STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G350	A. BUILDING ______ B. WING ______	C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA FARMS GROUP HOME #3	31713 HERB FARM CIRCLE ALBEMARLE, NC 28001

(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 NC#00182803	W 000		
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 facility records and interview, the facility failed to provide evidence an allegation of abuse was thoroughly investigated for 1 of 1 investigation reviewed involving client #1. The finding is: Review of internal facility documents on 11/15/21 revealed an investigation summary dated 10/26/21 and completed on 11/2/21. Review of the investigation summary revealed the facility's chief regulatory officer received a phone call from the Human Resources department on 10/26/21 informing her that staff A witnessed staff B to use inappropriate language towards client #1 and slap the client's head in his bedroom because the client wet the floor in the hallway. Further review revealed staff B was interviewed but not informed of the allegations and placed on suspension on 10/26/21. Staff A was also interviewed. Subsequent review revealed staff A and B were the only two staff on shift at the time of the alleged incident and there were no other witnesses to give an account of the incident. Additional review revealed the facility nurse checked the client and there was no physical evidence on the client's head that indicated an injury. Review of the conclusion of the investigation summary revealed the investigation was	W 154		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 154	Continued From page 1 inconclusive as Staff A and B were the only staff in the home and conflicting accounts were provided with interviews. Continued review of the conclusion revealed the investigator was unable to substantiate abuse and/or inappropriate interactions between staff B and client #1. Review of the recommendations of the investigative team revealed the recommendation for staff B to be transferred from the group home to avoid potential interactions with client #1 due to the inconclusive nature of the investigation. Continued review of the actions taken revealed the facility decided to bring back staff B with modification to staff B's working environment and the staff would have a six month probation period where she would be monitored and any violations during this time would result in further disciplinary actions. Review of the IRIS report dated 10/27/21 revealed facility administrative staff became aware of the allegation of abuse on 10/26/21. Persons contacted were the HR office, the facility regulatory officer, the guardian and social services. Interview with the regulatory officer on 11/15/21 confirmed the investigation started on 10/26/21 and ended on 11/2/21. The regulatory officer then confirmed the alleged staff (B) was placed on suspension pending the outcome of the investigation. Continued interview revealed staff B returned to work and was transferred to another facility on a six-month probationary status. The facility regulatory officer further confirmed there were conflicting reports between both staff interviewed and she felt there was no need to interview anyone else. Interview also confirmed	W 154		

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W 154	Continued From page 2 client #1 was unable to be interviewed because of communication deficits, as the client is non-verbal. Further interview verified one client in the group home to be verbal although the client was not interviewed as the client was not a witness to the alleged incident. Interview with the chief regulatory officer confirmed the investigation failed to include other staff or client interviews to ensure thorough interviews with investigating an allegation of abuse. Other interviews would have helped in determining if other incidents of possbile abuse could have occured and had not been reported. Additional interview verified a client rights training would be completed at a later date in the month. Interview with the chief regulatory officer additionally verified staff B was permitted to return to work without additional training and the staff would be part of the training later in the month.	W 154		