DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2021
FORM APPROVED
OMB NO. 0938-0391

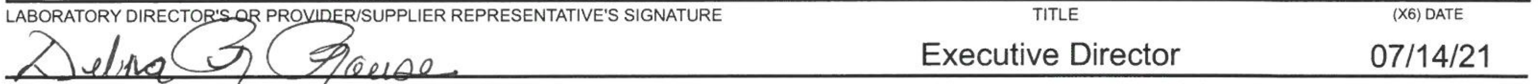
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G020	A. BUILDING ______ B. WING ______	C 06/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Complaint Intake#: NC00177935, NC00178091, NC00178097	W 000	Rouses clinical director and ED initiated an internal investigation on the allegation of client to client abuse. The clinical team will review the investigation outcome and institute recommendations to ensure the protection of clients rights. Addendum to Clients 'IHP and/or BSP will be implemented as needed. Monthly and/or as needed IHP and/or BSP reviews will be conducted during clinical reviews.	06/15/21
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	Administration Plan of Actions were completed to ensure documentation, reporting protocols and implementation of policies and procedures that prohibit mistreatment, neglect or abuse of clients is adhered to as written by agency, DHHS regulatory statues and state law. The clinical director will monitor clinical teams plan of actions weekly. All RGH Staff will receive training on Protection of client's rights, immediate reporting protocols to ensure adherence to Rouses policies and procedures and ICF/IDD regulatory guidelines. AQPs and Residential Supervisor will monitor staff daily to assure client's right protection and reporting protocols.	06/21/21 07/01/21
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	An Administrative Action Plan was developed for the clinical director and AQPs to ensure competency through training, supervision and oversight of clinical staff's implementation of Rouses Policies and Procedures and ICF/IDD regulatory requirements. ED and Quality Assurance Consultant will monitor Clinical CD weekly. Daily, the Clinical Director, AQPs, Safety Coordinator and Residential Supervisor will ensure any incident or report of abuse/neglect will be immediately reported, documented, and investigated to ensure client protection.	07/10/21 06/15/21

DHSR - Mental Health
JUL 16 2021
Lic. & Cert. Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 07/14/21



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	An Administrative Action Plan was developed for the clinical director to ensure competency through training, supervision and oversight of clinical staff's implementation of Rouses Policies and Procedures and ICF/IDD regulatory requirements. The Clinical Director will provide daily monitoring to ensure continuity of services of ICF/IDD regulatory requirements. An Administrative Action Plan will be developed for the Associate QPs to demonstrate competency in the implementation of ICF/IDD regulatory requirements and Rouses Policy and Procedures The AQP and Residential Supervisor will provide daily supervision to DSP staff to ensure compliance with regulatory and agency requirements. Quality Assurance Consultant will perform a client permanent records audit to ensure record and policy compliance with agency and ICF/IDD guidelines.	07/02/21 07/06/21 07/22/21 07/19/21

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W 149	Continued From page 2	W 149		

#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

Provider's Plan of Correction (W 149):

An internal investigation concerning the allegation indicated by client #13 was initiated by the clinical and executive director. — 06/21/21

The interdisciplinary team will assess agency's ability to meet client #13 needs as her behaviors of verbal/physical aggression, bullying peers, threating staff/peers, telling untruths and false sexual allegations. — 06/17/21

Per review of client #13's and client 19's records, documentation revealed the MCO and Rouses interdisciplinary team met in May 2020. The team established safety protocols for client #13 and client #19 to ensure safety in the bedroom. — 06/18/21

The Interdisciplinary Team will review and update Safety Protocols for client #13 and #19 as needed. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily. — 06/21/21

Staff will receive in-serviced on monitoring clients #13 & #19, addressing hx of inappropriate sexual behaviors and inappropriate sexual touching of others in private areas with or without permission. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily. — 06/18/21

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W 149	Continued From page 3 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	W 149	Staff will be in-serviced on client #13's history of false sexual allegations against others and attempting to force others into sexual activity. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily.	06/18/21
			All incident/injury and/or allegations of abuse will be communicated via call and documented to the ED, immediately. All safety reports, incidents/injury reports will be documented and forwarded to the ED daily.	07/01/21
			Clinical Director will perform weekly checks to ensure clinical staff submit inter-disciplinary notes and/or event logs are to be placed in the client's records daily.	06/15/21

