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ROUSE'S GROUP HOME	5949 NC 135 STONEVILLE, NC 27048

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W 000	INITIAL COMMENTS Complaint Intake#: NC00177935, NC00178091, NC00178097	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to ensure implementation of written policies and procedures that prohibit mistreatment, neglect or abuse of clients (W149); failed to ensure that all allegations of neglect and abuse were reported immediately to the administrator and to other officials in accordance with state law (W153); failed to provide evidence that all alleged violations were thoroughly investigated (W154) and failed to ensure timely corrective action was taken relative to a verified finding of client to client abuse (W157). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated client protections.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, record/document review and interview, the facility failed to assure it's	W 149		

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 149	Continued From page 1 policies and procedures that prohibit abuse and neglect were implemented to prevent the abuse of 1 of 5 sampled clients (#13). The finding is: Observation in house #5 on 6/14/21 revealed client #13 to share a room with client #19. Continued observation in house #5 revealed the bedroom of client #13 and client #19 to have no increased supervision than any other bedroom in the group home as clients were observed to enter and exit their bedrooms. Interview with client #13 on 6/14/21 revealed client #19 had sexually inappropriately touched her while both client's were in their bedroom and the incidents had been reported to the facility qualified intellectual disabilities professional (QIDP). Continued interview with client #13 revealed she did not remember the dates of the incidents but she did not feel safe in her bedroom at night. Further interview with client #13 revealed the facility QIDP had addressed the incidents with telling client #13 to keep her bedroom door open at night although client #19 would close the door after she went to sleep. Review of internal incident reports for the facility on 6/15/21 revealed no documented incident of client #13 reporting incidents of inappropriate touch by client #19. Review of internal facility investigations and inquiries over the past review year on 6/14/21 and 6/15/21 revealed no evidence of any inquiry or investigation related to client #13's alleged incident of being inappropriately sexually touched by client #19. Review of records for client #13 on 6/14/21 revealed a person centered plan (PCP) dated 4/17/21. Continued review of the PCP for client	W 149		

W 149 | W 149

Continued From page 2

#13 revealed a diagnosis history of Mild Intellectual Disability, Personality Disorder, Schizoaffective Disorder, Post Traumatic Stress Disorder with Major Depression, Bipolar I Disorder and Disruptive Behavior Disorder. Further review of the PCP for client #13 revealed a behavior support plan (10/10/20) with target behaviors of verbal aggression, physical aggression, property destruction, elopement, self injurious behaviors and suicidal gestures with darts in front of cars and walks in the streets.

Review of records for client #19 on 6/14/21 revealed a PCP dated 2/26/20. Continued review of the PCP for client #19 revealed a diagnosis history of Mild Intellectual Disability, Major Depressive Disorder (Severe), Oppositional Defiance Disorder, ADHD, and Borderline Personality. Further review of the PCP for client #19 revealed a behavior support plan with target behaviors of tantrum behavior, property destruction, inappropriate verbal behavior, self-injurious behavior, elopement, physical aggression, inappropriate sexual behavior (touching others in private areas without permission, attempting to force others into sexual activity, engaging in sexual activity prohibited by the group home).

Review on 6/15/21 of the facility's abuse and neglect policy titled "Protection from Harm, Abuse, Neglect or Exploitation" revealed all allegations of abuse or neglect are to receive immediate action to protect the client and to prevent further abuse or neglect. Continued review of the facility's abuse and neglect policy revealed procedures to ensure all incidents of abuse, neglect or exploitation are reported immediately and investigated. Further review of

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the facility's abuse and neglect policy revealed the facility will ensure appropriate remedial action for substantiated allegations of abuse or neglect.

