STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G176	A. BUILDING _____ B. WING _____	C 09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AIRPORT ROAD GROUP HOME	195 AIRPORT ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS An unannounced complaint survey was completed on September 1, 2021 for Intake #NC00179763. The complaint was substantiated. Deficiencies were cited as a result of this complaint investigation.	W 000		
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 review and interviews, the facility failed to ensure allegations regarding lack of staff supervision relative to possible neglect was reported to the administrator and to external officials in accordance with state law. This affected 2 of 6 clients (#2 and #5). The finding is: Interview on 9/1/21 with the residential manager (RM) and the qualified intellectual disabilities professional (QIDP) revealed they were told by third shift staff on 7/27/21 that clients #2 and #5 had slipped into each others bedrooms on 7/26/21 on third shift and may be involved in an intimate relationship. It was also reported to the RM and QIDP that a third shift staff were sleeping and were not monitoring clients. Interviews on 9/1/21 with direct care staff A and B on 9/1/21 revealed there are cameras in the common areas of the facility but that clients #2 and #5 also need to be visually monitored to ensure they do not enter other residents	W 153		

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

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W 153	Continued From page 1	W 153		

bedrooms. Staff also confirmed client #5 has the target behavior of elopement and is monitored about every 15 minutes in the facility.

Review on 9/1/21 of client #2's individual program plan (IPP) dated 7/9/20 revealed client #2 has a history of sexual inappropriate gestures, physical aggression, verbal aggression that is addressed by a Mental Health Program (MHP) "Across all settings [client #2] will have incident free days related to symptoms of DSM-5 Primary Psychiatric Disorder for 100/105 days." It is also noted in client #2's IPP that she does not consistently respect the privacy of her housemates. Further review of her program requires she is visually supervised and monitored frequently.

Review on 9/1/21 of client #5's IPP dated 3/30/21 revealed she has a MHP that states across all settings she will have incident free days related to symptoms of physical aggression and elopement for 30 out of 35 days. Further review of her program requires she is visually supervised and monitored frequently.

Further interview with the RM and the QIDP on 9/1/21 revealed they had not investigated this incident and management had not reviewed the camera footage in the common areas on that date. Additional interview revealed they had not completed an IRIS report to the health care personnel registry (HCPR) of these allegations. The QIDP stated she and the RM were the designated management staff responsible for investigating incidents. The QIDP stated however, facility management had failed to investigate this incident thoroughly, failed to notify the facility administrator as well as state and other local

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W 153	Continued From page 2 officials.	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. This STANDARD is not met as evidenced by: Based on review of records and interviews with staff, the facility failed to consider all sources of evidence to thoroughly investigate allegations of neglect to supervise 2 of 6 clients who may have engaged in sexually inappropriate behavior. This affected clients #2 and #5. The finding is: Review on 9/1/21 of an internal facility investigation dated 7/16/21 revealed client #2 made a remark to the facility nurse after an altercation with client #5 indicating she and client #5, who were roommates at the time, may have engaged in a sexual relationship. The allegations were investigated but the findings were unsubstantiated. The management team made a recommendation to separate clients #2 and #5 into different bedrooms. Client #5 has a separate bedroom and client #2 shares a bedroom with client #1. Interview on 9/1/21 with the residential manager (RM) and the qualified intellectual disabilities professional (QIDP) revealed they were told by third shift staff on 7/27/21 that clients #2 and #5 had slipped into each others bedrooms on 7/26/21 and may be involved in an intimate relationship. It was also reported to the RM and QIDP that a third shift staff was sleeping and not monitoring clients. Interviews on 9/1/21 with direct care staff A and B	W 154		

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W 154	Continued From page 3	W 154		

on 9/1/21 revealed there are cameras in the common area of the facility but that clients #2 and #5 also need to be visually monitored to ensure they do not enter other residents bedrooms. Staff also confirmed client #5 has the target behavior of elopement and is monitored about every 15 minutes in the facility.

Review on 9/1/21 of client #2's individual program plan (IPP) dated 7/9/20 revealed client #2 is adjudicated incompetent and assigned a legal guardian. Further review revealed client #2 has a history of sexual inappropriate gestures, physical aggression, verbal aggression that is addressed by a Mental Health Program (MHP) "Across all settings [client #2] will have incident free days related to symptoms of DSM-5 Primary Psychiatric Disorder for 100/105 days." It is also noted in client #2's IPP that she does not consistently respect the privacy of her housemates. Further review of her program requires she is visually supervised and monitored frequently.

Review on 9/1/21 of client #5's IPP dated 3/30/21 revealed she is adjudicated incompetent and is assigned a legal guardian. Further review revealed she has a MHP across all settings she will have incident free days related to symptoms of physical aggression and elopement for 30 out of 35 days. Additional review of her MHP requires that she is visually supervised and monitored frequently.

Further interview with the RM and the QIDP on 9/1/21 revealed they had not investigated this incident reported on 7/27/21 and management had not reviewed the camera footage in the common areas on that date. Additional interview

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W 154	Continued From page 4 revealed the RM and QIDP were the designated management staff responsible for investigating incidents involving safety concerns for clients, however management failed to investigate these allegations of neglect to supervise clients #2 and #5.	W 154		