DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FOR	MAPPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	<u> 0938-0391</u>	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		34G020	B. WING			C / 15/2021	
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE			
ROUSE'S	GROUP HOME			5949 NC 135 STONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS		W 0	00			
W 122	Complaint Intake#: N NC00178097 CLIENT PROTECTIC CFR(s): 483.420	IC00177935, NC00178091, DNS	W 1:	22			
	The facility must ensu protections requireme	ure that specific client ents are met.					
W 149	The facility failed to e written policies and p mistreatment, neglect failed to ensure that a abuse were reported administrator and to c with state law (W153) that all alleged violation investigated (W154) a corrective action was finding of client to client The cumulative effect resulted in the facility statutorily mandated of STAFF TREATMENT CFR(s): 483.420(d)(1)	other officials in accordance by failed to provide evidence ons were thoroughly and failed to ensure timely taken relative to a verified ent abuse (W157). To of these systemic practices is failure to provide client protections. OF CLIENTS)	W 1	49			
	policies and procedur mistreatment, neglect This STANDARD is r Based on observatio	elop and implement written res that prohibit t or abuse of the client. not met as evidenced by: n, record/document review ility failed to assure it's					

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

TITLE

(X6) DATE

PRINTED: 06/27/2021

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.

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 06/27/2021 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G020	B. WING		_	06/ [.]) 15/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
ROUSE'S	GROUP HOME			5949 NC 135 STONEVILLE, NC 2704	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 149	policies and procedur neglect were impleme of 1 of 5 sampled clier Observation in house client #13 to share a r Continued observatio bedroom of client #13 increased supervision the group home as cli and exit their bedroom Interview with client # client #19 had sexual her while both client's the incidents had bee qualified intellectual d (QIDP). Continued in revealed she did not r incidents but she did at night. Further inter revealed the facility Q incidents with telling of bedroom door open a would close the door Review of internal inc on 6/15/21 revealed n client #13 reporting in touch by client #19. F investigations and inq year on 6/14/21 and 6 evidence of any inquiti client #13's alleged in inappropriately sexual Review of records for revealed a person cer	es that prohibit abuse and ented to prevent the abuse ints (#13). The finding is: #5 on 6/14/21 revealed room with client #19. In in house #5 revealed the and client #19 to have no than any other bedroom in ents were observed to enter ins. 13 on 6/14/21 revealed y inappropriately touched were in their bedroom and n reported to the facility isabilities professional terview with client #13 emember the dates of the not feel safe in her bedroom view with client #13 IDP had addressed the client #13 to keep her t night although client #19 after she went to sleep. ident reports for the facility to documented incident of cidents of inappropriate Review of internal facility uiries over the past review S/15/21 revealed no ry or investigation related to cident of being lly touched by client #19.	W 149	}			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE COMP	
		34G020	B. WING				_ 15/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
ROUSE'S	GROUP HOME				949 NC 135 STONEVILLE, NC 27048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
W 149	#13 revealed a diagner Intellectual Disability, Schizoaffective Disore Disorder with Major D Disorder and Disrupti Further review of the a behavior support play behaviors of verbal ag aggression, property injurious behaviors ar darts in front of cars a Review of records for revealed a PCP date of the PCP for client # history of Mild Intellect Depressive Disorder, AI Personality. Further of #19 revealed a behave behaviors of tantrum destruction, inapprop self-injurious behavio aggression, inapprop (touching others in pr permission, attemptin activity, engaging in s the group home). Review on 6/15/21 of neglect policy titled "F Abuse, Neglect or Ex allegations of abuse of immediate action to p prevent further abuse review of the facility's revealed procedures abuse, neglect or exp	osis history of Mild Personality Disorder, der, Post Traumatic Stress Pepression, Bipolar I ve Behavior Disorder. PCP for client #13 revealed an (10/10/20) with target ggression, physical destruction, elopement, self and walks in the streets. client #19 on 6/14/21 d 2/26/20. Continued review #19 revealed a diagnosis ctual Disability, Major (Severe), Oppositional DHD, and Borderline review of the PCP for client vior support plan with target behavior, property riate verbal behavior, r, elopement, physical riate sexual behavior ivate areas without g to force others into sexual eexual activity prohibited by the facility's abuse and Protection from Harm, ploitation" revealed all or neglect are to receive rotect the client and to or or neglect. Continued abuse and neglect policy to ensure all incidents of		149			

Facility ID: 922506

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PRINTED: 06/27/2021

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 06/27/2021 MAPPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G020	B. WING				06/	C 15/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CO	DDE		
				59	949 NC 135			
ROUSE'S	GROUP HOME			S	TONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI		(X5) COMPLETION DATE
W 149	the facility will ensure for substantiated alleg Interview with the qua professional (QIDP) of had been two incident client #19 had inappro- her in their bedroom. the QIDP revealed an been completed regat of client #13 for either and she was unable to the incidents. Further 6/15/21 revealed no in inquiry was conducted allegations except to in QIDP confirmed client incident during intervi- second incident befor second incident. Due must be noted the dat #19 by the QIDP are to interview with the QID formal interventions w verified incident of ina client #19 towards client incident prevention. Interview with the faci revealed she was una reported incidents of it client #13 and client # with the facility admin report regarding the a #13 should have beer internal inquiry/investi	d neglect policy revealed appropriate remedial action gations of abuse or neglect. Ilified intellectual disabilities on 6/14/21 confirmed there ts of client #13 alleging opriately sexually touched Continued interview with incident report had not roling the reported allegation incident involving client #19 or recall the exact dates of r interview with the QIDP on thernal investigation or d relative to client #13's interview client #19. The t #19 admitted to the first ew and initially denied the e later admitting to the to lack of documentation it tes of interview with client		149				

