STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G175	A. BUILDING _____ B. WING _____	R-C 12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHWAY 117 GROUP HOME	3801 US 117 NORTH 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 on-site follow up and complaint investigation was completed on 12/20/21 for Intake # NC00184101. Deficiencies were cited as a result of a complaint survey.	{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 3 of 6 sampled clients (#1, #2 and #3). The finding is: Review on 12/ 20/21 of the facility's internal investigation dated 12/6/21 revealed staff A reported to Nursing on 12/3/21 that clients #1 and #2 were fighting in the facility on 12/2/21 and staff A ran after client #2 and tried convince him to come back inside the facility. Staff A also stated that he and staff B took clients #1, #2 , #3, #4, #5 and #6 to the vocational center. In addition, he stated when they arrived back at the facility that clients #1 and #2 started physically fighting again and staff A broke them apart. Additional review revealed all clients involved in the altercation were physically assessed by Nursing. Review on 12/20/21 of staff B's statement in the internal investigation dated 12/6/21 revealed that client #3 and client #2 got into a physical altercation with client #1 on 12/2/21 and that all three clients used belts as weapons during the physical altercation.	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 Interview on 12/20/21 with Nursing revealed staff A told Nursing client #3 was involved in a physical altercation and had sustained a laceration to his mouth that had been treated with an oral antibiotic. Review on 12/20/21 of client 3's record revealed a telephone order dated 12/3/21 for Augmentin 500 mg. twice daily by mouth for 5 days to prevent possible infection in his mouth. Interview on 12/20/21 with the Consumer Affairs Coordinator revealed she had not realized that there were discrepancies in the statements given by staff A and staff B revealing that all three clients #1, #2 and #3 were involved in the physical altercation. She also stated she did not realize there were two separate physical altercations. Further interview revealed she and the Program Director had reviewed the camera footage at the facility. She stated the footage coincided with staff A's statement but they had not re-interviewed staff A, staff B nor had they interviewed the three clients involved to ascertain more details about the physical alteration on 12/2/21.	W 154		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on review of facility records and	W 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G175	A. BUILDING _____ B. WING _____	R-C 12/20/2021

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W 156	Continued From page 2	W 156		

interviews, the facility failed to ensure 1 of 1 investigation reviewed was concluded and results were reported to the administrator or to other officials in accordance with state law within 5 working days of an allegation of client to client abuse. The finding is:

Review on 12/ 20/21 of the facility's internal investigation dated 12/6/21 revealed staff A reported to Nursing on 12/3/21 that clients #1 and #2 were fighting in the facility on 12/2/21 and staff A ran after client #2 and tried convince him to come back inside the facility. Staff A also stated that he and staff B took clients #1, #2 , #3, #4, #5 and #6 to the vocational center. In addition, he stated when they arrived back at the facility that clients #1 and #2 started physically fighting again and staff A broke them apart. Additional review revealed all clients involved in the altercation were physically assessed by Nursing.

Review on 12/20/21 of staff B's statement in the internal investigation dated 12/6/21 revealed that client #3 and client #2 got into a physical altercation with client #1 on 12/2/21 and that all three clients used belts as weapons during the physical altercation.

Interview on 12/20/21 with the Consumer Affairs Coordinator revealed she had not realized that there were discrepancies in the statements given by staff A and staff B revealing that all three clients #1, #2 and #3 were involved in the physical altercation. She also stated she did not realize there were two separate physical alterations. Further interview revealed she and the Program Director had reviewed the camera footage at the facility that coincided with staff A's statement but they had not re-interviewed staff A,

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W 156	Continued From page 3 staff B nor had they interviewed the three clients involved, to ascertain more details about the physical alteration on 12/2/21. Additional interview confirmed that she had not concluded the investigation as of 12/20/21, as she was awaiting the findings of the local department of social services, who was also investigating this incident. Interview on 12/20/21 with the Executive Director confirmed the results of this investigation had not been finalized as the facility was awaiting the results of the local department of social services who was investigating this incident that was reported on 12/6/21.	W 156		