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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	An internal investigation concerning the allegation indicated by client #13 was initiated by the clinical and executive director. All BSP data, facility documentation, record review, staff and client interviews relevant to the investigation will be examined. An Administrative Action Plan was developed for the clinical director to ensure training competencies, supervision and oversight of clinical staff's implementation of Rouses Policies and Procedures and ICF/IDD regulatory requirements. The Clinical Director will provide daily monitoring to ensure continuity of services of ICF/IDD regulatory requirements.	06/15/21 07/02/21

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W 153	Continued From page 5 sexual inappropriate touch involving client #13 was reported to the facility administrator. For example:	W 153	An Administrative Action Plan will be developed for the Associate QPs to demonstrate competency in the implementation of ICF/IDD regulatory requirements and Rouses Policy and Procedures.	07/06/21
	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.		The AQPs and Residential Supervisor will provide daily supervision to DSP staff to ensure compliance with regulatory and agency requirements.	07/22/21
			Quality Assurance Consultant will perform a client permanent records audit to ensure record and policy compliance with agency and ICF/ IDD guidelines.	07/19/21
	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.		The Clinical Director, AQPs, Residential Supervisor, Med Tech and Safety Coordinator were in-serviced to ensure continuous documentation and follow up on the onset of any client crisis/event/or/concern.	06/21/21
			The CD, AQPs, Residential Supervisor, Med Tech and Safety Coordinator will submit weekly reports to the ED on the status of IRIS reporting, client communication/notification, incident/injury, health care status and/or other changes in client active treatment status.	06/21/21
	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		The Interdisciplinary team will meet to ensure an addendum of Client 13's IHP and BSP to include investigation findings of the following target behaviors of lying, making false sexual allegations, inappropriate touching others and attempting to force others into sexual activity.	07/01/21
			The Clinical Director will be schedule an appointment for Client #13 to be assessed by behavioral counselor Dr. Wanda Ramseur will be completed by the Clinical Director.	07/01/21

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W 153	Continued From page 6	W 153		

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

Provider's Plan of Correction:

Appointment will be scheduled by the Clinical Director for Client #19 to be assessed by behavioral counselor Dr. Wanda Ramsuer. — 07/01/21

Interdisciplinary team will assess agency's ability to meet client #13 needs as her behavioral and safety needs (eloping, physical aggression) pose a threat to her and others. Additionally, team will assess Client #13's infringement of the rights of others due to her episodes of bullying,verbal aggression and threats to staff and peers to make false allegations against others. — 06/30/21

AQP received in-service training on timely reporting of IRIS submissions. Clinical Director will provide supervision to the AQPs to address timeliness of IRIS reporting weekly and/or as incidents occur. — 07/01/21

Clinical Director will advise ED via written and verbal communication of all incidents that require IRIS reporting daily Clinical Director will submit all clinical staff's to the ED weekly advising of IRIS reporting, client communication/notification, incident/injury, health care status and/or any other changes in client active treatment status. — 07/10/21

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W 153	Continued From page 7 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.	W 153	Per review of client #13's and client 19's records, documentation revealed the MCO and Rouses interdisciplinary team met in May 2020. The team established safety protocols for client #13 and client #19 to ensure safety in the bedroom. The Interdisciplinary Team will review and update Safety Protocols for client #13 and #19 as needed. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily. Staff will be in-serviced on monitoring clients #13 & #19, addressing hx of inappropriate sexual behaviors and inappropriate sexual touching of others in private areas with or without permission. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily. Staff will be in-serviced on client #13's history of false sexual allegations against others and attempting to force others into sexual activity. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily. All incident/injury and/or allegations of abuse will be communicated via call and documented to the ED, immediately. All safety reports, incidents/injury reports will be documented and forwarded to the ED daily. AQPs, Residential Supervisor and Safety Coordinator will be in-serviced to assure incident/injury reports, inter-disciplinary notes/ event logs and pertinent historical information is included in each client's active treatment plan.	06/18/21 06/21/21 06/18/21 07/06/21 07/10/21 06/15/21