Facility ID: 922506

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 06/27/2021 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G020	B. WING		-	(/06	C 15/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ROUSE'S	GROUP HOME			949 NC 135 STONEVILLE, NC 27048	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 149 W 153	occurred with the veri acknowledging inappr client #13 to help ensu that incidents did not of interview with the faci with observation, reve 6/14/21 client #19 was bedroom in group hor The facility failed to re- immediately to admini- facility's policy and pro- failed to provide evide violations were thorou- to ensure timely corre- relative to a verified fil sexual abuse therefor be neglectful. STAFF TREATMENT CFR(s): 483.420(d)(2) The facility must ensu- mistreatment, neglect injuries of unknown so immediately to the ad officials in accordance established procedure. This STANDARD is n Based on record revi facility failed to ensure immediately reported other officials in accor 3 reviewed incidents.	I interventions should have fied statements of client #19 opriate sexual touching of ure client #13's safety and occur again. Subsequent lity administrator, as verified ealed on the evening of s moved to a private ne #4. eport all allegations of abuse istration as required by the occdures. The facility also ence that all alleged ughly investigated and failed ctive action was taken nding of client to client e, the facility was found to OF CLIENTS) ure that all allegations of or abuse, as well as ource, are reported ministrator or to other e with State law through es. not met as evidenced by: ews and interviews the e allegations of abuse were to the administrator and to rdance with state law for 2 of	W 149				

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					OMB NO. 0938-0		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
			A. DOILDING	<u> </u>	с		
		34G020	B. WING		06/15/2021		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C			
ROUSE'S	GROUP HOME			5949 NC 135			
	I			STONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
W 153	Continued From page	e 5	W 15	52			
W 100		touch involving client #13	VV 10	55			
		acility administrator. For					
	Interview with client #	#13 on 6/14/21 during a					
		mplaint investigation survey					
		ad sexually inappropriately					
		th clients were in their					
ł		revealed the incidents had facility qualified intellectual					
	-	nal (QIDP). Continued					
		#13 revealed she did not					
	remember the dates	of the incidents and she did					
	not feel safe in her be	edroom at night as client #19					
	was still her roomma	te.					
		cident reports for the facility					
		no documented incident of					
		ncidents of inappropriate Review of internal facility					
		quiries over the past review					
	year on 6/14/21 and	•					
		iry or investigation related to					
	client #13's alleged ir						
	inappropriately sexua	ally touched by client #19.					
	Interview with the qua	alified intellectual disabilities					
	,	on 6/14/21 confirmed there					
		nts of client #13 alleging					
		opriately sexually touched					
		Continued interview with n incident report had not					
		arding the reported allegation					
		r incident involving client #19					
		to recall the exact dates of					
		er interview with the QIDP on					
		internal investigation or					
		ed relative to client #13's					
	allegations except to	interview client #19. The					

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	-	ID HUMAN SERVICES				FOR	M APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		34G020	B. WING				C / 15/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ROUSE'S	GROUP HOME				5949 NC 135 STONEVILLE, NC 27048		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 153	QIDP confirmed client incident during intervi second incident befor second incident. Due must be noted the dat #19 by the QIDP are to interview with the QID formal interventions we verified incident of inac client #19 towards clie survey date of 6/14/2 moved to a private be The QIDP also verifie conducted with staff to prevention. Interview with the faci- revealed she was una- reported incidents of in- client #13 and #19. Co- facility administrator r (1) incident of an alleg- sexual inappropriate to did not remember the Subsequent interview administrator verified #13 should have been QIDP and an internal have been conducted address investigation B. The facility failed to sexual inappropriate to was reported to extern with state law for 1 of example: Review of documental	t #19 admitted to the first ew and initially denied the e later admitting to the a to lack of documentation it tes of interview with client unknown. Additional DP on 6/15/21 verified no vere put in place after either appropriate sexual touch of ent #13, until the current 1, when client #19 was edroom in group home #4. d no additional training was o address incident dity director on 6/14/21 aware there had been (2) inappropriate touch between ontinued interview with the evealed she was aware of gation of client #13 reporting touch by client #19 but she date of this allegation. with the facility both allegations by client in reported to her by the inquiry/investigation should with appropriate action to findings. D ensure an allegation of behavior involving client #22 nal officials in accordance 1 investigations. For		153	3		

