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 _____	C 07/12/2022

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 #NC00190844	W 000		
W 122	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: implement written policies and procedures that prohibit mistreatment, neglect and abuse of a client (W149), ensure that all allegations of mistreatment, neglect or abuse as well injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures (W153), and have evidence that all alleged violations are thoroughly investigated (W154). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutorily mandated services of client protections to its clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure clients are free of neglect. This affected 2 of 6 audit clients (#5 and #6) The finding is: Review on 7/11/22 of the facility's investigation initiated 7/5/22 revealed that client #5 and client #6 were involved in sexual misconduct on	W 149		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 149	Continued From page 1 6/29/22. Review on 7/11/22 of the facility's video surveillance camera and audio recordings revealed on 6/29/22 client #5 and client #6 were alone on the back porch of the home between 4:51pm and 5:02pm. During this time client #5 and client # 6 engaged in sexual behavior. Review on 7/11/22 of the Narrative Report of Findings completed by Consumer Affairs Coordinator (CAC) revealed one group home staff (Staff B) working on 6/29/22 from 6:15am to 6:15pm received a reprimand on 7/7/22 for Personnel Policy #31, 1.3 negligence in performance of duties and 1.4 negligence in monitoring or supervising clients. Staff B was seen on video during the incident in the medication room on her cell phone and walking around the home. Staff A was seen on video in the kitchen with other clients preparing dinner and was not reprimanded following the investigation. Review on 7/11/22 of client #5's Mental Health Plan (MHP) dated 5/24/22 revealed a target behavior for sexual advances towards peers/roommate. Review on 7/11/22 of client #6's MHP dated 5/9/22 revealed a target behavior for sexual advances towards peers/roommate. Review on 7/11/22 of Consumer Rights and Affairs Policy #2 Abuse, Neglect and/or Exploitation defines neglect as "acts or omission rather than commission, the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. To be classified as neglect, an act (or omission of an	W 149		

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W 149	Continued From page 2 act) must constitute actual damage to the physical, emotional, or social development of the consumer. Further definition of neglect is as follows: 1. Inadequate supervision or control of the consumer...." Observations in the home on 7/12/22 from 6:24am - 7:33am revealed client #5 and client #6 sitting in the living room alone for extended periods of time. During this time, Staff D was in other client's bedrooms and the bathroom, the Residential Services Supervisor (RSS) was in the medication room and Staff A was in the kitchen cooking breakfast. Interviews on 7/11-7/12/22 with Staff A, Staff C, Staff D and Staff E all confirmed that client #5 and client #6 should never be left alone together. Interview on 7/12/22 with Qualified Intellectual Disabilities Professional (QIDP) revealed that all staff have been educated on client #5 and client #6 not being allowed to be left alone together. The facility was notified by the surveyors on 7/12/22 that a Condition of Participation in Client Protections existed in the facility based on review of the facility's internal investigation, staff statements that indicate failure to report a known incident of a rights violation, review of documentation, video footage and staff statements that showed no evidence existed that client #5 and client #6 were adequately supervised during the sexual misconduct incident on 6/29/22.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)	W 153		

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W 153	Continued From page 3 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 reviews and interviews, the facility failed to ensure that management was notified immediately of an incident of sexual misconduct and neglect due to inadequate supervision. This affected 2 of 6 audit clients (#5 and #6). The finding is: Review on 7/11/22 of the facility's internal investigation dated 7/5/22 revealed that on 6/29/22, client #5 and client #6 were alone on the back porch from 4:51pm - 5:02pm. During this time, client #5 and client #6 were involved in a sexual encounter. Staff A was in the kitchen cooking, and Staff B was in the medication room on her cell phone and walking around the home. Review on 7/11/22 of the written statement dated 7/5/22 completed by Staff F revealed that on 6/29/22, client #5 told him about the sexual encounter. Client #5 informed Staff F that he had told Staff A and Staff B about the incident. Review on 7/11/22 of the written statement dated 7/5/22 completed by Staff C revealed that on 7/1/22, Client #5 told her about the sexual encounter between he and client #6. Staff C asked client #5 where the staff were during this time, and he stated they were in the house and he and client #6 were outside, alone. Staff C stated in the written statement she immediately notified the Residential Services Supervisor (RSS).	W 153		