Interview with the qualified intellectual disabilities professional (QIDP) on 6/14/21 confirmed there had been two incidents of client #13 alleging client #19 had inappropriately sexually touched her in their bedroom. Continued interview with the QIDP revealed an incident report had not been completed regarding the reported allegation of client #13 for either incident involving client #19 and she was unable to recall the exact dates of the incidents. Further interview with the QIDP on 6/15/21 revealed no internal investigation or inquiry was conducted relative to client #13's allegations except to interview client #19. The QIDP confirmed client #19 admitted to the first incident during interview and initially denied the second incident before later admitting to the second incident. Due to lack of documentation it must be noted the dates of interview with client #19 by the QIDP are unknown. Additional interview with the QIDP on 6/15/21 verified no formal interventions were put in place after either verified incident of inappropriate sexual touch of client #19 towards client #13 and no additional training was conducted with staff to address incident prevention.

Interview with the facility administrator on 6/14/21 revealed she was unaware there had been (2) reported incidents of inappropriate touch between client #13 and client #19. Continued interview with the facility administrator verified an incident report regarding the alleged incidents of client #13 should have been completed and a thorough internal inquiry/investigation should have been conducted. Further interview with the facility

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W 149	Continued From page 4 director verified formal interventions should have occurred with the verified statements of client #19 acknowledging inappropriate sexual touching of client #13 to help ensure client #13's safety and that incidents did not occur again. Subsequent interview with the facility administrator, as verified with observation, revealed on the evening of 6/14/21 client #19 was moved to a private bedroom in group home #4. The facility failed to report all allegations of abuse immediately to administration as required by the facility's policy and procedures. The facility also failed to provide evidence that all alleged violations were thoroughly investigated and failed to ensure timely corrective action was taken relative to a verified finding of client to client sexual abuse therefore, the facility was found to be neglectful.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure allegations of abuse were immediately reported to the administrator and to other officials in accordance with state law for 2 of 3 reviewed incidents. The findings are: A. The facility failed to ensure (2) allegations of	W 153		

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sexual inappropriate touch involving client #13 was reported to the facility administrator. For example:

Interview with client #13 on 6/14/21 during a recertification and complaint investigation survey revealed client #19 had sexually inappropriately touched her while both clients were in their bedroom. Client #13 revealed the incidents had been reported to the facility qualified intellectual disabilities professional (QIDP). Continued interview with client #13 revealed she did not remember the dates of the incidents and she did not feel safe in her bedroom at night as client #19 was still her roommate.

Review of internal incident reports for the facility on 6/15/21 revealed no documented incident of client #13 reporting incidents of inappropriate touch by client #19. Review of internal facility investigations and inquiries over the past review year on 6/14/21 and 6/15/21 revealed no evidence of any inquiry or investigation related to client #13's alleged incident of being inappropriately sexually touched by client #19.

Interview with the qualified intellectual disabilities professional (QIDP) on 6/14/21 confirmed there had been two incidents of client #13 alleging client #19 had inappropriately sexually touched her in their bedroom. Continued interview with the QIDP revealed an incident report had not been completed regarding the reported allegation of client #13 for either incident involving client #19 and she was unable to recall the exact dates of the incidents. Further interview with the QIDP on 6/15/21 revealed no internal investigation or inquiry was conducted relative to client #13's allegations except to interview client #19. The

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QIDP confirmed client #19 admitted to the first incident during interview and initially denied the second incident before later admitting to the second incident. Due to lack of documentation it must be noted the dates of interview with client #19 by the QIDP are unknown. Additional interview with the QIDP on 6/15/21 verified no formal interventions were put in place after either verified incident of inappropriate sexual touch of client #19 towards client #13, until the current survey date of 6/14/21, when client #19 was moved to a private bedroom in group home #4. The QIDP also verified no additional training was conducted with staff to address incident prevention.

Interview with the facility director on 6/14/21 revealed she was unaware there had been (2) reported incidents of inappropriate touch between client #13 and #19. Continued interview with the facility administrator revealed she was aware of (1) incident of an allegation of client #13 reporting sexual inappropriate touch by client #19 but she did not remember the date of this allegation. Subsequent interview with the facility administrator verified both allegations by client #13 should have been reported to her by the QIDP and an internal inquiry/investigation should have been conducted with appropriate action to address investigation findings.