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PRINTED: 06/27/2021

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM): 06/27/2021 APPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		34G020	B. WING		_	06/*) 15/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ROUSE'S	GROUP HOME			5949 NC 135 STONEVILLE, NC 27048	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 153	from 6/14/21 - 6/15/27 internal investigative s facility incident report reports from 7/1/20 to incident reports from 3 support plans and bel Review of the IRIS re- did not reveal allegati- trauma. Further review of the IRIS repo- of the IRIS report date abuse and/or neglect assault. Further revie 6/11/21 indicated that on therapeutic leave w to his grandmother th- assaulted by one of h incident report also re- grandmother immedia information to client # representative on 5/27 reported to the facility administrator on the s indicated that client #2 emergency room for e Subsequent review of 6/15/21 revealed a re- investigation dated 6/ revealed that client #2 another facility that is the alleged offender (the internal investigat alleged incident that of	1 included the following: summary dated 6/10/21, improvement system (IRIS) o 6/10/21, facility internal 3/2021-6/2021, individual havior support plans. ports from 7/1/20-6/10/21 ons of sexual assault or documenation on 6/15/21 ort dated 6/11/21. The scope ed 6/11/21 was to rule out for allegations of sexual ew of the IRIS report dated to n 5/23/21 client #22 was with his family and reported at he was sexually is housemates. The evealed that the ately reported this 22's guardian 3/21, which was also or management and same day. The IRIS report 22 was transported to the evaluation on 5/23/21. If the documentation on port of a pending internal 11/21. Further review 22 was temporarily moved to not within close proximity of client #7). Further review of ive summary revealed the occurred on 5/23/21 was system on 6/11/21 which is	W 153				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 06/27/2021 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G020	B. WING _					C 15/2021
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATI	E, ZIP CODE		
ROUSE'S	GROUP HOME				949 NC 135 TONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
W 153	Interview with the Ass verified that an IRIS m 6/11/2021 because sh information to enter in the Associate QIDP c was submitted on 6/1 the 72-hour timeframe according to state law Interview with the faci that the facility had a investigation and clier client #7 by moving h from the main campus QIDP verified that the was reported to IRIS of the 72-hour timefra incidents according to the QIDP further conf incidents must be rep facility being made av Interview with the Fac 6/15/21 verified that s incident reported 5/23 the facility administrat appropriate measures separated during the Continued interview v confirmed that all IRIS completed and submit the facility was made STAFF TREATMENT CFR(s): 483.420(d)(3)	acciate QIDP on 6/15/21 eport was submitted on the was not sure of what the report. Interview with confirmed that the IRIS report 1/21 which was outside of e for reporting incidents lity QIDP on 6/15/21 verified pending internal th #22 was separated from in to another facility away s. Further interview with the 5/23/21 alleged incident on 6/11/21 which is outside me required for Level II to state law. Interview with irmed that all Level II and III orted with 72 hours of the ware of the incident. cility Administrator on he was aware of the alleged 4/21. Further interview with tor verified the facility took is to keep the clients internal investigation. with the facility administrator S reporting must be tted within 72 hours of when aware of the incident. OF CLIENTS) e evidence that all alleged	W -					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/27/2021 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G020	B. WING			06/	C 15/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				5949 NC 135			
ROUSES	GROUP HOME			STONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 154	Continued From page	9	W 154	L.			
	Based on review of fa the facility failed to pro- of abuse was thoroug sampled clients (#13) Interview with client # recertification and cor- revealed the client to sexually inappropriate clients were in their bo- revealed the incidents facility qualified inteller professional (QIDP). client #13 revealed sh dates of the incidents her bedroom at night roommate. Review of internal inc on 6/15/21 revealed n client #13 reporting in touch by client #19. F investigations and inq year on 6/14/21 and 6 evidence of any inquit client #13's alleged in inappropriately sexua Interview with the qua professional (QIDP) of had been two incident client #19 had inappro- her in their bedroom. the QIDP revealed an been completed regat	13 on 6/14/21 during a mplaint investigation survey report client #19 had ely touched her while both edroom. Client #13 s had been reported to the ectual disabilities Continued interview with he did not remember the and she did not feel safe in as client #19 was still her ident reports for the facility to documented incident of cidents of inappropriate Review of internal facility juries over the past review 5/15/21 revealed no ry or investigation related to cident of being Ily touched by client #19. alified intellectual disabilities on 6/14/21 confirmed there ts of client #13 alleging opriately sexually touched Continued interview with i incident report had not rding the reported allegation					
	of client #13 for either	rding the reported allegation incident involving client #19 o recall the exact dates of					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	· · · ·	E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		34G020	B. WING		C 06/15/2021		
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD			
ROUSE'S	GROUP HOME			49 NC 135 ONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
W 154		r interview with the QIDP on	W 154				
	inquiry was conducted allegations except to QIDP confirmed client incident during interviti second incident before second incident. Due must be noted the da #19 by the QIDP are interview with the QID formal interventions we verified incident of inacclient #19 towards client survey date of 6/14/2 moved to a private be	DP on 6/15/21 verified no vere put in place after either appropriate sexual touch of ent #13, until the current 1, when client #19 was edroom in group home #4. ed no additional training was					
W 157	revealed she was una reported incidents of client #13 and client # with the facility admin aware of (1) incident reporting sexual inap but she did not remer allegation. Subseque administrator verified inquiry/investigation s	ent interview with the facility an internal should have been conducted on to address investigation	W 157				
VV 157	CFR(s): 483.420(d)(4		VV 157				

Facility ID: 922506

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/27/2021 APPROVED 0: 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE COMP	SURVEY LETED
		34G020	B. WING		_	06/ [.]	; 15/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ROUSE'S	GROUP HOME			949 NC 135 STONEVILLE, NC 27048	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 157	Continued From page	9 11	W 157				
	Based on facility reco interviews, the facility timely corrective actio allegations of abuse. Observation in house client #13 to share a r Continued observatio bedroom of client #13 increased supervision the group home as cli and exit their bedroom Interview with client # client to report client # inappropriately touche were in their bedroom incidents had been re qualified intellectual d (QIDP). Continued in	The finding is: #5 on 6/14/21 revealed room with client #19. n in house #5 revealed the a and #19 to have no than any other bedroom in ents were observed to enter ns. 13 on 6/14/21 revealed the #19 had sexually ed her while both clients n. Client #13 revealed the ported to the facility isabilities professional terview with client #13 remember the dates of the not feel safe in her					
	on 6/15/21 revealed n client #13 reporting in touch by client #19. F investigations and inq year on 6/14/21 and 6 evidence of any inquir client #13's alleged in inappropriately sexual	ry or investigation related to cident of being Ily touched by client #19.					
	Interview with the qua	lified intellectual disabilities					

