STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G345	A. BUILDING _____ B. WING _____	C 01/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUSE'S GROUP HOME #6	5820 NC HIGHWAY 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	W 000		
	Intake# NC00184531			
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure privacy was maintained for 1 sampled and 1 non-sampled client (#1 and #4) during medication administration. The findings are: A. The facility failed to assure privacy for client #4 during medication administration. For example: Observation in the group home on 1/12/22 at 7:05 AM revealed client #4 to enter the medication room and to leave the medication room door open. Continued observation at 7:05 AM revealed staff B to observe client #5 walk by the medication room while administering medications to client # 4 and to verbally talk to the med. technician while standing in front of the open medication door. Further observation revealed staff B to administer all medications to client #4 without closing the medication room door. Interview with the facility med. technician on 1/12/21 verified all clients must have privacy while medications are being administered. Continued interview with the med technician verified that privacy was not offered to client #4 during medication administration. B. The facility failed to assure privacy for client	W 130		

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

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W 130	Continued From page 1 #1 during medication administration. For example: Observation at 7:20 AM revealed client #1 to enter the medication room and staff B to administer all morning medications to client #1 with the medication room door open. Continued observation at 7:25 AM revealed client #4 to walk by the medication room with the door open as staff B asked client #1 to take his medications. At no time during observation was privacy offered or maintained. Interview with the facility med. technician on 1/12/21 verified all clients must have privacy while medications are being administered. Continued interview with the qualified intellectual developmental professional (QIDP) revealed privacy should be maintained for all clients during medication administration to limit distractions and while additional training was needed with staff, the facility will discuss other options relative to ensuring privacy.	W 130		
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 record review and verified by interview, the facility failed to complete a thorough investigation for 1 of 1 sampled clients (#5) to investigate injuries sustained by client on client abuse. The finding is: Review of internal records on 1/12/22 revealed an	W 154		

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incident report dated 8/11/21 that indicated client #5 was involved in an altercation with a housemate and sustained numerous scratches and bruises. Review of pictures included in the 8/2021 incident report revealed client #5 sustained significant scratches and bruises to the face and neck as well as a bruised, swollen lip. Review of the body check and med. technician note dated 8/11/21 indicated that client #5 was assessed and treated and did not need further medical attention. Further review of the med. technician note dated 8/11/21 indicated that the LRP was called and client #5 was taken home with the LRP on 8/11/21-8/12/21 for therapeutic leave. Review of the IRIS report dated 8/11/21 indicated that there was no need for an internal investigation and client #5 did not need medical attention. Subsequent review of the 8/11/21 incident report revealed a recommendation that an additional staff member is needed due to the increasing needs and behavior of the clients.

Review of the 12/27/21 incident report revealed that client #5 returned home from the day program cursing and slapping his peers which resulted in a physical altercation with another housemate. Continued review of the 12/2021 incident report indicated client #5 was hit with a power cord and punched twice in the back with a closed fist. Further review of the 12/27/21 incident report also revealed that the med. technician assessed client #5's injuries and further medical attention was not necessary. Subsequent review of the 12/27/21 incident report revealed a recommendation that an additional staff member is needed in the group home. Review of the facility documentation did not reveal evidence of team meeting notes, internal investigations, staff inservice training or changes

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to clients' ISPs and/or BSPs relative to the previous incidents.

Review of the facility's incident report policy indicates that the facility will facilitate injury prevention analysis, promote safety improvement initiatives and monitor its effectiveness in terms of incident rates. Continued review of the incident report policy indicates that the QIDP will further investigate incidents and clarification to assess outcomes and formulate recommendations.

Interview with staff D on 1/11/22 revealed that a second staff is needed in the group home due to the increasing needs of all clients in the group home. Staff D also reported during the interview that it is difficult for 1 staff to manage client behaviors and meet the needs of all of the clients in the group home.

Interview with the med. technician on 1/12/22 revealed she was present during the altercation on 8/11/21 between client #5 and his housemate. The med. technician also reported during the interview that the housemates are much larger in size than client #5 although the client initiates the altercations. Continued interview with the med. technician revealed she did not know why an internal investigation was not completed for the incidents that led to client #5's multiple injuries and bruises.

Interview with the associate qualified intellectual disabilities professional (QIDP) on 1/12/22 revealed that client #5 is much smaller in stature than his peers and although the housemates fight often with client #5 there was no need for an internal investigation or further follow up. The Associate QIDP also verified during the interview

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W 154	Continued From page 4 that following the 8/11/21 incident, the housemate involved in the altercation with client #5 was discharged and the housemate involved in the 12/27/21 altercation with the client was temporarily transferred to another home for 1 week. Further interview with the Associate QIDP verified that there were no team meetings to discuss the client behaviors of the individuals involved in physical altercations. Interview with the facility QIDP on 1/12/22 verified that she was aware of client #5's injuries and bruising but was not sure why an internal investigation was not initiated. The QIDP also verified during the interview that it is the facility protocol that once an injury occurs the staff are to report it to the clinical team immediately. Continued interview with the QIDP also revealed that client #5 received substantial injuries however he did not need medical attention from a medical professional. Further interview with the QIDP relative to the 12/27/21 incident revealed the housemate who attacked client #5 was temporarily transferred to another home and returned to the group home on 1/7/21. The QIDP also verified that they will hire and secure a second staff in the group home to assist with the increasing needs of the clients in the home.	W 154		
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	W 249		

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plan.

This STANDARD is not met as evidenced by:
Based on observation, interviews, and record reviews, the facility failed to assure a continuous active treatment program was provided to support the achievement of the objectives identified in the individual support plans (ISP) for 3 of 5 clients (#1, #2, and #5). The findings are:

A. The facility failed to provide adequate active treatment to engage client #1 during large amounts of unstructured time. For example:

Afternoon observations in the group home on 1/11/22 from 4:40 PM to 6:40 PM revealed client #1 to pace throughout the group home, refuse the dinner meal and resume to pace the area for 100 of the 120 minutes observations. At no point during the observation period was client #1 offered choices in leisure activities.