B. The facility failed to ensure an allegation of sexual inappropriate behavior involving client #22 was reported to external officials in accordance with state law for 1 of 1 investigations. For example:

Review of documentation during the recertification and complaint investigation survey

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from 6/14/21 - 6/15/21 included the following: internal investigative summary dated 6/10/21, facility incident report improvement system (IRIS) reports from 7/1/20 to 6/10/21, facility internal incident reports from 3/2021-6/2021, individual support plans and behavior support plans. Review of the IRIS reports from 7/1/20-6/10/21 did not reveal allegations of sexual assault or trauma.

Further review of the documenation on 6/15/21 revealed an IRIS report dated 6/11/21. The scope of the IRIS report dated 6/11/21 was to rule out abuse and/or neglect for allegations of sexual assault. Further review of the IRIS report dated 6/11/21 indicated that on 5/23/21 client #22 was on therapeutic leave with his family and reported to his grandmother that he was sexually assaulted by one of his housemates. The incident report also revealed that the grandmother immediately reported this information to client #22's guardian representative on 5/23/21, which was also reported to the facility management and administrator on the same day. The IRIS report indicated that client #22 was transported to the emergency room for evaluation on 5/23/21.

Subsequent review of the documentation on 6/15/21 revealed a report of a pending internal investigation dated 6/11/21. Further review revealed that client #22 was temporarily moved to another facility that is not within close proximity of the alleged offender (client #7). Further review of the internal investigative summary revealed the alleged incident that occurred on 5/23/21 was submitted to the IRIS system on 6/11/21 which is outside of the reporting timeframe.

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W 153	Continued From page 8 Interview with the Associate QIDP on 6/15/21 verified that an IRIS report was submitted on 6/11/2021 because she was not sure of what information to enter in the report. Interview with the Associate QIDP confirmed that the IRIS report was submitted on 6/11/21 which was outside of the 72-hour timeframe for reporting incidents according to state law. Interview with the facility QIDP on 6/15/21 verified that the facility had a pending internal investigation and client #22 was separated from client #7 by moving him to another facility away from the main campus. Further interview with the QIDP verified that the 5/23/21 alleged incident was reported to IRIS on 6/11/21 which is outside of the 72-hour timeframe required for Level II incidents according to state law. Interview with the QIDP further confirmed that all Level II and III incidents must be reported with 72 hours of the facility being made aware of the incident. Interview with the Facility Administrator on 6/15/21 verified that she was aware of the alleged incident reported 5/23/21. Further interview with the facility administrator verified the facility took appropriate measures to keep the clients separated during the internal investigation. Continued interview with the facility administrator confirmed that all IRIS reporting must be completed and submitted within 72 hours of when the facility was made aware of the incident.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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This STANDARD is not met as evidenced by:
Based on review of facility records and interview, the facility failed to provide evidence an allegation of abuse was thoroughly investigated for 1 of 5 sampled clients (#13). The finding is:

Interview with client #13 on 6/14/21 during a recertification and complaint investigation survey revealed the client to report client #19 had sexually inappropriately touched her while both clients were in their bedroom. Client #13 revealed the incidents had been reported to the facility qualified intellectual disabilities professional (QIDP). Continued interview with client #13 revealed she did not remember the dates of the incidents and she did not feel safe in her bedroom at night as client #19 was still her roommate.

Review of internal incident reports for the facility on 6/15/21 revealed no documented incident of client #13 reporting incidents of inappropriate touch by client #19. Review of internal facility investigations and inquiries over the past review year on 6/14/21 and 6/15/21 revealed no evidence of any inquiry or investigation related to client #13's alleged incident of being inappropriately sexually touched by client #19.