Facility ID: 922506

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	OF DEFICIENCIES	MEDICAID SERVICES			STRUCTION		IO. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	, í				IPLETED		
			AL DOILDI				С		
		34G020	B. WING			0	6/15/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE				
				5949 N	IC 135				
ROUSES	GROUP HOME			STON	EVILLE, NC 27048				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
\N/ 4E7		- 10							
W 157	Continued From pag		W 1	157					
		on 6/14/21 confirmed there							
		nts of client #13 alleging							
		ropriately sexually touched Continued interview with							
		n incident report had not							
		arding the reported allegation							
		er incident involving client #19							
	and she was unable	to recall the exact dates of							
		er interview with the QIDP on							
		internal investigation or							
		ed relative to client #13's							
		interview client #19. The nt #19 admitted to the first							
		riew and initially denied the							
	-	re later admitting to the							
		e to lack of documentation it							
	must be noted the da	ates of interview with client							
	#19 by the QIDP are	unknown. Additional							
		DP on 6/15/21 verified no							
		were put in place after either							
		appropriate sexual touch of							
		ient #13 until 6/14/21 when d to a private bedroom in							
		e QIDP also verified no							
		d been conducted with staff							
	to address incident p								
	Interview with the fac	cility director on 6/14/21							
		aware there had been (2)							
		inappropriate touch between							
	client #13 and client	#19. Continued interview							
	-	nistrator revealed she was							
		of an allegation of client #13							
		propriate touch by client #19							
	but she did not reme								
	administrator verified	ent interview with the facility I an internal							
	inquiry/investigation								
		should have been conducted							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/27/2021 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		34G020	B. WING			06/*	; 15/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	_	
ROUSE'S	GROUP HOME			5949 NC 135 STONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 157	facility administrator, a revealed client #19 wa bedroom in group hor 6/14/21.	Additional interview with the as verified with observation, as moved to a private me #4 during the evening of	W 15				
W 186	staff to manage and s accordance with their Direct care staff are d on-duty staff calculate period for each define This STANDARD is r Based on observation verification the facility direct care staff to ma appropriately. The fin A. The facility failed t supervision during an therapeutic leave for g example: Interview with the faci revealed in 5/2021 sh home #5 and took clie across the group hom home for a night out of Continued interview w revealed the home us clients was her brother	-2) ide sufficient direct care supervise clients in individual program plans. lefined as the present ed over all shifts in a 24-hour ed residential living unit. not met as evidenced by: ns, interviews and record failed to provide sufficient anage and supervise clients ndings are: to provide sufficient staff e event of referenced group home #5. For lity administrator on 6/14/21 ne worked third shift in group ents #13, #19, #25 and #26 ne property to a relatives	W 18	36			

Facility ID: 922506

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/27/2021 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		34G020	B. WING				C / 15/2021
NAME OF PI	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROUSE'S	GROUP HOME				5949 NC 135 STONEVILLE, NC 27048		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 186	bedrooms and all clie The facility administra she was the only staff supervision by staying monitoring all clients. Interview with clients 6/14/21 revealed all c of the group home wa completing cleaning r in the group home. C clients #15, #19, #25 administrator slept in the home and intermi check on the clients. clients #15, #19, #25 to report sleeping on home. Therefore, as confirm facility administrator t shift during the group reported in interview i the administrator stay the home, the facility supervision to manage B. The facility failed t care staff to manage a group home #5 on thi Afternoon observation from 4:15 PM to 7:15 home working with fiv observations between revealed all clients in	d the relatives home had 3 nts slept in the living room. ator subsequently revealed f on shift and she provided g in the vicinity and #13, #19, #25 and #26 on lients to report the night out as a "surprise" for esponsibilities, on third shift, continued interviews with and #26 revealed the facility a bedroom in the upstairs of ttently came back down to Further interview with and #26 revealed all clients the living room floor of the ed in interview with the hat she was the only staff on home outing and all clients nconsistent supervision with ing in a bedroom upstairs in failed to provide appropriate e and supervise clients. o provide sufficient direct and supervise clients in rd shift. For example: ms on 6/14/21 in House #5 PM revealed one staff in the re clients. Continued	W	186			