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W 153	Continued From page 4 Review on 7/11/22 of the written statement dated 7/5/22 completed by Staff D revealed that when he returned to work on 7/1/22, client #6 told him that he and client #5 were involved in a sexual encounter. Review on 7/11/22 of the facility's Consumer Rights and Affairs Policy #2, "Abuse, Neglect and/or Exploitation of Consumers" revealed "Staff should immediately report any actual suspected rights violations to the Qualified Professional. If the Qualified Professional is unavailable, the Qualified Professional On-Call is to be contacted. Failure to report actual or suspected rights violation can be grounds for termination." Interview on 7/11/22 with the Consumer Affairs Coordinator (CAC) revealed that she was notified by the Qualified Intellectual Disabilities Professional (QIDP) on 7/4/22 about the incident between client #5 and client #6. The CAC reported that she was off of work on 7/4/22, and began her investigation on 7/5/22 after video surveillance footage could be obtained. The CAC revealed that Staff A and Staff B were not officially interviewed as part of the internal investigation as they both reported no knowledge of the incident. However, the CAC confirmed that based on Staff F's written statement Staff A and Staff B knew about the incident and should have been interviewed. Interview on 7/11/22 with Staff D revealed he was informed about the incident on 7/1/22 by client #6. Staff D stated he reported the incident to the RSS on that date. Interview on 7/12/22 with the RSS revealed she	W 153		

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W 153	Continued From page 5 was notified of the incident only after she was told by staff that client #6's eyeglasses were broken following a physical fight between client #5 and client #6. The RSS stated that when she was told about the incident, she asked what happened between client #5 and client #6 to cause the physical fight and was then told about the sexual incident. The RSS stated that at that time, she notified the QIDP and Administrator On Call (AOC). Interview on 7/12/22 with the QIDP revealed she was notified of the incident on 7/1/22 by the RSS. The QIDP revealed she called the CAC to report the incident on 7/1/22. However, the QIDP stated she was off of work at this time. The QIDP confirmed the report should have been made to the AOC. Interview on 7/12/22 with the Program Director (PD) revealed that the AOC on 7/1/22 reported she was not notified of any incident related to a sexual encounter between client #5 and client #6. Continued interview on 7/12/22 with the CAC, PD and QIDP confirmed that Staff F should have immediately reported the incident and inadequate supervision on 6/29/22 when he was told about it, and based on Staff F's statement that Staff A and Staff B were aware of the incident, they should have also immediately reported the incident and inadequate supervision. Further interview with the CAC, PD and QIDP confirmed that the RSS, based on the facility's policy regarding Abuse, Neglect and Exploitation of Consumers, should have immediately reported the incident to the AOC in order for an investigation to be initiated.	W 153		
W 154	STAFF TREATMENT OF CLIENTS	W 154		

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W 154	Continued From page 6 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 interviews, the facility failed to ensure an incident of neglect and failure to report was thoroughly investigated. This affected 2 of 6 audit clients (#5 and #6). The finding is: Review on 7/11/22 of the facility's internal investigation dated 7/5/22 revealed that on 6/29/22, client #5 and client #6 were alone on the back porch from 4:51pm - 5:02pm. During this time, client #5 and client #6 were involved in a sexual encounter. During this time, Staff A was in the kitchen cooking, and Staff B was in the medication room on her cell phone and walking around the home. Review on 7/11/22 of the written statement dated 7/5/22 completed by Staff F revealed that on 6/29/22, client #5 told him about the sexual encounter. Client #5 informed Staff F that he had told Staff A and Staff B about the incident. Review on 7/11/22 of the written statement dated 7/5/22 completed by Staff C revealed that on 7/1/22, Client #5 told her about the sexual encounter between he and client #6. Staff C asked client #5 where the staff were during this time, and he stated they were in the house and he and client #6 were outside, alone. Staff C stated in the written statement she immediately notified the Residential Services Supervisor (RSS). Review on 7/11/22 of the written statement dated	W 154		