Interview with the qualified intellectual disabilities professional (QIDP) on 6/14/21 confirmed there had been two incidents of client #13 alleging client #19 had inappropriately sexually touched her in their bedroom. Continued interview with the QIDP revealed an incident report had not been completed regarding the reported allegation of client #13 for either incident involving client #19 and she was unable to recall the exact dates of

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W 154	Continued From page 10 the incidents. Further interview with the QIDP on 6/15/21 revealed no internal investigation or inquiry was conducted relative to client #13's allegations except to interview client #19. The QIDP confirmed client #19 admitted to the first incident during interview and initially denied the second incident before later admitting to the second incident. Due to lack of documentation it must be noted the dates of interview with client #19 by the QIDP are unknown. Additional interview with the QIDP on 6/15/21 verified no formal interventions were put in place after either verified incident of inappropriate sexual touch of client #19 towards client #13, until the current survey date of 6/14/21, when client #19 was moved to a private bedroom in group home #4. The QIDP also verified no additional training was conducted with staff to address incident prevention. Interview with the facility director on 6/14/21 revealed she was unaware there had been (2) reported incidents of inappropriate touch between client #13 and client #19. Continued interview with the facility administrator revealed she was aware of (1) incident of an allegation of client #13 reporting sexual inappropriate touch by client #19 but she did not remember the date of this allegation. Subsequent interview with the facility administrator verified an internal inquiry/investigation should have been conducted with appropriate action to address investigation findings.	W 154		
W 157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken.	W 157		

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This STANDARD is not met as evidenced by:
Based on facility record/document review and interviews, the facility failed to show evidence of timely corrective action for 2 of 2 verified allegations of abuse. The finding is:

Observation in house #5 on 6/14/21 revealed client #13 to share a room with client #19. Continued observation in house #5 revealed the bedroom of client #13 and #19 to have no increased supervision than any other bedroom in the group home as clients were observed to enter and exit their bedrooms.

Interview with client #13 on 6/14/21 revealed the client to report client #19 had sexually inappropriately touched her while both clients were in their bedroom. Client #13 revealed the incidents had been reported to the facility qualified intellectual disabilities professional (QIDP). Continued interview with client #13 revealed she did not remember the dates of the incidents and she did not feel safe in her bedroom at night as client #19 was still her roommate.

Review of internal incident reports for the facility on 6/15/21 revealed no documented incident of client #13 reporting incidents of inappropriate touch by client #19. Review of internal facility investigations and inquiries over the past review year on 6/14/21 and 6/15/21 revealed no evidence of any inquiry or investigation related to client #13's alleged incident of being inappropriately sexually touched by client #19.

Interview with the qualified intellectual disabilities

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W 157	Continued From page 12 professional (QIDP) on 6/14/21 confirmed there had been two incidents of client #13 alleging client #19 had inappropriately sexually touched her in their bedroom. Continued interview with the QIDP revealed an incident report had not been completed regarding the reported allegation of client #13 for either incident involving client #19 and she was unable to recall the exact dates of the incidents. Further interview with the QIDP on 6/15/21 revealed no internal investigation or inquiry was conducted relative to client #13's allegations except to interview client #19. The QIDP confirmed client #19 admitted to the first incident during interview and initially denied the second incident before later admitting to the second incident. Due to lack of documentation it must be noted the dates of interview with client #19 by the QIDP are unknown. Additional interview with the QIDP on 6/15/21 verified no formal interventions were put in place after either verified incident of inappropriate sexual touch of client #19 towards client #13 until 6/14/21 when client #19 was moved to a private bedroom in group home #4. The QIDP also verified no additional training had been conducted with staff to address incident prevention. Interview with the facility director on 6/14/21 revealed she was unaware there had been (2) reported incidents of inappropriate touch between client #13 and client #19. Continued interview with the facility administrator revealed she was aware of (1) incident of an allegation of client #13 reporting sexual inappropriate touch by client #19 but she did not remember the date of this allegation. Subsequent interview with the facility administrator verified an internal inquiry/investigation should have been conducted with timely and appropriate action to address	W 157		

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investigation findings. Additional interview with the facility administrator, as verified with observation, revealed client #19 was moved to a private bedroom in group home #4 during the evening of 6/14/21.