Facility ID: 922506

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/27/2021 APPROVED . 0938-0391
STATEMENT C	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G020			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G020	B. WING		_	06/'	; 15/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ROUSE'S	GROUP HOME			5949 NC 135 STONEVILLE, NC 2704	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 186	that she didn't know. Further observation re- intellectual developme enter the home and v- working tonight?" The staff's name and client informed the QIDP the The QIDP then exited 8:00 PM revealed no- third shift in the group observation revealed be outside and to stat had not shown up for want to spend the nig Review of the facility v- revealed multiple ope 6/4/21. Continued rev revealed third shift op 6/20/21, 6/22/21. Interview with client # there had been times other group homes be scheduled to work wit #19 revealed she had group homes because staff to work third shift revealed ever since a terminated it was hard willing to work with he because no one want #5 also revealed she	to respond to each client evealed the qualified ental professional (QIDP) to arious clients to ask "Who is e QIDP responded with a at #26 and client #13 then e staff scheduled was off. I the home. Observation at staff had arrived to work o home. Subsequent clients #26 and client #13 to to the surveyor that staff third shift and they did not ht anywhere else. June schedule on 6/15/21 nings on third shift since iew of the schedule enings on 6/18/21, 6/19/21, 13 on 6/14/21 revealed when they had to sleep at ecause no staff was h them. Interview with client I spent the night at other e the facility couldn't find t. Interview with client #26 former employee was d to find staff who were er and her housemates s to work with them. Client had spent the night at other o one was scheduled.	W 18	6			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 34G020 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE C ROUSE'S GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE (A) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) DR (A) ID PREFIX TAG Continued From page 16 revealed a third shift staff had been identified and would arrive at the home at 10:00 PM. Subsequent interview with the QIDP on 6/15/21 confirmed due to a third shift staff had been, at times the clients at group home #5 had to spend the assistant QIDP on 6/15/21 revealed there had been two occasions where clients in house #5 had spent the night in other homes due to shortage with third shift staff. Further interview with the assistant QIDP verified when clients in house #5 had to go to other group homes for the W 186		-	ID HUMAN SERVICES				FORM): 06/27/2021 MAPPROVED). 0938-0391
MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES D PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X4) ID SUMMARY STATEMENT OF DEFICIENCIES D (X4, ID, REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION MUST BE PRECEDED BY FULL Y (K4, ID, REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX W 186 Continued From page 16 W 186 W 186 revealed a third shift staff had been identified and would arrive at the home at 10:00 PM. W 186 Subsequent interview with the QIDP on 6/15/21 W 186 V 186 Subsequent interview with the QIDP on 6/15/21 revealed there had been two occasions where clients in house #5 had spent the night in other homes due to shortage with third shift staff. Further interview with the assistant QIDP verified when clients in house #5 had spent the night in other homes due to shortage with third shift staff. Further interview with the assistant QIDP verified when clients in house #5 had to go to other group homes for the<	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ROUSE'S GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES 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 OCRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x3) W 186 Continued From page 16 revealed a third shift staff had been identified and would arrive at the home at 10:00 PM. Subsequent interview with the QIDP on 6/15/21 confirmed due to a third shift staff shortage, at times the clients at group homes. Interview with the assistant QIDP on 6/15/21 revealed there had been two occasions where clients in house #5 had spent the night in other homes due to shortage with third shift staff. Further interview with the assistant QIDP verified when clients in house #5 had to go to other group homes for the W 186			34G020	B. WING		_		
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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE W 186 Continued From page 16 revealed a third shift staff had been identified and would arrive at the home at 10:00 PM. Subsequent interview with the QIDP on 6/15/21 confirmed due to a third shift staff shortage, at times the clients at group home #5 had to spend the night at other group homes. Interview with the assistant QIDP on 6/15/21 revealed there had been two occasions where clients in house #5 had spent the night in other homes due to shortage with third shift staff. Further interview with the assistant QIDP verified when clients in house #5 had to go to other group homes for the W 186	NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE W 186 Continued From page 16 revealed a third shift staff had been identified and would arrive at the home at 10:00 PM. Subsequent interview with the QIDP on 6/15/21 confirmed due to a third shift staff shortage, at times the clients at group home #5 had to spend the night at other group homes. Interview with the assistant QIDP on 6/15/21 revealed there had been two occasions where clients in house #5 had spent the night in other homes due to shortage with third shift staff. Further interview with the assistant QIDP verified when clients in house #5 had to go to other group homes for the W 186	ROUSE'S	GROUP HOME				8		
revealed a third shift staff had been identified and would arrive at the home at 10:00 PM. Subsequent interview with the QIDP on 6/15/21 confirmed due to a third shift staff shortage, at times the clients at group home #5 had to spend the night at other group homes. Interview with the assistant QIDP on 6/15/21 revealed there had been two occasions where clients in house #5 had spent the night in other homes due to shortage with third shift staff. Further interview with the assistant QIDP verified when clients in house #5 had to go to other group homes for the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE) CROSS-REFEREI	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA		COMPLETION
night, it put the ratio of client to staff in other group homes above the appropriate ratio for those homes. W 189 STAFF TRAINING PROGRAM W 189 CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained in hygiene methods specific to ensuring paper supplies were accessible in bathrooms for House #2, #3 and #4. The finding is: Observation in group homes #2, #3 and #4 on 6/14/21 and 6/15/21 revealed bathrooms of each group home to be tillized by clients of the group home at various times. Continued observation revealed various findings of the lack of paper supplies and hand soap in various bathroom of various homes. During observations on 6/14/21		revealed a third shift s would arrive at the ho Subsequent interview confirmed due to a thi times the clients at gr the night at other grout the assistant QIDP or been two occasions w had spent the night in shortage with third sh with the assistant QID house #5 had to go to night, it put the ratio of group homes above to those homes. STAFF TRAINING PF CFR(s): 483.430(e)(1) The facility must prov initial and continuing to employee to perform efficiently, and competent This STANDARD is r Based on observation failed to ensure staff w hygiene methods spe supplies were accesss #2, #3 and #4. The fir Observation in group 6/14/21 and 6/15/21 r group home to be utili home at various times revealed various findi supplies and hand so	staff had been identified and ome at 10:00 PM. with the QIDP on 6/15/21 ird shift staff shortage, at oup home #5 had to spend up homes. Interview with of 6/15/21 revealed there had where clients in house #5 o other homes due to ift staff. Further interview OP verified when clients in o other group homes for the of client to staff in other he appropriate ratio for ROGRAM) ide each employee with training that enables the his or her duties effectively, etently. not met as evidenced by: ns and interviews, the facility were sufficiently trained in cific to ensuring paper ible in bathrooms for House homes #2, #3 and #4 on revealed bathrooms of each ized by clients of the group s. Continued observation ngs of the lack of paper ap in various bathroom of			JEFICIENCY)		