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W 154	Continued From page 7 7/5/22 completed by Staff D revealed that when he returned to work on 7/1/22, client #6 told him that he and client #5 were involved in a sexual encounter. Review on 7/11/22 of the facility's Consumer Rights and Affairs Policy #2, "Abuse, Neglect and/or Exploitation of Consumers" revealed "Staff should immediately report any actual suspected rights violations to the Qualified Professional. If the Qualified Professional is unavailable, the Qualified Professional On-Call is to be contacted. Failure to report actual or suspected rights violation can be grounds for termination." The policy also revealed "The Qualified Professional or QP On-Call shall immediately notify Guardians, Department of Social Services, Health Care Personnel Registry within 24 hours, and stakeholders as per NOVA policy and regulatory reporting requirements. Interview on 7/11/22 with the Consumer Affairs Coordinator (CAC) revealed that she was notified by the Qualified Intellectual Disabilities Professional (QIDP) on 7/4/22 about the incident between client #5 and client #6. The CAC reported that she was off of work on 7/4/22, and began her investigation on 7/5/22 after video surveillance footage could be obtained. The CAC revealed that Staff A and Staff B were not officially interviewed as part of the internal investigation as they both reported no knowledge of the incident. However, the CAC confirmed that based on Staff F's written statement Staff A and Staff B knew about the incident and should have been interviewed. The CAC also revealed that no interviews for client #5 nor client #6 were available.	W 154		

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W 154	Continued From page 8 Interview on 7/11/22 with Staff D revealed he was informed about the incident on 7/1/22 by client #6. Staff D stated he reported the incident to the RSS on that date. Interview on 7/12/22 with the RSS revealed she was notified of the incident only after she was told by staff that client #6's eyeglasses were broken following a physical fight between client #5 and client #6. The RSS stated that when she was told about the incident, she asked what happened between client #5 and client #6 to cause the physical fight and was then told about the sexual incident. The RSS stated that at that time, she notified the QIDP and Administrator On Call (AOC). Interview on 7/12/22 with the QIDP revealed she was notified of the incident on 7/1/22 by the RSS. The QIDP revealed she called the CAC to report the incident on 7/1/22. However, the QIDP stated she was off of work at this time. The QIDP confirmed the report should have been made to the AOC. Interview on 7/12/22 with the Program Director (PD) revealed that the AOC on 7/1/22 reported she was not notified of any incident related to a sexual encounter between client #5 and client #6. Continued interview on 7/12/22 with the CAC, PD and QIDP confirmed that Staff F should have immediately reported the incident and inadequate supervision on 6/29/22 when he was told about it, and based on Staff F's statement that Staff A and Staff B were aware of the incident, they should have also immediately reported the incident and inadequate supervision. Further interview with the CAC, PD and QIDP confirmed that the RSS,	W 154		

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W 154	Continued From page 9 based on the facility's policy regarding Abuse, Neglect and Exploitation of Consumers, should have immediately reported the incident to the AOC in order for an investigation to be initiated. The CAC and QIDP confirmed no staff was reprimanded for failure to report immediately.	W 154		
W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the use of systematic interventions to manage clients inappropriate behaviors were incorporated into the client's individual program plan (IPP). This affected 4 of 6 audit clients (#2, #3, #5 and #6). The findings are: A. During observations in the home throughout the survey on 7/11/22 - 7/12/22, knives and sharp/blunt objects were kept locked in the medication room and the broom closet was kept locked with only staff having a key to unlock the broom closet door. Review on 7/11/22 of client #6's Mental Health Plan (MHP) dated 5/9/22 revealed client #6 has a rights restriction for the locked broom closet. Further review of the MHP did not reveal a rights restriction for knives and sharp/blunt objects. Interview on 7/12/22 with the Qualified Intellectual	W 289		