W 186 DIRECT CARE STAFF W 186
CFR(s): 483.430(d)(1-2)

The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

This STANDARD is not met as evidenced by:
Based on observations, interviews and record verification the facility failed to provide sufficient direct care staff to manage and supervise clients appropriately. The findings are:

A. The facility failed to provide sufficient staff supervision during an event of referenced therapeutic leave for group home #5. For example:

Interview with the facility administrator on 6/14/21 revealed in 5/2021 she worked third shift in group home #5 and took clients #13, #19, #25 and #26 across the group home property to a relatives home for a night out of the group home. Continued interview with the facility administrator revealed the home used for a night out for the clients was her brothers home and her brother had passed away in 3/2021 from pancreatic cancer. Further interview with the facility

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administrator revealed the relatives home had 3 bedrooms and all clients slept in the living room. The facility administrator subsequently revealed she was the only staff on shift and she provided supervision by staying in the vicinity and monitoring all clients.

Interview with clients #13, #19, #25 and #26 on 6/14/21 revealed all clients to report the night out of the group home was a "surprise" for completing cleaning responsibilities, on third shift, in the group home. Continued interviews with clients #15, #19, #25 and #26 revealed the facility administrator slept in a bedroom in the upstairs of the home and intermittently came back down to check on the clients. Further interview with clients #15, #19, #25 and #26 revealed all clients to report sleeping on the living room floor of the home.

Therefore, as confirmed in interview with the facility administrator that she was the only staff on shift during the group home outing and all clients reported in interview inconsistent supervision with the administrator staying in a bedroom upstairs in the home, the facility failed to provide appropriate supervision to manage and supervise clients.

B. The facility failed to provide sufficient direct care staff to manage and supervise clients in group home #5 on third shift. For example:

Afternoon observations on 6/14/21 in House #5 from 4:15 PM to 7:15 PM revealed one staff in the home working with five clients. Continued observations between 6:00 PM - 7:15 PM revealed all clients in the home to repeatedly ask staff on shift "Who is scheduled to work tonight?"

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Staff G was observed to respond to each client that she didn't know.

Further observation revealed the qualified intellectual developmental professional (QIDP) to enter the home and various clients to ask "Who is working tonight?" The QIDP responded with a staff's name and client #26 and client #13 then informed the QIDP the staff scheduled was off. The QIDP then exited the home. Observation at 8:00 PM revealed no staff had arrived to work third shift in the group home. Subsequent observation revealed clients #26 and client #13 to be outside and to state to the surveyor that staff had not shown up for third shift and they did not want to spend the night anywhere else.

Review of the facility June schedule on 6/15/21 revealed multiple openings on third shift since 6/4/21. Continued review of the schedule revealed third shift openings on 6/18/21, 6/19/21, 6/20/21, 6/22/21.

Interview with client #13 on 6/14/21 revealed there had been times when they had to sleep at other group homes because no staff was scheduled to work with them. Interview with client #19 revealed she had spent the night at other group homes because the facility couldn't find staff to work third shift. Interview with client #26 revealed ever since a former employee was terminated it was hard to find staff who were willing to work with her and her housemates because no one wants to work with them. Client #5 also revealed she had spent the night at other group homes when no one was scheduled.