Morning observations in the group home on 1/12/22 from 6:55 AM to 8:20 AM revealed all clients to sit in the living room area and watch television. Continued observations revealed client #1 to pace around the group home unengaged without activity for 90 minutes of observations. At no point during the observation period was client #1 offered choices in leisure activities from the leisure closet.

Review of the record for client #1 revealed an ISP dated 11/3/21. Review of the ISP revealed that client #1 has the following diagnoses: I/DD profound, Autism Spectrum Disorder, Enlarged Prostate, Anorexia and High Blood Pressure.

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Further review of the ISP revealed training objectives to address privacy, handwashing, set his own place setting, clear his place setting, tying his shoes independently and task performance.

Interview with staff B on 1/11/22 revealed that there is usually only one staff on shift with the clients which makes it difficult to engage the clients in structured activities. Interview with staff D on 1/12/22 revealed that since there is only one staff on shift there is not enough time to engage clients in leisure activities due to getting clients ready for the day and addressing any client behaviors as they arise.

Interview with the qualified intellectual disabilities professional (QIDP) on 1/12/22 revealed client #1's training objectives were current. Continued interview with the QIDP verified that staff should have been offered leisure activities during periods of inactivity. Further interview with the QIDP revealed that staff should implement active training programs specific to client #1's program goals and ensure that the client #1 is offered meaningful activities throughout the day.

B. The facility failed to provide adequate active treatment to engage client #2 during large amounts of unstructured time. For example:

Afternoon observations in the group home on 1/11/22 from 4:40 PM to 6:40 PM revealed client #2 to sit in the living room, participate in the dinner meal and return to the living room unengaged without activity for 90 of the 120 minutes of observations. Further observations at 5:15 PM revealed client #2 to engage in tantrum behaviors and staff to offer snack choices. At no point during the observation period was client #2

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offered leisure activities.

Morning observations in the group home on 1/12/22 from 6:55 AM to 8:20 AM revealed all clients to sit in the living room area and watch television. Further observations revealed client #2 to sit in the living room area unengaged without activity for 70 of the 90 minutes of observations. Additional observations at 8:20 AM revealed staff to assist client #2 with putting on his coat and prepare for loading the van to be transported to the day program. At no point during the observation period was client #2 offered choices in leisure activities from the leisure closet.

Review of the record on 1/12/22 for client #2 revealed an ISP dated 8/3/21. Review of the ISP revealed that client #2 has the following diagnoses:I/DD, severe, Autism Spectrum Disorder, Seizure Disorder and bilateral hydrocele right and left. Continued review of the ISP revealed training objectives to address handwashing before lunch, oral hygiene, privacy, and task performance. Review of the behavior support plan (BSP) revealed the following target behaviors: aggression, self-injurious behaviors (SIBs), disruptive behaviors, elopement, property destruction, inappropriate sexual behaviors and stealing.

Interview with staff B on 1/11/22 revealed that there is usually only one staff on shift with the clients which makes it difficult to engage client #2 in leisure activities. Interview with staff D on 1/12/22 revealed that since there is only one staff on shift there is not enough time to engage clients in leisure activities due to getting clients ready for the day and address client #2's behaviors.

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Interview with the QIDP on 1/12/22 revealed all client training objectives were current. Continued interview with the QIDP verified that all clients should be offered leisure activities during periods of inactivity. Further interview with the QIDP revealed that staff should implement active training programs specific to each client throughout the day and offer client #2 meaningful activities according to his program goals.

C. The facility failed to provide adequate active treatment to engage client #5 during large amounts of unstructured time. For example:

Afternoon observations in the group home on 1/11/22 from 4:40 PM to 6:40 PM revealed client #5 to pace throughout the group home, sit for the dinner meal and resume pacing for 90 of the 120 minutes of observations. At no point during the observation period was client #5 offered choices in leisure activities.

Morning observations in the group home on 1/12/22 from 6:55 AM to 8:20 AM revealed all clients to sit in the living room area and watch television. Continued observations revealed client #5 to pace around the group home unengaged without activity for 90 minutes of observations. Additional observations at 8:20 AM revealed staff to prompt client #5 to put on his coat and prepare for loading the van to transport the client to the day program. At no point during the observation period was client #5 offered choices in leisure activities from the leisure closet.

Review of the record for client #5 revealed an ISP dated 7/1/21. Review of the ISP revealed the

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following diagnoses for client #5: I/DD, Severe, Microcephaly, Impulse Control and Conduct Disorder, Cerebral Palsy, Tinea Pedis, kyphotic posture and knees bent gait. Continued review of the ISP revealed training objectives to address dry lower body, oral hygiene, handwashing, personal space and social distancing. Review of the BSP for client #5 revealed the following target behaviors: aggression, SIBs, disruptive behavior, stealing, elopement, suicidal gestures, property destruction and inappropriate verbal gestures.

Interview with staff B on 1/11/22 revealed that there is usually only one staff on shift with the clients which makes it difficult to engage the clients in leisure activities. Interview with staff D on 1/12/22 revealed that since there is only one staff on shift there is not enough time to engage clients in leisure activities due to getting clients ready for the day and addressing client #5's behaviors.

Interview with the QIDP on 1/12/22 revealed all client training objectives were current. Continued interview with the QIDP verified that all clients should be offered leisure activities during periods of inactivity. Further interview with the QIDP revealed that staff should implement active training programs specific to client #5's program goals throughout the day and offer all clients meaningful activities.