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W 289	Continued From page 10 Disabilities Professional (QIDP) confirmed client #6's MHP should include a rights restriction for knives and sharp/blunt objects. B. During observations in the home throughout the survey on 7/11/22 - 7/12/22, knives and sharp/blunt objects were kept locked in the medication room and the broom closet was kept locked with only staff having a key to unlock the broom closet door. Review on 7/12/22 of client #2's MHP dated 4/4/22 revealed client #2 has a rights restriction for knives and sharp/blunt objects. Further review of the MHP did not reveal a rights restriction for the locked broom closet. Interview on 7/12/22 with the qualified intellectual disabilities professional (QIDP) confirmed client #2's MHP should include a rights restriction for the locked broom closet. C. During observations in the home throughout the survey on 7/11/22 - 7/12/22, a pack of cigarettes were observed laying on the table. Interview on 7/12/22 with Staff D revealed client #2 is one of three clients that smoke. Further interview with Staff D revealed that client #2's cigarette's are supposed to be locked in the PRN medication cabinet in the medication room. Interview on 7/12/22 with the Residential Services Supervisor (RSS) revealed client #2's cigarettes are supposed to be locked in the PRN medication cabinet in the medication room. The RSS showed the surveyor a locked cabinet in the medication room where cigarettes were kept.	W 289		

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W 289	Continued From page 11 Review on 7/12/22 of client #2's MHP dated 4/4/22 revealed no rights restriction to cigarettes. Interview on 7/12/22 with the QIDP revealed client #2's cigarette's are not supposed to be locked up and he should have access to them. D. During observations in the home throughout the survey on 7/11/22 - 7/12/22, a pack of cigarettes were observed laying on the table. Interview on 7/12/22 with Staff D revealed client #3 is one of three clients that smoke. Further interview with Staff D revealed that client #3's cigarette's are supposed to be locked in the PRN medication cabinet in the medication room. Interview on 7/12/22 with the Residential Services Supervisor (RSS) revealed client #3's cigarettes are supposed to be locked in the PRN medication cabinet in the medication room. The RSS showed the surveyor a locked cabinet in the medication room where cigarettes were kept. Review on 7/12/22 of client #3's MHP dated 4/14/22 revealed no rights restriction to cigarettes. Interview on 7/12/22 with the QIDP revealed client #3's cigarette's are not supposed to be locked up and he should have access to them. E. During observations in the home throughout the survey on 7/11/22 - 7/12/22, a pack of cigarettes were observed laying on the table. Interview on 7/12/22 with Staff D revealed client #5 is one of three clients that smoke. Further interview with Staff D revealed that client #5's	W 289		

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W 289	Continued From page 12 cigarette's are supposed to be locked in the PRN medication cabinet in the medication room. Interview on 7/12/22 with the RSS revealed client #5's cigarettes are supposed to be locked in the PRN medication cabinet in the medication room. The RSS showed the surveyor a locked cabinet in the medication room where cigarettes were kept. Review on 7/12/22 of client #5's MHP dated 4/21/22 revealed no rights restriction to cigarettes. Interview on 7/12/22 with the QIDP revealed client #5's cigarette's are not supposed to be locked up and he should have access to them.	W 289		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all medications used to address client's inappropriate behaviors were included in a formal active treatment program. This affected 2 of 6 audit clients (#5 and #6). The findings are: A. Review on 7/12/22 of client #5's Mental Health Plan (MHP) dated 5/24/22 revealed an objective to have incident free days related to symptoms of Schizoaffective disorder specifically elopement across all settings for 40 out of 45 days. Additional review of the plan identified target	W 312		