Interview with the facility qualified intellectual disabilities professional (QIDP) on 6/14/21

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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 night, it put the ratio of client to staff in other group homes above the appropriate ratio for those homes.	W 186		
W 189	STAFF TRAINING PROGRAM 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 utilized 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	W 189		

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W 189	Continued From page 17 and 6/15/21 in house #2 observations revealed 2 of 2 bathrooms to have no paper towels; in house #3 observations revealed 2 of 2 bathrooms to have no paper towels or soap and for toilet paper to be in 1 of 2 bathrooms and under the bathroom sink, unaccessible from the toilet; in house #4 observations revealed 2 of 2 bathrooms to have no paper towels and 1 of 2 bathrooms to have no toilet paper. Interview with the qualified intellectual developmental professional (QIDP) on 6/15/21 verified that all bathrooms should have an ample supply of paper products available to clients when occupying the bathrooms in all group homes. Continued interview with the QIDP, and verified by observations, revealed additional paper supplies to be be on site and available for each home. Further interview with the QIDP confirmed staff had failed to stock each bathroom with paper products and soap to ensure proper hygiene of the group home client's.	W 189		
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 review of records and interview, the individual support plan (ISP) failed to have sufficient training or interventions to meet identified needs for 1 of 4 sampled clients (#7). The finding is:	W 227		

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Observations of the group home during the recertification and complaint investigation survey from 6/14/21 - 6/15/21 revealed that all medication closets had a double lock which included a lock with a numerical keypad and a deadbolt lock. Further observation on 6/15/21 of group homes #1- #5 revealed that the deadbolt lock was not utilized to secure medications in the medication closet.

Review of records for client #7 on 6/14/21 revealed an ISP dated 7/18/20. Further review of the record for client #7 included a behavior support plan (BSP) dated 3/17/21 which listed the following target behaviors: non-compliance, inappropriate touching, unwanted touching of others and verbal aggression. Review of the BSP did not include interventions relative to stealing or breaking and entering into restricted areas without permission.

Subsequent review of records for client #7 on 6/15/21 revealed an incident report (IRIS) dated 4/15/21 which indicated that client #7 attempted to enter the medication cabinet several times without staff permission. The 4/15/21 IRIS report also indicated that client #7 broke into the medication cabinet and removed all of his controlled medication from the cabinet. Further review of the IRIS report indicated that client #7 removed all of the pain medication from the bubble packs and staff could not locate the contents of the medication bubble packs. Staff alerted management who contacted the poison control center and called 911. The local police department arrived in response to the 911 call and client #7 was transported to the local emergency department for evaluation. Client #7

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W 227	Continued From page 19 was released to the group home on the same day. Interview with Staff Z on 6/15/21 verified that on 4/15/21 client #7 broke into the medication cabinet and retrieved his medications from the bubble packs without staff permission. Staff Z also verified during the interview that as an intervention to client #7's behavior, management installed a deadbolt lock to all facility medication cabinets to secure controlled medications. Further interview with Staff Z verified that she did not have a key to secure to the deadbolt lock which is why there was only one lock secured on the medication cabinet. Interview with the facility qualified intellectual disabilities professional (QIDP) verified that group home medication closets were installed with a double lock to ensure client #7 could not enter the area without permission. Continued interview with the QIDP verified that the deadbolt lock installations were a result of client #7 breaking into the medication cabinet and stealing medications. The QIDP also verified that all controlled medications should be secured in an area with a double lock at all times. Further interview with the QIDP confirmed that all of client #7's program goals were active and current. The QIDP also confirmed that client #7 could benefit from programming and interventions relative to stealing and entering areas without staff permission.	W 227		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and	W 247		

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self-management.
This STANDARD is not met as evidenced by:
Based on interview and document review the facility failed to assure opportunities for client choice and self-management were provided and encouraged for 4 of 5 clients in House #5 (#13, #18, #25, and #26) relative to spending the night away from their home. The finding is:

Review of a complaint allegation dated 6/10/21 alleged the owner of the facility had to work at House #5 on third shift and did not want to stay at the facility. Continued review of the complaint allegation alleged the owner took all of the clients to her deceased brother's house and slept in the bedroom while the clients slept on the floor.

