PRINTED: 11/01/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G105	B. WING _	B. WING		C 10/19/2021	
	ROVIDER OR SUPPLIER			804 I	EET ADDRESS, CITY, STATE, ZIP CODE EAST 23RD STREET VTON, NC 28658	10,	10/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS		W	000			
W 122	A revisit was conducted on 10/19/2021 for all previous deficiencies cited on 8/24/2021. All deficiencies cited 8/24/21 have been corrected. New non-compliance was identified with a complaint investigation also conducted 10/19/21. Intake #NC00182308 CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must 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 administration (W153); failed to provide evidence that all alleged violations were thoroughly investigated (W154); failed to implement sufficient client protection measures after becoming aware of abuse allegations and after an investigation was in process (W155); and show evidence of appropriate corrective action for verified violations (W157). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated client protections.		W ·				
ADODATODY		not met as evidenced by:			TITI F		(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 pa		W 1	49				
	document review, the policies and proced ensuring procedure of 1 sampled client. Review on 10/19/21 10/13/21 and comp qualified intellectual (QIDP) to inquire at the guardian of client QIDP's inquiry reve of client #2 contacted client #2 had alleged client. Further review.	rview, record review and the facility failed to implement the sto prevent neglect by not as to assure client safety for 1 (#2). The finding is: of an internal inquiry dated deted 10/14/21 revealed the disabilities professional pout an allegation reported by an the the disabilities professional pout an allegation reported by a the disabilities professional pout an allegation reported by a the the QIDP and reported that distaff A had pushed the the word of the internal inquiry to interview staff A and staff B						
	on 10/13/21 revealed engaged in a verbal and staff A intervended in a verbal and staff A intervended in the reported to pushed her; Staff A staff B that she was apologized and said of the interview by the 10/13/21 revealed the medication room interaction between to the allegation of the interview of the additional staff interfaction bedoes the services of client #2	riew by the QIDP with staff A and on 10/12/21 client #2 altercation with another client ed and placed her hand on and requested the client to ew with staff A also revealed a staff B that staff A had asked client #2 why she told pushed and client #2 dishe would do better. Review the QIDP with staff B on the staff to report she was in an and did not see any staff A and client #2 relative client #2. The internal inquiry revealed no views, no interview with client or evaluation by nursing the inquiry and no						

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23RD STR	EET HOME			NEWTON, NC 28658			
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W 149	Continued From page recommended action findings from the inte	s relative to staff based on	W 1	49			
	of records for client # dated 3/22/21 with a						
	home revealed the cl A had pushed her on door "loud". Continue revealed she had rep sister and to her guar client #2 revealed the also pushed client #1 interview with client # "staff B gets mad at m my bed. If I lay down should be noted clien	ere on 10/19/21 at the group lient to report last week staff her back and closed her led interview with client #2 orted the incident to her lied dian. Further interview with le client to allege staff A had on the back. Subsequent 2 revealed the client to state lie and won't let me lay on she tells me to get up". It t #2 was unable to provide a tions other than "last week".					
	home revealed staff t week, when she cam crying in her bedroom not let her load the di gets fired". Continued revealed the staff to r and also reported oth not understand. Sub C revealed she did not client #2's report to awas not sure what client bout. Staff C further	on 10/19/21 at the group or report during the previous e to work client #2 was an and reported staff A would shwasher and "I hope she dinterview with staff C eport client #2 was upset er information that she could sequent interview with staff of report concerns about diministration because she ent #2 was really upset revealed it is common for with redirection although					

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W 149	Review of the facility exploitation policies revealed the definiting statement "failure to supports necessary serious physical and Continued review of and exploitation policies investigation specific to Review of investigation investigator will determined alleged to have conshould be suspended uration of the investigation of the investigation is need take appropriate action people involved. Interview with the Continued interview with the QIDP also werbal client in the gale history of making untruths or reporting staff. Continued into she had only intervient inquiry as they were time of the reported Interview with the Coreports, incident reported documentation had	rienced the client to make "I hope she gets fired". y abuse, neglect and and procedures on 10/19/21 on of "neglect" included the provide services and to protect a person from d/or psychological harm". If the facility abuse, neglect icies and procedures revealed investigations (102.058). Ition procedures revealed the ermine if the staff member mitted the act of abuse ed immediately for the stigation, or if clinical ed in lieu of suspension, and tion to assure the safey of the IIDP on 10/19/21 verified she client #2 during the 10/13/21 ot think about it. Interview verified client #2 was the only group home and did not have false statements, telling g false allegations against erview with the QIDP revealed ewed staff A and B during the ethe only staff on shift at the allegation by client #2. IIDP also verified behavior	W	149			
		th the QIDP verified there had c of client #2 after the alleged					