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W 312	Continued From page 13 behaviors of elopement, physical aggression, threats, property damage, theft, verbal aggression, leaving the assigned area and sexual advances towards peers/roommate. The plan included the use of Haldol, Thorazine, Valium, Benadryl and other medications at the disposal of the doctor in the event client #5 destabilizes and is currently prescribed Haldol, Depakote and Klonopin. Further review of a physician's order for client #5 dated 12/2/21 revealed orders for Risperdal, Invega, Celexa and Cogentin. Interview on 7/12/22 with the facility nurse confirmed Risperdal, Invega, Celexa and Cogentin are ordered for client #5 and should have been included in the BSP. B. Review on 7/11/22 of client #6's MHP dated 5/9/22 revealed an objective to have incident free days related to symptoms of Schizoaffective Disorder, Bipolar type specifically for physical aggression for 105 out of 110 days. Further review of the MHP revealed identified target behaviors of elopement, physical aggression, threats, property damage, theft, verbal aggression, leaving the assigned area and sexual advances towards peers/roommates. The MHP included the use of anti-psychotic medications consisting of Abilify, Lamictal, Haldol and Depakote. Review on 7/12/22 of client #6's physician's orders dated 12/2/21 revealed orders for anti-psychotic medications consisting of Abilify, Lamictal, Haldol, Depakote and Geodon. Interview on 7/12/22 with the facility nurse revealed the use of Geodon should be incorporated into client #6's MHP.	W 312		

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 _____	C 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHWAY 117 GROUP HOME	3801 US 117 NORTH GOLDSBORO, NC 27530

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W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all drugs were administered without error. This affected 2 of 6 clients (#1 and #5). The findings are: A. During observations of medication administration in the home on 7/11/22 at 4:40pm, client #1 ingested Ativan and Vitamin B12. No other medications were administered. Staff C revealed that client #1 is supposed to receive eye drops at this time but she is unable to administer due to the prescription needing a refill. Review on 7/12/22 of client #1's physician's orders dated 12/2/21 revealed Artificial tears solution 1.4% is to be administered at 8:00am, 12:00pm, 5:00pm and 8:00pm. B. During observations of medication administration in the home on 7/12/22 at 7:22am, client #5 ingested Sodium Chloride, Folic Acid, Paliperidone, Synthroid, Celexa, Cogentin, Thorazine, Risperidal, Catapress, Haldol, Lactulose and Chlorhexidine. No other medications were administered at this time. Review on 7/12/22 of client #5's physician's orders dated 12/2/21 revealed an order for Triamcinolone ointment to be applied to affected area twice daily at 8:00am and 8:00pm. Interview on 7/12/22 with the facility nurse confirmed client #1 should have received Artificial	W 369		

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	34G175	A. BUILDING _____ B. WING _____	C 07/12/2022

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W 369	Continued From page 15 tears solution and client #5 should have received Triamcinolone during the medication passes observed.	W 369		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 6 audit clients (#6) was taught to use and make informed choices about the use of eyeglasses. The finding is: During observations throughout the survey on 7/11/22 - 7/12/22, client #6 was not wearing eyeglasses. Review on 7/11/22 of an internal investigation completed 7/5/22 revealed client #6's eyeglasses were broken during a physical altercation with one of his peers. Interview on 7/11/22 with Staff C revealed client #6's eyeglasses were broken on 6/29/22 during a physical altercation with one of his peers. Staff C revealed staff should have gave client #6's eyeglasses to the facility nurse for them to be repaired. Interview on 7/12/22 with the facility nurse revealed she had no knowledge of client #6's eyeglasses being broken until asked about them	W 436		

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 _____	C 07/12/2022

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W 436	Continued From page 16 by the surveyor on 7/12/22, but confirmed client #6 should be wearing eyeglasses.	W 436		