Interview with client #13 on 6/14/21 revealed on 5/2021 the facility administrator was scheduled to work third shift and informed her and her housemates that once they were finished with cleaning, she had a surprise for them. Continued interview with client #13 revealed the clients spent the night at the home of the facility administrator's brother. Further interview revealed client #13 along with her housemates spent the night in the living room area on the floor and sofa. Additional interview with client #13 revealed the owner slept upstairs but checked on them periodically throughout the night.

Interview with client #26 revealed (on unknown date) she and her peers spent the night at the facility administrators brother's house and she kept hearing noises outside which kept her up most of the night. Continued interview with client #26 revealed she was told that they were going to have fun and she slept on the couch with a flat sheet to cover. Further interview with client #26

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revealed they woke up the next morning, had breakfast and then went back home. Additional interview with client #26 revealed she felt uncomfortable and would not go back to that house again to sleep.

Interview with the facility administrator/owner on 6/14/21 revealed she was working third shift on 5/29/2021 and when clients #13, #18, #25 and #26 completed their chores, she transported them across the group home property (around 12:30 AM) to her deceased brother's home to enjoy a movie/girls night. Continued interview with the facility administrator revealed her brother had passed away in 3/2021 from pancreatic cancer. Further interview with the facility administrator revealed the relatives home had 3 bedrooms and all clients slept in the living room. Subsequent interview with the facility administrator revealed the clients did not go to bed until 2 AM, had breakfast and returned to House #5 at 10:30 am. Additional interview with the facility administrator confirmed clients slept in the living room floor and were not assured opportunities for client choice and self-management relative to sleeping arrangements or choice of going on the outing.

W 247

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

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.

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This STANDARD is not met as evidenced by:
Based on observations, record review, and interview the facility failed to ensure objectives relative to behavior management were implemented with sufficient frequency for 5 of 5 (#13, #18, #19, #25 and #26 clients in House #5 relative to door chimes.

Observations in the group home on 6/14/21 - 6/15/21 revealed door chimes on both external doors. Continued observations revealed clients as well as visitors to enter and exit the external doors of the group home. Further observations revealed at no point during observations did the door chimes work when the doors were opened.

Review of records for client #13 revealed a behavior support plan dated (BSP) dated 10/10/20 to include target behaviors of verbal and physical aggression, property destruction, elopement, and suicidal gestures.

Review of records for client #18 revealed a BSP dated 8/6/20 to include target behaviors of disruptive behavioral/verbal aggression, physical aggression, manipulative behavior, suicidal ideation behavior and elopement.

Review of client #19's record revealed a BSP dated 10/26/20 to include target behaviors of tantrums, self-injurious behavior (SIB), elopement, physical aggression, inappropriate sexual behavior, inappropriate phone usage and suicidal ideation.

Review of records for client #25 revealed a BSP dated 2/14/20 to include target behaviors of

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W 249	Continued From page 23 verbal aggression, suicidal ideation, elopement, physical aggression, disruptive behavior and property destruction. Review of client #26's record revealed a BSP dated 2/19/20 to include target behaviors of verbal and physical aggression, suicidal ideation, elopement, and SIB. Interview with the qualified intellectual disabilities professional (QIDP) on 6/15/21 verified the door chimes installed on the external doors of the group home were implemented due to client history of elopement. Continued interview with the QIDP verified the chimes should be on at all times. The QIDP also revealed both staff and clients have a history of turning them off. Further interview with the QIDP confirmed all door chimes should be on at all times to alert staff when clients attempt to leave the group home per their current BSP's.	W 249		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure 3 of 3 clients (#1, #4 and #23) observed during medication administration were provided the opportunity to participate in	W 371		

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medication self-administration. The findings are:

A. The system for drug administration failed to assure client #4 was provided the opportunity to participate in medication self-administration. For example:

Observation in house #3 on 6/15/21 at 7:16 AM revealed staff W to walk to the medication closet of the home and to verbally call out to client #4 to walk to the medication closet for morning medications. Continued observation revealed client #4 to walk from the living room to the medication closet where the client was handed a cup with medications that the client took whole with water and walked back to the living room. Further observation of the medication closet revealed multiple cubby holes with a small cup in each cubby hole. Client #4 was not observed to receive any training during the medication pass or to participate beyond taking a cup of medications from staff W and accessing water to follow medications.