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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	AQP received in-service training on timely reporting of IRIS submissions. Clinical Director will provide supervision to the AQP to address timeliness of IRIS reporting weekly and/or as incidents occur. Clinical Director will advise ED via written and verbal communication of all incidents that require IRIS reporting. All clinical staff will submit weekly reports to the ED advising of IRIS reporting, client communication/ notification, incident/injury, health care status and/or any other changes in client active treatment status.	06/16/21 06/16/21
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	Rouses clinical director and ED initiated an internal investigation on the allegation of client to client abuse. The clinical team will review the investigation outcome and institute recommendations to ensure the protection of clients rights.	06/21/21

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W 154	Continued From page 9 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	W 154	Per review of client #13's and client 19's records, documentation revealed the MCO and Rouses interdisciplinary team met in May 2020. The team established safety protocols for client #13 and client #19 to ensure safety in the bedroom. The Interdisciplinary Team will review and update Safety Protocols for client #13 and #19 as needed. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily. Staff will be in-serviced on monitoring clients #13 & #19, addressing hx of inappropriate sexual behaviors and inappropriate sexual touching of others in private areas with or without permission. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily. Staff will be in-serviced on client #13's history of false sexual allegations against others and attempting to force others into sexual activity. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily. All incident/injury and/or allegations of abuse will be communicated via call and documented to the ED, immediately. All safety reports, incidents/injury reports will be documented and forwarded to the ED daily. AQPs, Residential Supervisor and Safety Coordinator will be in-serviced to assure incident/injury reports, inter-disciplinary notes/ event logs and pertinent historical information is included in each client's active treatment plan.	06/18/21 06/21/21 06/18/21 07/06/21 07/01/21 06/15/21

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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	AQP received in-service training on timely reporting of IRIS submissions. Clinical Director will provide supervision to the AQP to address timeliness of IRIS reporting weekly and/or as incidents occur. Clinical Director will advise ED via written and verbal communication of all incidents that require IRIS reporting. All clinical staff will submit weekly reports to the ED advising of IRIS reporting, client communication/ notification, incident/injury, health care status and/or any other changes in client active treatment status. A Quality Assurance Consultant will perform a client permanent records and policy audit to ensure client record and policy compliance with agency and ICF/IDD guidelines. The Clinical Director, AQPs, Residential Supervisor, Med Tech and Safety Coordinator/Community Liaison were in-serviced by the ED to ensure continuous documentation and follow up of the onset of any client crisis/event/and/or concern is placed in the client's interdisciplinary charts.	06/16/21 06/16/21 07/19/21 06/16/21
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	An internal investigation concerning the allegation indicated by client #13 was initiated by the clinical and executive director. All BSP data, facility documentation, record review, staff and client interviews relevant to the investigation will be examined.	06/14/21

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W 157	Continued From page 11 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	W 157	An Administrative Action Plan was developed for the clinical director to ensure training competencies, supervision and oversight of clinical staff's implementation of Rouses Policies and Procedures and ICF/IDD regulatory requirements. The Clinical Director will provide daily monitoring to ensure continuity of services of ICF/IDD regulatory requirements. An Administrative Action Plan will be developed for the Associate QPs to demonstrate competency in the implementation of ICF/IDD regulatory requirements and Rouses Policy and Procedures. The AQP and Residential Supervisor will provide daily supervision to DSP staff to ensure compliance with regulatory and agency requirements. Quality Assurance Consultant will perform a client permanent records audit to ensure record and policy compliance with agency and ICF/IDD guidelines. The Clinical Director, AQPs, Residential Supervisor, Med Tech and Safety Coordinator were in-serviced to ensure continuous documentation and follow up on the onset of any client crisis/event/or/concern. Interdisciplinary team will assess agency's ability to meet client #13 needs as her behavioral and safety needs (eloping, physical aggression) pose a threat to her and others. Additionally, team will assess Client #13's infringement of the rights of others due to her episodes of bullying,verbal aggression and threats to staff and peers to make false allegations against others.	07/02/21 07/06/21 07/22/21 07/19/21 06/21/21 07/01/21