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W 149	and no increased clir interview with the QII conclusion of the intercommended action with a psych appoint with frustrations due to her sister that resuguardian. Interview with the fact 10/19/21 revealed ar with an allegation to investigation is need the facility administration investigation had not #2's allegation as the had not determined a necessary. Interview administrator further the lack of thoroughn inquiry and a formal induiry and a forma	of staff during the inquiry nical monitoring. Subsequent DP verified with the emal inquiry the only was to support client #2 ment to discuss coping skills to the client making reports alt in complaints to the client inquiry is usually conducted determine if a more formal been conducted with client endings from the inquiry an investigation to be with the facility verified she was unaware of these conducted with the initial investigation should have insure client protections from the or abuse, as well as source, are reported diministrator or to other e with State law through these. To continue the inquiry was an analy failed to ensure an or 1 of 1 sampled client (#2)	W 1			

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W 153	2:15 PM revealed clie looking at a coloring the levision. Continued #2 to invite the survey Interview with client # report last week staff back and closed here interview with client # the incident to her sis Further interview with to allege staff A had a back. Subsequent intervealed the client to me and won't let me I she tells me to get up #2 was unable to provallegations other than Interview with staff C home revealed staff to week, when she came crying in her bedroom not let her load the digets fired". Continued revealed the staff to rand also reported oth not understand. Subsequent in the client #2's report to acknowledges and such was not sure what client #2 to get upset she had never experi	oup home on 10/19/21 at ent #2 to sit in her room book and watching dobservation revealed client yor into her bedroom. E2 revealed the client to A had pushed her on her door "loud". Continued E2 revealed she had reported eter and to her guardian. In client #2 revealed the client also pushed client #1 on the erview with client #2 state "staff B gets mad at any on my bed. If I lay down with client wide a timeframe with	W 1					
	 Review on 10/19/21 o	of an internal inquiry dated						

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
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W 153	10/13/21 and comple qualified intellectual of (QIDP) to inquire about the guardian of client QIDP's inquiry reveal of client #2 contacted client #2 had alleged client. Further review revealed the QIDP to Review of notes by the staff A revealed the significant #2 told staff B to staff A asked the client was going to do better was going to do better was going to do better inquiry. Continued in verified staff B should allegation to administ with the QIDP reveals occurred relative to the aconfirmed interview staff A had pushed he the allegation. Additiverified she had not instaff during the inquire STAFF TREATMENT CFR(s): 483.420(d)(3)	ted 10/14/21 revealed the disabilities professional but an allegation reported by #2. Continued review of the ed on 10/13/21 the guardian of the QIDP and reported that staff A had pushed the for of the internal inquiry interview staff A and staff B. The QIDP during interview with the foregoing interview with the taff to report (on 10/13/21) that staff A pushed her and the why she reported she was the apologized and said she for the foregoing the 10/13/21 the treview with the QIDP of the treview of the treview with the QIDP of the treview of the treview of the treview with the QIDP of the treview of the tre	W 1	153		
	violations are thoroug This STANDARD is a Based on review of f the facility failed to pr	not met as evidenced by: acility records and interview, covide evidence an allegation ghly investigated for 1 of 1				

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W 154	Continued From pa	ge 7	W 1	54		
	10/13/21 and comply qualified intellectual (QIDP) to inquire at the guardian of clier QIDP's inquiry reverse of client #2 contacted client #2 had alleged client. Further review revealed the QIDP to only. Review of the intervor on 10/13/21 revealed engaged in a verbal and staff A intervence client #2's shoulder calm down. Interview client #2 reported to pushed her; Staff A staff B that she was apologized and said of the interview by the 10/13/21 revealed the medication room interaction between to the allegation of the interview of the additional staff interwitzer, no body check of services of client #2 removal of any staff recommended action findings from the interview of the commended action of the commended actions of the commended ac	e internal inquiry revealed no views, no interview with client or evaluation by nursing s, no protection of clients with during the inquiry and no ons relative to staff based on				