Review of records for client #4 revealed an independent living evaluation dated 5/10/20. Review of the independent living assessment revealed client #4 is able to participate in medication administration with the ability to punch a hole in the pill pack and is able to put pills in the medication cup.

B. The system for drug administration failed to assure client #23 was provided the opportunity to participate in medication self-administration. For example:

Observation in house #3 on 6/15/21 at 7:21 AM revealed staff W to call out to client #23 from the

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medication closet while the client was in the living room and for client #23 to walk to the medication closet for morning medications. Continued observation revealed client #23 to be handed a cup of medications from a cup in a cubby hole and for the client to take all medications whole followed with water. Client #23 was not observed to receive any training during the medication pass or to participate beyond taking a cup of medications from staff W and accessing water to follow medications.

Review of records for client #23 revealed an independent living evaluation dated 10/8/20. Review of the independent living assessment revealed client #23 is able to participate in medication administration with the ability to access his own water from the tap, locate his cubby and punch his own pills from the pack. Continued review of the independent living assessment for client #23 revealed the client can indicate time of medications with "In the Morning" and staff should continue to encourage client to medicate as independently as possible.

C. The system for drug administration failed to assure client #1 was provided the opportunity to participate in medication self-administration. For example:

Observation in house #3 on 6/15/21 at 7:23 AM revealed staff W to call out to client #1 from the medication closet and for client #1 to walk to the medication closet for morning medications. Continued observation revealed client #1 to be handed a cup of medications from a cup in a cubby hole and for the client to take all medications whole followed with water. Client #1 was not observed to receive any training during

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W 371	Continued From page 26 the medication pass or to participate beyond taking a cup of medications from staff W and accessing water to follow medications. Review of records for client #1 revealed an independent living evaluation that reflected client #1 is able to participate in medication administration with the ability to take his own pill and water. Continued review of the independent living assessment for client #1 revealed staff will attempt hand over hand to assist the client with punching his medications. Interview with staff W on 6/15/21 revealed she punched all client morning medications about 6:45 AM and placed each client's medications in a medication cup that was placed in each clients cubby space. Continued interview with staff W revealed after preparing each client's medications for administration she locked the medication closet until it was time for the medication pass. Interview with the facility assistant qualified intellectual disabilities professional and facility administrator revealed staff should provide education and the opportunity for client participation with administering medications.	W 371		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to implement the internal security system for locking medications for 4 of 5 homes (#1, #2,	W 382		

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#3 and #4). The finding is:

Observation on 6/15/21 revealed the medication closet of house #1, house #2, house #3 and house #4 to have a double lock security system that included a electronic code and a dead bolt lock. Continued observation after the morning medication pass for house #1, #2, #3 and #4 revealed the ability for staff to access the medication closet with the electronic code only. Subsequent observation revealed the key to the dead bolt lock in house #2 to be lost.

A review on 6/15/21 of internal incident reports over the past year revealed an incident of client #7 in house #1 that indicated the client broke into the medication closet of the home and accessed an undetermined number of pain medications.

Interview with the facility qualified intellectual disabilities professional (QIDP) on 6/15/21 verified the security lock and dead bolt on each medication closet of each home should be used to secure medications when medications are not being administered. Continued interview with the QIDP verified the deadbolt lock on each medication closet door was implemented after client #7 was able to successfully break into the medication closet of house #1 with the electronic lock and access pain medications.