STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G332	A. BUILDING _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD AVENUE HOME	2510 NORWOOD AVENUE GOLDSBORO, NC 27530

(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 A complaint survey was conducted during the recertification survey for intake #NC00173749. No deficiencies were cited as a result of the complaint survey; however, a deficiency was cited during the recertification survey.	W 000		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 3 audit clients (#5). The finding is: Review on 4/6/21 of client #5's Mental Health Plan (MHP) dated 7/25/20 revealed the objective, "[Client #5] will have incident free days related to symptoms of his DSM-5 diagnosis of Schizoaffective Disorder Bipolar type, specifically self-injurious behavior for 160 of 165 days." The MHP incorporated the use of Depakote, Luvox, Seroquel, Haldol, and Benadryl. Additional review of a consent for the MHP revealed it was effective from 7/25/19 to 7/25/20. The consent noted, "I understand that this consent is voluntary and is valid for 1 year." No current consent was available for review. Interview on 4/6/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no	W 263		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G332	A. BUILDING _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD AVENUE HOME	**2510 NORWOOD AVENUE GOLDSBORO, NC 27530**

(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 263	Continued From page 1 current consent had been obtained from client #5's guardian.	W 263		