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

PRINTED: 05/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G278	A. BUILDING _____ B. WING _____	C 05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENT FERRY HOME	804 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540

(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 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 document review and interviews, the facility failed to ensure an allegation was thoroughly investigated. This affected 2 of 3 audit clients (#3, #4). The finding is: An allegation of abuse involving client #3 and client #4 was not thoroughly investigated. Review on 5/15/18 of an IRIS report and facility investigation report revealed an anonymous call came in on 4/30/18 indicating that a staff had slapped and punched client #3 and client #4. The report noted the accused staff had been suspended and an investigation was initiated. Additional review of the investigation revealed the Qualified Intellectual Disabilities Professional (QIDP) had conducted the investigation including "all interviews". The report's documents included two written statements from staff and two statements from interviews with client #3 and client #4. No other staff statements were included. The investigation report also concluded the allegation was not substantiated. Interviews on 5/15/18 with six staff including the home manager, four direct care staff and the accused staff, revealed none of the staff had been formally interviewed by anyone at the facility. Additional interview with the accused staff revealed she was only told to write a statement indicating if she had ever witnessed abuse in the home and no one had questioned her directly	W 154	RECEIVED JUL 18 2018 DHSR-MH Licensure Sect	

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

ICF Division Director 7-18-18

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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	34G278	A. BUILDING _____ B. WING _____	C 05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENT FERRY HOME	904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540

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W 154	Continued From page 1 regarding the accusations. Interview on 5/15/18 via telephone with the QIDP indicated she had only interviewed client #3 and client #4 and had not conducted any staff interviews. The QIDP further revealed those were the instructions she had been given and she assumed staff interviews had been completed by the facility's Director. During an interview on 5/15/18, the Director acknowledged more thorough interviews needed to be conducted.	W 154		
W 259	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #1's individual program plan (IPP) was reviewed at least annually. This affected 1 of 3 audit clients. The finding is: Client #1's record did not include a current IPP. Review on 5/15/18 of client #1's record revealed an IPP dated 11/22/16. No current IPP could be located in the client's record. Interview on 5/15/18 with the facility's Director revealed a current IPP could not be located and a team meeting would need to be held for client #1 to update his plan.	W 259		

W154 – The facility will ensure that all allegations of abuse, exploitation have evidence that all alleged violations are thoroughly investigated.

Treatment team will ensure that all future investigations are thorough and all staff members working at facility are interviewed for statements before rendering a decision.

QP will monitor monthly

W259 – The facility will ensure at least annually a comprehensive functional assessment is completed on each individual.

The QP will ensure that client #1's IPP is located and placed in his record.

QP will monitor monthly