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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	Per review of client #13's and client 19's records, documentation revealed the MCO and Rouses interdisciplinary team met in May 2020. The team established safety protocols for client #13 and client #19 to ensure safety in the bedroom.	06/18/21
			The Interdisciplinary Team will review and update Safety Protocols for client #13 and #19 as needed. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily.	06/21//21
			Staff will be in-serviced on monitoring clients #13 & #19, addressing hx of inappropriate sexual behaviors and inappropriate sexual touching of others in private areas with or without permission. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily.	06/18//21
			Staff will be in-serviced on client #13's history of false sexual allegations against others and attempting to force others into sexual activity. Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor residential and day program areas daily.	07/06/21
			All incident/injury and/or allegations of abuse will be communicated via call and documented to the ED, immediately. All safety reports, incidents/injury reports will be documented and forwarded to the ED daily.	07/01/21
			AQPs, Residential Supervisor and Safety Coordinator will be in-serviced to assure incident/injury reports, inter-disciplinary notes/ event logs and pertinent historical information are included in client's active treatment plan.	06/15/21

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W 157	Continued From page 13 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 157		
W 186	DIRECT CARE STAFF 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	W 186	On 06/15/21, the facility completed an internal investigation of the allegations of the 06/10/21 investigation. Per Rouses Group Home Inc. Annual Consents each client's guardian signed permission for Field Trips 1 day or less. The property located was leased by Rouses Group Home in May 2021. The property is a ranch design with no upstairs and has an unfinished basement. The property contains 4 beds available for clients to sleep. Clients elected to remain in the common den area of the home. Client #13 acknowledged, she requested ED to provide 45 minute reminders to use the bathroom. Client #13 also acknowledged she lied to state surveyors during interview. Clients stated it was their choice to go to the property on May 29, 2021. Client #13, #19, #25 and #26 asked permission to stay the remainder of the Memorial Day Holiday at the property. Clients were provided continuous supervision during the night by ED who worked in the room adjacent to the area the clients were located. Clinical Director acknowledged ED provided her with audit review of client charts completed on May 29th upon her return to work.	06/15/21 06/15/21 06/15/21 06/15/21 06/15/21 07/14/21 06/15/21 06/15/21 06/15/21

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W 186	Continued From page 14 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.	W 186	Client # 26 was asleep while the other clients were socializing. Client # 26 remained sleep until the morning. Client #26 asked if they could return to the property for the rest of the weekend.	06/15/21
	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.		Prior to survey, Rouses had terminated the employee scheduled to work House 5 and 2 other staff were on early medical leave. Rouses Communication Board posted shifts available to work House 5, but it was updated on the printed schedule.	06/15/21
	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.		The printed schedule provided the survey staff did not include the names of the employees that worked the home on the following days: • 6/18 Staff House 5 - H. King • 6/19 Staff House 5 - H. King • 6/20 Staff House 5 - C. Barber • 6/21 Staff House 5 - C. Barber	06/15/21
	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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W 186	Continued From page 15 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	W 186	Staffing schedules will be reviewed and revised on a weekly and/or as needed basis by Clinical Director, Lead Staff, Office Administrator and Residential Supervisor. Administrative staff will perform back up staffing support in the event relief DSP is not available for shift coverage.	06/19/21
			Rouses implemented an employee incentive program for employees who work non-scheduled hours and/or provided employee referrals. The Office Manager will monitor the program bi-weekly.	06/15/21
			Client #13 and #26 were both upset about a preferred House 5 employee being terminated. The terminated requested client #13 and #26 to get Rouses to get her back. Rouses shared texts messages, staff statements and friend requests to employees and their families with client #13's guardian, APS, and DHHS.	06/15/21
			DSP Staff was in-serviced on Communication and HIPPA when terminated staff attempt to contact them in reference to Rouses. Client #13 and #26's Guardian were informed by Clinical Director and restrictions put in place for communication with former employee.	06/16/21
			Confidentiality, Incident Reporting Protocols and Ethics. Clinical Director, AQPs and Residential will provide daily communication and follow up with staff.	07/15/21
			An interdisciplinary meeting was scheduled to address and monitor trends in client #26's transitioning throughout the day. If the team deems appropriate an objective will be added to client's 26's habilitation plan. The inter-disciplinary team will review the results monthly.	07/07/21

