STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G020	A. BUILDING ______ B. WING ______	C 10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUSE'S GROUP HOME	**5949 NC 135** **STONEVILLE, NC 27048**

(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 Intake # NC00170127, NC00166622	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure environmental safety. The finding is: Observations at the group home on 10/5/20 at 3:45 PM revealed environmental concerns with a collection of broken items outside the group home on the lawn of the facility. Observations revealed a non-operational outdoor grill with various pieces of rusted metal with sharp edges under the lid of the grill and an non-operational outdoor sink with rusted metal baskets collected on top to sit collected to the side of the group home lawn. Continued observation of the outside environment of the group home revealed a glass table with collected dirt that evidenced lack of use, unused lumber with protruding rusted nails, broken wicker furniture with sharp edges, a metal chair in front of the group home with detached metal from the frame with sharp edges and a table on the front porch of the group home with a glass tray that contained cigarette butts. Subsequent review of the outdoor property of the group home site revealed a broken lantern light at the top of the group home driveway. Observation	W 104		

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.

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W 104	Continued From page 1 near the broken lantern revealed multiple pieces of broken glass compiled at the base of the light. Interview with the facility qualified intellectual disabilities professional (QIDP) on 10/5/20 revealed glass from the broken lantern of the driveway of the group home was reported to have been cleaned up. Continued interview with QIDP and the facility administrator on 10/5/20 verified there were items in the lawn of the group home that were to be hauled off and thrown away. Further interview with the QIDP and facility administrator verified the need for closer supervision of environmental safety of the group home with identified behaviors of a new client in the group home.	W 104		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, review of records and interview the individual support plan (ISP) failed to have sufficient training objectives or interventions relative to behavior management for 1 of 1 sampled client (#1). The finding is: Review on 10/5/20, during a complaint investigation survey, revealed an internal investigation dated 10/1/20. Review of the 10/1/20 investigation revealed an allegation that client #1 alleged staff A slapped her.	W 227		

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W 227 Continued From page 2

Review of records for client #1 on 10/5/20 revealed an ISP dated of 6/25/20 with a diagnosis that included: moderate intellectual disability, disruptive mood disorder, borderline personality and conduct disorder. Further record review revealed a behavior support plan (BSP) dated 5/31/20 with target behaviors of property destruction, inappropriate verbal behavior, self-injurious behavior, elopement, physical aggression and crisis behavior with suicidal ideation. Review of a psychological assessment for client #1 dated 10/17/19 revealed the client to sometimes lie to obtain things, favors or to avoid obligations; sometimes lies to get out of trouble and sometimes lies to deceive others.

Interview with the facility qualified intellectual disability professional (QIDP) on 10/5/20 revealed the internal investigation initiated 10/1/20 was still open and findings had not been concluded. Continued interview with the QIDP revealed after client #1 made the allegation against staff A, there were no observed marks on client #1 relative to the allegation. Subsequent interview with the QIDP revealed staff interviews had thus far, not confirmed any observation of abuse towards client #1 by any staff. Additional interview with the QIDP revealed client #1 has a history of not telling the truth and this behavior had caused past issues with other clients.
Interview with the associate QIDP revealed client #1's identified behavior of telling stories or half truths had not been included in client #1's BSP and guidelines to address the behavior had also been omitted.

W 227

W 249 PROGRAM IMPLEMENTATION
CFR(s): 483.440(d)(1)

W 249

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W 249	Continued From page 3	W 249		

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:
Based on review of records and interviews, the individual support plan (ISP) failed to include sufficient interventions, as identified by the interdisciplinary team (IDT), to address behavior management for 1 of 1 sampled client (#1). The finding is:

Review on 10/5/20, during a complaint investigation survey, revealed an internal investigation dated 10/1/20. Review of the 10/1/20 investigation revealed an allegation that client #1 alleged staff A slapped her. Further review of the internal investigation revealed client #1 to have had a behavior incident on 9/30/20 that resulted in the client breaking a lantern light fixture in the driveway of the group home that the client then used a piece of glass to cut herself. Additional review revealed client #1 was taken to the local emergency room and treated with dermabond glue to close the wound.

Review of records for client #1 on 10/5/20 revealed and admit date of 5/25/20. Continued record review revealed an ISP dated of 6/25/20 with a diagnosis that included: moderate intellectual disability, disruptive mood disorder,

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W 249	Continued From page 4 borderline personality and conduct disorder. Further record review revealed a behavior support plan (BSP) dated 5/31/20 with target behaviors of property destruction, inappropriate verbal behavior, self-injurious behavior, elopement, physical aggression and crisis behavior with suicidal ideations. Review of internal documentation relative to client #1's behaviors revealed the client to have been hospitalized on 7/21/20 by IVC for aggression. Further review of documentation revealed behavior dates of 7/2020, 8/2020 and 9/2020 to include multiple bx's of elopement, physical aggression and property destruction. Interview with the facility qualified intellectual disabilities professional (QIDP) and facility administrator on 10/5/20 revealed the facility had identified the need for increased supervision of client #1 to support client safety due to the severity of behaviors. Further interview with the QIDP and facility administrator verified efforts to coordinate with outside services, the local MCO and DSS, regarding an enhanced rate of pay to cover the need for increased supervision of client #1. Subsequent interview with the QIDP confirmed increased supervision, as identified by the IDT, had not been identified in client #1's BSP as a behavior intervention or prevention measure to any identified target behavior.	W 249		