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W 154	disability and chronic of records for client # dated 3/22/21 with a target behaviors of c stuffing. Interview with client: home revealed the c A had pushed her or door "loud". Continurevealed she had repsister and to her guaclient #2 revealed the also pushed client # interview with client: "staff B gets mad at my bed. If I lay down should be noted client timeframe with allegal Interview with staff C home revealed staff week, when she can crying in her bedroon not let her load the digets fired". Continue revealed the staff to and also reported oth not understand. Sut C revealed she did in client #2's report to a	e 8 c anxiety. Continued review #2 revealed a habilitation plan behavior support plan for rying, skin picking and food #2 on 10/19/21 at the group lient to report last week staff her back and closed her red interview with client #2 corted the incident to her rdian. Further interview with e client to allege staff A had 1 on the back. Subsequent #2 revealed the client to state me and won't let me lay on a she tells me to get up". It not #2 was unable to provide a actions other than "last week". 5 on 10/19/21 at the group to report during the previous me to work client #2 was me and reported staff A would ishwasher and "I hope she d interview with staff C report client #2 was upset mer information that she could osequent interview with staff tot report concerns about administration because she ient #2 was really upset	W 1	,		
	client #2 to get upse she had never exper statements such as ' Interview with the QI	er revealed it is common for t with redirection although ienced the client to make 'I hope she gets fired". DP on 10/19/21 verified she client #2 during the 10/13/21				

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with the QIDP also verbal client in the a history of makin untruths or reporti staff. Continued i she had only inter inquiry as they we time of the reporte Interview with the reports, incident redocumentation had inquiry into client. Further interview been no body che incident and no reinquiry. Subseque verified with the cothe only recomme client #2 with a psecoping skills with making reports to complaints to the Interview with the 10/19/21 revealed with an allegation investigation is net the facility adminisinvestigation had #2's allegation as had not determine necessary. Interview administrator furth the lack of thorouginquiry and a form	not think about it. Interview of verified client #2 was the only a group home and did not have grales statements, telling ang false statements, telling ang false allegations against anterview with the QIDP revealed viewed staff A and B during the are the only staff on shift at the end allegation by client #2. QIDP also verified behavior apports or any other don't been used to conduct the #2's allegation against staff A. With the QIDP verified there had ack of client #2 after the alleged amoval of staff during the pent interview with the QIDP conclusion of the internal inquiry anded action was to support sych appointment to discuss frustrations due to the client her sister that result in	W 15.	4			

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W 155	CFR(s): 483.420(d)(3 The facility must prev while the investigation This STANDARD is not and interviews, the fasufficient client ptoted after becoming aware of 1 investigation reviews qualified intellectual of (QIDP) to inquire about the guardian of client QIDP's inquiry revealed client #2 contacted client #2 had alleged client. Further reviews revealed the QIDP to only. Review of the interview on 10/13/21 revealed engaged in a verbal and staff A intervened client #2's shoulder and calm down. Interviews client #2 reported to spushed her; Staff A as staff B that she was papologized and said sof the interview by the 10/13/21 revealed the the medication room and the staff	ent further potential abuse is in progress. Into met as evidenced by: acility records/documents cility failed to implement tion measures immediately of an abuse allegation for 1 ewed. The finding is: If an internal inquiry dated and 10/14/21 revealed the isabilities professional ut an allegation reported by #2. Continued review of the ed on 10/13/21 the guardian the QIDP and reported that staff A had pushed the of the internal inquiry interview staff A and staff B w by the QIDP with staff A on 10/12/21 client #2 Itercation with another client and placed her hand on and requested the client to with staff A also revealed staff B that staff A had sked client #2 why she told ushed and client #2 the would do better. Review e QIDP with staff B on e staff to report she was in and did not see any taff A and client #2 relative	W 1	55		

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W 155	Continued From page	÷ 11	W 1	55			
	Further review of the additional staff interview #2, no body check or services of client #2 a with removal of any significant with removal of any significant interviewed conquiry as she did not with the QIDP also verbal client in the ground have a history of a telling untruths or repragainst staff. Continuate continuity as the shift at the time of the #2. Interview with the reports, incident reports, incident reports documentation had not inquiry into client #2's Further interview with been no body check coincident and no removing in the reports interview with the fact and the client #2's allegation in interview with the fact staff A would be immediated investigation of thoroughness with investigations.	internal inquiry revealed no lews, no interview with client evaluation by nursing and no protection of clients taff during the inquiry. OP on 10/19/21 verified she lient #2 during the 10/13/21 think about it. Interview wrified client #2 was the only oup home and client #2 did making false statements, orting false allegations led interview with the QIDP or interviewed staff A and B hey were the only staff on reported allegation by client QIDP also verified behavior and the staff and the allegation against staff A. The QIDP verified there had of client #2 after the alleged and of staff during the anthe facility administrator on sures to ensure client een taken with regard to involving staff A. Continued lity administrator verified ediately suspended while an was initiated to ensure vestigating client #2's					
W 157	CFR(s): 483.420(d)(4	OF CLIENTS	W 1	57			

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W 157	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		W 1	57			

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W 157	with a psych appointn	nent to discuss coping skills o the client making reports	W 15	57			