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 06/27/2021 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		34G020	B. WING _					C 15/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
ROUSE'S	GROUP HOME				949 NC 135 TONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 189 W 227	of 2 bathrooms to haw #3 observations revea have no paper towels to be in 1 of 2 bathroo sink, unaccessible fro observations revealed no paper towels and 7 toilet paper. Interview with the qua developmental profes verified that all bathroo supply of paper produ occupying the bathroo Continued interview w by observations, reve supplies to be be on s home. Further intervi staff had failed to stoc paper products and se hygiene of the group I INDIVIDUAL PROGR CFR(s): 483.440(c)(4 The individual program objectives necessary as identified by the co required by paragraph This STANDARD is r Based on review of re individual support plan sufficient training or in	#2 observations revealed 2 re no paper towels; in house aled 2 of 2 bathrooms to or soap and for toilet paper oms and under the bathroom m the toilet; in house #4 d 2 of 2 bathrooms to have 1 of 2 bathrooms to have no diffied intellectual sional (QIDP) on 6/15/21 oms should have an ample tots available to clients when oms in all group homes. <i>vi</i> th the QIDP, and verified aled additional paper site and available for each ew with the QIDP confirmed to ensure proper nome client's. AM PLAN) m plan states the specific to meet the client's needs, imprehensive assessment n (c)(3) of this section.	W 2					

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	MENT OF HEALTH AN						FORM	D: 06/27/2021 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE COMP	SURVEY LETED
		34G020	B. WING					C 15/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE,	ZIP CODE	-	
ROUSE'S	GROUP HOME				949 NC 135 STONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
W 227	Continued From page	: 18	w	227				
	from 6/14/21 - 6/15/2 ⁻⁷ medication closets had included a lock with a deadbolt lock. Furthe group homes #1- #5 r lock was not utilized to medication closet. Review of records for revealed an ISP dated the record for client # support plan (BSP) da following target behav inappropriate touching others and verbal agg did not include interve breaking and entering without permission. Subsequent review of 6/15/21 revealed an in 4/15/21 which indicate to enter the medication without staff permissio also indicated that clie medication cabinet an controlled medication review of the IRIS rep removed all of the pai bubble packs and stat contents of the medic alerted management to control center and cal department arrived in and client #7 was tran	nplaint investigation survey 1 revealed that all id a double lock which numerical keypad and a r observation on 6/15/21 of evealed that the deadbolt o secure medications in the client #7 on 6/14/21 d 7/18/20. Further review of 7 included a behavior ated 3/17/21 which listed the viors: non-compliance, g, unwanted touching of pression. Review of the BSP entions relative to stealing or 1 into restricted areas F records for client #7 on neident report (IRIS) dated ed that client #7 attempted on cabinet several times on. The 4/15/21 IRIS report ent #7 broke into the nd removed all of his from the cabinet. Further ort indicated that client #7 n medication from the ff could not locate the ation bubble packs. Staff who contacted the poison led 911. The local police response to the 911 call						

Facility ID: 922506

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CENTER	S FOR MEDICARE &					O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G020	B. WING		0	C 06/15/2021	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP C			
ROUSE'S	GROUP HOME			949 NC 135 TONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
W 227	Continued From pag was released to the g day.	e 19 group home on the same	W 227				
	4/15/21 client #7 bro cabinet and retrieved bubble packs without also verified during to intervention to client installed a deadbolt I cabinets to secure co Further interview with not have a key to sec	Z on 6/15/21 verified that on ke into the medication d his medications from the t staff permission. Staff Z the interview that as an #7's behavior, management ock to all facility medication ontrolled medications. h Staff Z verified that she did cure to the deadbolt lock ras only one lock secured on net.					
W 247	disabilities profession home medication clo double lock to ensure area without permiss with the QIDP verifie installations were a r into the medication of medications. The QI controlled medication area with a double loc interview with the QI #7's program goals v QIDP also confirmed from programming at stealing and entering permission.	IDP also verified that all hs should be secured in an ock at all times. Further DP confirmed that all of client vere active and current. The I that client #7 could benefit and interventions relative to g areas without staff RAM PLAN	W 247				
	CFR(s): 483.440(c)(6 The individual progra						

