STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G345	A. BUILDING _____ B. WING _____	C 10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUSE'S GROUP HOME #6	5820 NC HIGHWAY 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 NC00167876	W 000		
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 (#4). The finding is: Review of rcords for client #4 on 10/5/20, during a complaint investigation survey, revealed an ISP dated 2/12/20. Review of the ISP revealed client #4 to have training objectives relative to the following: straighten closet, clean bathroom, time management, clean his room, toothbrushing, and work on unhealthy boundaries. Continued review of the ISP indicated that client #4 tells half-truths, misinterprets kindness from girls as love and becomes disillusioned with the status of his relationship. Further record review for client #4 revealed a behavior support plan (BSP) dated 2/18/20 which identified the following target behaviors: verbal aggression, cursing, name-calling, racial epithets, lying, elopement, physical aggression, and property destruction. The ISP review for client #4 did not include training objectives or programming to address not telling the truth or telling half-truths.	W 227		

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	(X3) DATE SURVEY COMPLETED
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W 227	Continued From page 1 Interview with the qualified intellectual disability professional (QIDP) on 10/5/20 revealed the facility had not received any complaints from client #4 regarding privacy concerns. Further interview with the QIDP revealed that client #4 has a history of not telling the truth to staff and family and when confronted he denies any wrongdoing. Further interview with the QIDP verified that client #4 did not have any guidelines or training objectives relative to not telling the truth or half truths. Continued interview with the QIDP confirmed that client #4 could benefit from programming and/or guidelines relative to not telling the truth or half-truths.	W 227		