive Director							
.	revealed interviews were	not conducted with the		1		-		
1	clients at the facility or sta						ĺ	
	workshop in conjunction	with the this			,	1		
-	investigation. He also cor	ntirmed information						
	about client #2's target be	enaviors and supervision]	
	requirements were not co	insidered when the			•			
	investigation was being c	ompleted. In addition,					Ì	
	the Executive Director ac	knowledged the neglect					l	
	of staff #2 leaving client #	2 at the facility on 5/1/18		1			- 1	

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 A. BUILDING (X3) DATE SURVEY COMPLETED R-C (X4) MULTIPLE CONSTRUCTION A. BUILDING R-C (X5) MULTIPLE CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE

		34G293	B. WING_				FIREIRAAR
NAME OF F	PROVIDER OR SUPPLIER			Sī	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	5/25/2018
STONEG	ATE	•			109 STONEGATE DR		
					ALEIGH, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
{W 154}		5	{ VV 18	54}			
	met the facility's definition the findings indicated in substantiated.	tion for neglect, although neglect was not	_		Please see page 4.		
	·					i	
		·					