Facility ID: 922506

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 06/27/2021 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		34G020	B. WING			-	06/	C 15/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
ROUSE'S	GROUP HOME				949 NC 135 STONEVILLE, NC 27048	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 247	Based on interview a facility failed to assure choice and self-mana encouraged for 4 of 5 #18, #25, and #26) re away from their home. Review of a complain alleged the owner of thouse #5 on third shift the facility. Continued allegation alleged the to her deceased broth bedroom while the client #5/2021 the facility adm work third shift and inthousemates that once cleaning, she had a si interview with client # spent the night at the administrator's brothe revealed client #13 alles spent the night in the and sofa. Additional i revealed the owner sl them periodically thro Interview with client # date) she and her peet facility administrators kept hearing noises o most of the night. Co #26 revealed she was have fun and she slep	not met as evidenced by: nd document review the e opportunities for client gement were provided and clients in House #5 (#13, lative to spending the night . The finding is: t allegation dated 6/10/21 he facility had to work at ft and did not want to stay at d review of the complaint owner took all of the clients ter's house and slept in the ents slept on the floor. 13 on 6/14/21 revealed on ninistrator was scheduled to formed her and her the they were finished with urprise for them. Continued 13 revealed the clients home of the facility r. Further interview ong with her housemates living room area on the floor nterview with client #13 ept upstairs but checked on	W	247				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/27/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G020	B. WING		_	06/ [,]	C 15/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ROUSE'S	GROUP HOME			5949 NC 135 STONEVILLE, NC 2704	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 247 W 249	breakfast and then we interview with client # uncomfortable and we house again to sleep. Interview with the faci 6/14/21 revealed she 5/29/2021 and when a #26 completed their of them across the group 12:30 AM) to her dece enjoy a movie/girls nig the facility administrat passed away in 3/202 Further interview with revealed the relatives all clients slept in the interview with the faci the clients did not go breakfast and returne Additional interview w confirmed clients slep were not assured opp and self-management arrangements or choic PROGRAM IMPLEME CFR(s): 483.440(d)(1 As soon as the interdif formulated a client's in each client must receit treatment program co interventions and serv and frequency to supp	p the next morning, had ent back home. Additional 26 revealed she felt build not go back to that lity administrator/owner on was working third shift on clients #13, #18, #25 and hores, she transported o home property (around eased brother's home to ght. Continued interview with or revealed her brother had end for pancreatic cancer. the facility administrator home had 3 bedrooms and living room. Subsequent lity administrator revealed to bed until 2 AM, had d to House #5 at 10:30 am. ith the facility administrator t in the living room floor and ortunities for client choice a relative to sleeping ce of going on the outing. ENTATION) sciplinary team has ndividual program plan, ive a continuous active	W 247				

Facility ID: 922506

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONS		(X3) DATE COMF	SURVEY PLETED	
		34G020	B. WING _			C 06/15/2021		
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET	ADDRESS, CITY, STATE, ZIP CODE			
ROUSE'S	GROUP HOME			5949 NC STONE	: 135 :VILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 249	Continued From page	22	W 2	49				
	Based on observatio interview the facility fa- relative to behavior m- implemented with suf (#13, #18, #19, #25 a- relative to door chime Observations in the g 6/15/21 revealed doo doors. Continued obs as well as visitors to e- doors of the group ho- revealed at no point of door chimes work wh Review of records for behavior support plan 10/10/20 to include ta physical aggression, elopement, and suicio Review of records for dated 8/6/20 to includ disruptive behavioral/ aggression, manipula- ideation behavior and Review of client #19's dated 10/26/20 to include tantrums, self-injuriou elopement, physical a sexual behavior, inap suicidal ideation. Review of records for	ficient frequency for 5 of 5 and #26 clients in House #5 es. roup home on 6/14/21 - r chimes on both external servations revealed clients enter and exit the external one. Further observations during observations did the en the doors were opened. client #13 revealed a n dated (BSP) dated arget behaviors of verbal and property destruction, dal gestures. client #18 revealed a BSP le target behaviors of verbal aggression, physical tive behavior, suicidal l elopement. s record revealed a BSP lude target behaviors of						

