

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/25/2018
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NAME OF PROVIDER OR SUPPLIER STONEGATE	STREET ADDRESS, CITY, STATE, ZIP CODE 8609 STONEGATE DR RALEIGH, NC 27615
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W 000	INITIAL COMMENTS	W 000		
{W 149}	<p>"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."</p> <p>STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>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:</p> <p>Facility Management failed to implement policies intended to prevent neglect of clients in the facility.</p> <p>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</p>	{W 149}	<p>The deficiencies will be corrected by the following actions:</p> <p>A. Management personnel, including all persons responsible for investigations, will be re-trained on Rescare's policy and definitions of abuse and neglect.</p> <p>B. Once investigations have been concluded, they will be reviewed by a team consisting of, but not limited to, Program Managers, Executive Director & Human Resources personnel. Review committee will be responsible for ensuring that findings are consistent with the agencies policies. Recommendations will be provided by this committee.</p> <p>C. An investigation checklist will be implemented to assist investigators to complete thorough investigations that consider all support needs of an individual and to ensure that all relevant persons are interviewed. Once developed, management personnel will be trained prior to its implementation.</p> <p>D. Once an investigation has been initiated, Program Managers and Executive Director will monitor the progress of the investigation daily until completed.</p>	06/24/18

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

TITLE

(X6) DATE



Executive Director

6/8/18

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 149}	<p>Continued From page 1</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Review on 5/25/18 of the facility's policy on Neglect # C.4.5 revealed, "Defined in 10A NCAC</p>	{W 149}	Please see page 1.	
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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}	Please see page 1.		
{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}	Please see page 4.		

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{W 154}	<p>Continued From page 3</p> <p>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.</p> <p>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.</p> <p>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</p>	{W.154}	<p>The deficiencies will be corrected by the following actions:</p> <p>A. Qualified Professional (QP) will revise and/or add addendums to all Individual Support Plans to include supervision requirements for all Individuals.</p> <p>B. QP will re-train all staff on sleep log documentation. Training will include how and when to conduct sleep checks.</p> <p>C. QP will re-train all staff on room check documentation. Training will include how and when to conduct room checks.</p> <p>D. Residential Manager (RM) and QP will monitor and document adherence to all corrective measures daily for a month. Afterwards, they will each provide on-going monitoring 3x/weekly.</p> <p>E. Program Manager will monitor and document adherence to all corrective measures weekly for a month. Afterwards, Program Manager will provide on-going monitoring bi-weekly.</p>	06/24/18	

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{W 154}	<p>Continued From page 4</p> <p>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.</p> <p>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."</p> <p>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."</p> <p>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</p>	{W 154}	Please see page 4.		

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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}	Please see page 4.		