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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		07/17/221 06/12/21
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	Globally staff will receive training on ensuring paper supplies and/or hand soap is readily available in all bathrooms. Staff will perform shift checks to verify and document the bathroom's cleanliness. During checks, the staff will clean the bathroom as needed, ensure paper supplies and/or hand soap is available. Paper products distributed or soap containers filled during check will be documented on the form as well. Inventories of paper products and hand soaps will be maintained in the cleaning closet. Prior to the end of each shift, the home's staff on duty is responsible for replenishing paper products and/or ensuring hand soap dispensers are sufficient. Daily during client house meetings and pro social groups, client will review proper hygiene for good health and infection control practices.	06/16/21 07/01/22 07/22/21

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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	Weekly the Residential Manager, AQPs and Clinical Director will perform checks during observations to ensure all bathrooms are adequately stocked with paper supplies and hand soaps. Follow ups with the staff and clients will conducted as needed. Houses that show trends of excess usage of paper products and/or hand soaps will receive additional in-service training to ensure that items are being utilized appropriately by the clients/staff in the homes. The inter-disciplinary team will implement training objectives as needed for clients that are identified to need training on usage of paper products and/or hand soaps.	07/17/21 07/21/21
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	In-service training will be provided to all staff to ensure both the dead bolt lock and the keypad are locked when medication is not being administered. Homes that contain dead bolt locks are as follows (House 1. House 2, and House 4 and H5) Med Tech, AQPs, Clinical Director, Residential Manager and Safety Coordinator will perform weekly checks on various shifts to ensure both the dead bolt and key pad entries are locked when medication is not being administered.	06/16/21 07/10/21

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W 227	Continued From page 18	W 227		
	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.		The clinical team deemed client #7 BSP's needed to be updated to include interventions relative to stealing or breaking and entering into restricted areas without permission.	07/17/21
			The Psychologist will update his BSP and the appropriate behavioral consents will be obtained.	07/15/21
	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.		DSP staff and Hab. Assistants will be in-serviced on BSP modification. Weekly the Residential Manager, AQPs and Clinical Director will monitor BSP documentation and implementation.	07/16/21
			Monthly, the clinical team will perform a review of client #7's BSP data to ensure interventions are in place into restricted areas without permission.	07/22/21
	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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUSE'S GROUP HOME	5949 NC 135 STONEVILLE, NC 27048

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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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W 247	Continued From page 20 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	W 247	Per the survey exit performed on 06/15/21, the facility completed an internal investigation of the allegations of the 06/10/21 investigation.	06/18/21
			On 06/15/21, the facility completed an internal investigation of the allegations of the 06/10/21 investigation.	06/18/21
			Per Rouses Group Home Inc. Annual Consents each client's guardian signed permission for Field Trips 1 day or less.	06/15/21
			The property located was leased by Rouses Group Home in May 2021.	06/15/21
			The property is a ranch design with no upstairs and has an unfinished basement.	06/15/21
			The property contains 4 beds available for clients to sleep. Clients elected to remain in the common den area of the home. Client #13 acknowledged, she requested ED to provide 45 minute reminders to use the bathroom.	06/15/21
			Clients stated it was their choice to go to the property on May 29, 2021. Client #13, #19, #25 and #26 asked permission to stay the remainder of the Memorial Day Holiday at the property.	06/15/21
			Clients were provided continuous supervision during the night by ED who worked in the room adjacent to the area the clients were located.	0615/21
			Clinical paperwork and chart review completed by ED was provided to Clinical Director and AQP upon their return to work.	06/15/21

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W 247	Continued From page 21 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.	W 249	Post survey, client #13 boasted to staff and other clients about the allegations made to surveyors and laughed at the "state." Client Client #13 informed terminated employee the "state" that was going to **#$ up Rouses. Client #13's guardian has recommended no further communication with former employee. Per counseling, Dr. Ramseur, informed the staff, particularly administrative staff to remain cautious, and expect more false allegations to be made by Client #13. Client #13 believes the false allegations against the agency will allow biological mother	06/15/21 07/02/212