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	D: 06/27/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G020	B. WING _			-		C 15/2021
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STA	ATE, ZIP CODE	•	
ROUSE'S	GROUP HOME				49 NC 135 FONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 249	physical aggression, oproperty destruction. Review of client #26's dated 2/19/20 to incluverbal and physical agelopement, and SIB. Interview with the quaprofessional (QIDP) ochimes installed on the group home were imphistory of elopement. the QIDP verified the times. The QIDP also clients have a history interview with the QID should be on at all time attempt to leave the gBSP's. DRUG ADMINISTRATCFR(s): 483.460(k)(4) The system for drug at that clients are taught medications if the interdetermines that self-a is an appropriate obje does not specify other the system failed to assure 3 of 3 observed during medications medications are taught for the system failed to assure 3 of 3 observed during medications medications for the system failed to assure 3 of 3 observed during medications medications for the system failed to assure 3 of 3 observed during medications medications medications for the system failed to assure 3 of 3 observed during medications medications medications for the system failed to assure 3 of 3 observed during medications medications medications medications medications medications for the system failed to assure 3 of 3 observed during medications medications medications medications medications medications medications for the system failed to assure 3 of 3 observed during medications medications medications medications medications medications medications for the system failed to assure 3 of 3 observed during medications	icidal ideation, elopement, disruptive behavior and a record revealed a BSP de target behaviors of ggression, suicidal ideation, lified intellectual disabilities n 6/15/21 verified the door e external doors of the lemented due to client Continued interview with chimes should be on at all o revealed both staff and of turning them off. Further IP confirmed all door chimes roup home per their current FION ddministration must assure to administer their own rdisciplinary team dministration of medications ctive, and if the physician wise.	W 2					
	This STANDARD is n Based on observation interview, the system failed to assure 3 of 3	ot met as evidenced by: n, record review and for drug administration clients (#1, #4 and #23) cation administration were						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/27/2021 APPROVED 0: 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		34G020	B. WING		_		; 15/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ROUSE'S	GROUP HOME			949 NC 135 STONEVILLE, NC 27048	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 371	 medication self-admir A. The system for dru assure client #4 was p participate in medicati example: Observation in house revealed staff W to wa of the home and to ve walk to the medication medications. Continu client #4 to walk from medication closet whe cup with medications with water and walked Further observation of revealed multiple cubil each cubby hole. Clie receive any training d to participate beyond from staff W and acce medications. Review of records for independent living eva Review of the indepent revealed client #4 is a medication administration a hole in the pill pack medication cup. B. The system for dru 	histration. The findings are: Ig administration failed to provided the opportunity to ion self-administration. For #3 on 6/15/21 at 7:16 AM alk to the medication closet erbally call out to client #4 to n closet for morning red observation revealed the living room to the ere the client was handed a that the client took whole d back to the living room. If the medication closet by holes with a small cup in ent #4 was not observed to luring the medication pass or taking a cup of medications essing water to follow f client #4 revealed an aluation dated 5/10/20. ndent living assessment able to participate in ation with the ability to punch and is able to put pills in the	W 371		JEFICIENCY)		
	participate in medicati example: Observation in house	#3 on 6/15/21 at 7:21 AM					
1	revealed staff W to ca	all out to client #23 from the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/27/2021 APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		SURVEY PLETED
		34G020	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROUSE'S	GROUP HOME				5949 NC 135 STONEVILLE, NC 27048		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 371	room and for client #2 closet for morning me observation revealed cup of medications for and for the client to ta followed with water. Of to receive any training or to participate beyon medications from staf follow medications. Review of records for independent living eve Review of the indepent revealed client #23 is medication administra access his own water cubby and punch his Continued review of the assessment for client indicate time of medica and staff should contin medicate as independent C. The system for dru assure client #1 was participate in medicate example: Observation in house revealed staff W to ca medication closet for Continued observatio handed a cup of medication cubby hole and for the medications whole fol	le the client was in the living 23 to walk to the medication edications. Continued client #23 to be handed a om a cup in a cubby hole ake all medications whole Client #23 was not observed g during the medication pass and taking a cup of f W and accessing water to r client #23 revealed an aluation dated 10/8/20. Indent living assessment able to participate in ation with the ability to from the tap, locate his own pills from the pack. he independent living #23 revealed the client can cations with "In the Morning" nue to encourage client to dently as possible. ug administration failed to provided the opportunity to ion self-administration. For #3 on 6/15/21 at 7:23 AM all out to client #1 from the d for client #1 to walk to the morning medications. n revealed client #1 to be ications from a cup in a	W	371			

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	S FOR MEDICARE &				OMB NO. 093		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 34G020					(X3) DATE SURVEY COMPLETED		
		A. BUILDING	C	с			
		B. WING		06/15/20	021		
NAME OF PROVIDER OR SUPPLIER			- 1	STREET ADDRESS, CITY, STATE, ZIP CO			
	GROUP HOME			5949 NC 135			
				STONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM IE APPROPRIATE	(X5) MPLETIO DATE	
W 371	Continued From page	e 26	W 37	1			
		or to participate beyond					
	taking a cup of medic	ations from staff W and					
	accessing water to fo	llow medications.					
	Review of records for client #1 revealed an						
	independent living evaluation that reflected client						
	#1 is able to participa						
		e ability to take his own pill d review of the independent					
		client #1 revealed staff will					
	attempt hand over ha	and to assist the client with					
	punching his medicat	tions.					
	Interview with staff W	on 6/15/21 revealed she					
	-	rning medications about					
		each client's medications in					
		t was placed in each clients ued interview with staff W					
		ing each client's medications					
		e locked the medication					
		e for the medication pass.					
		ility assistant qualified s professional and facility					
		d staff should provide					
	education and the op	portunity for client					
		ninistering medications.					
W 382	CFR(s): 483.460(I)(2)	ND RECORDKEEPING)	W 38	2			
	The facility must keep	o all drugs and biologicals					
	locked except when b	u					
	administration.						
	This STANDARD is I	not met as evidenced by:					
	Based on observatio	n and interview, the facility					
	failed to implement th	ne internal security system					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/27/2021 APPROVED D: 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
34G020		B. WING			-	C 06/15/2021		
NAME OF PI	ROVIDER OR SUPPLIER		ł	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
ROUSE'S	GROUP HOME				949 NC 135 TONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 382	Continued From page #3 and #4). The findi Observation on 6/15/2 closet of house #1, ho house #4 to have a do that included a electro lock. Continued obser medication pass for h revealed the ability fo medication closet with Subsequent observat dead bolt lock in house A review on 6/15/21 of over the past year rev #7 in house #1 that in the medication closet an undetermined num Interview with the faci disabilities profession verified the security for medication closet of et to secure medications being administered. O QIDP verified the dea medication closet doo client #7 was able to se	e 27 ng is: 21 revealed the medication puse #2, house #3 and puble lock security system poinc code and a dead bolt ervation after the morning ouse #1, #2, #3 and #4 r staff to access the n the electronic code only. ion revealed the key to the se #2 to be lost. If internal incident reports realed an incident of client dicated the client broke into of the home and accessed aber of pain medications. Ility qualified intellectual al (QIDP) on 6/15/21 ock and dead bolt on each each home should be used s when medications are not Continued interview with the		382				
	lock and access pain	medications.						

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