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W 249	Continued From page 22	W 249		
	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.		Currently, door chimes are utilized by the facility for the safety and protection of clients and staff due House 5's close proximity to the highway	07/08/21
	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.		The Interdisciplinary Team (Clinical Director, AQP, Residential Supervisor and Safety Coordinator) will meet to discuss each client's target behavior of elopement. Based upon record review, behavioral documentation and psychiatric records the team will access if chimes are needed to address elopement behavior for clients #13, #18, #19, #25 and #26.	07/10/21
	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.		If door chimes are deemed appropriate to address elopement for the safety of the client, the psychologist will add chimes to the client's BSP. Prior to the implementation of the BSP Plan addendum, each client's guardian and Human Rights Signatures will be obtained.	07/12/21
	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.		Global training to assure all staff adhere to all systems and/or equipment identified in client's habilitation plan should be operable and utilized per the plan at all times. The Safety Coordinator, Residential Supervisor, AQPs and Med Tech will monitor daily.	07/22/21
	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.		The Clinical Director, AQPs, Residential Manager, and Safety Coordinator will provide weekly monitoring to assure disciplinary actions for any staff that tampers with systems and/or equipment identified in client's habilitation plan.	07/22/21
	Review of records for client #25 revealed a BSP dated 2/14/20 to include target behaviors of		Any client identified tampering with systems and/or equipment identified in client's habilitation plans or facility safety precautions for the home will be assessed by the interdisciplinary team to determine the appropriate actions to address client's behavior .	07/12/21

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W 371	Continued From page 24	W 371		

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

Provider's Plan of Correction:

House #3 staff was provided a medication administration review on the 6 rights of medication administration. Med Tech will provide training to House #3 staff to assure during medication administration each client incorporates client's self medication administration as independently as possible. — 07/10/21

Globally, the Med Tech, Residential Supervisor, Clinical Director and AQP will provide ongoing medication administration monitoring throughout the week. — 07/22/21

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W 371	Continued From page 25	W 371		

Continued From page 25

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	Maintenance provided an inspection of all locking systems on the medication doors and cabinets in each home. Med Tech, Safety Coordinator, Residential Manager and AQPs verified key codes, locking mechanism for all medication doors and assured that keys were in located on each house key ring.	06/15/21 06/15/21

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W 382	Continued From page 27 #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.	W 382	Globally all DSP and Hab staff were in-serviced on assuring locks on medication doors are operable and locked when not being accessed to administer medication. Additionally, staff was in-serviced on keeping the home's keys in their possession while on duty and the transfer of keys to the next on duty staff or placing key in a designated location during the weekday at end of their shift. The Clinical Director, AQPs, Residential Supervisor and Safety Coordinator will monitor staff to assure medication security systems are locked when not in use and the staff maintain possession of the keys while on duty. House 2 DSP staff was in-serviced on identifying and maintaining the house keys for locking the dead bolt lock on the medication door in House #2.	06/16/21 07/23/21 06/15/21

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JUL 16 2021
CONSTRUCTION SECTION

"Serving Others So They May Better Serve Themselves"

Ms. Kaila Mitchell
Facility Compliance Consultant II
Division of Health Service Regulation
2718 Mail Service Center
Raleigh, North Carolina 27699 - 2718

DHSR - Mental Health
JUL 16 2021
Lic. & Cert. Section

July 13, 2021

Re: Rouse's Group Home Inc. Complaint and Annual Survey

Dear Ms. Mitchell

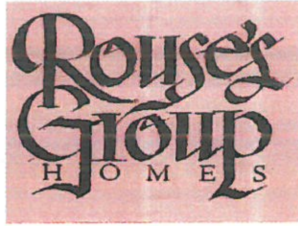
Attached is the plan of correction for the survey completed at Rouses on 06/15/2021 for Homes 1-5. During exit you indicated that we would need to schedule a follow up visit to address the Condition Level Citations received during that survey. If the materials provided meet compliance requirements for revisit, I would like to schedule our revisit prior to the 28th of July if possible.

Please advise if additional information is needed to address any of the deficiencies indicated. I can be reached at our administrative office at (336) 427-2562 or via cell at (336)339-8404.Thank you for your assistance in this matter.

Best Regards,

Rouse's Group Home, Inc.

Debra R. Rouse,
Executive Director



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Facility Compliance Consultant II
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Raleigh, North Carolina 27699 - 2718

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