DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OI	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		34G345	B. WING _			01/ [.]	18/2023
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ROUSE'S	GROUP HOME #6				20 NC HIGHWAY 135 TONEVILLE, NC 27048		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 227	INDIVIDUAL PROC CFR(s): 483.440(c) The individual prog objectives necessa as identified by the required by paragra This STANDARD is Based on observat interview, the facility objectives necessa clients (#1). The fin A. The facility failed relative to personal example: Observations throu 1/17/23 revealed cl around the house a verbal directions to a puzzle or block ac revealed approxima client #1 grabbing t jerking, and sticking face. Further obser redirect client #1 av attempt to engage I activity. Observations in the revealed client #1 to the surveyors. Cont AM and 8:05 AM re	ARAM PLAN (4) ram plan states the specific ry to meet the client's needs, comprehensive assessment aph (c)(3) of this section. s not met as evidenced by: tions, record review and y failed to implement specific ry to meet the needs of 1 of 4 dings are: I to address behavioral issues space and boundaries. For ghout the group home on ient #1 to constantly pace and for staff to attempt multiple the client to sit and engage in civity. Continued observations ately one dozen instances of he surveyor by the wrist, g his face in the surveyor's vations revealed staff to vay from the surveyors and him in a puzzle or block e group home on 1/18/23 o break personal space with tinued observations at 7:59 evealed client #1 to tap client tor client #2 to respond by	W 22	27			
	Review of client #1 he was admitted to Continued review o	's record on 1/18/23 revealed the facility on 10/6/21. f the record revealed a					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 01/20/2023

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.

		AND HUMAN SERVICES				FORM	01/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G345	B. WING	i		01/	18/2023
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROUSE'S	S GROUP HOME #6				820 NC HIGHWAY 135 STONEVILLE, NC 27048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 227	diagnosis of Severe Autism Spectrum D support plan (ISP) of ISP indicated client include privacy (cloc hands after toileting place setting, clear and perform a task. record revealed no to be present. Interview with staff frequently engages without permission verbally redirect. C revealed there are r place to address cli with the qualified im professional (QIDP) no BSP in place for shown any inapprop month. B. The facility failed routine relative to an example: Observations throug 1/17/23 revealed cli around the house a verbal directions to block activity. Conti client #1 to be non- directions to sit dow return to pacing arc observations reveal	age 1 e Intellectual Disability and Disorder, and an individual dated 10/27/22. Review of the #1's habilitation goals to sing the bathroom door), wash g, brush teeth, setting his own his place setting from table, . Further review of client #1's behavior support plan (BSP) on 1/18/23 revealed client #1 in touching or grabbing others and staff will attempt to continued interview with staff no formal interventions in ient #1's behaviors. Interview tellectual disabilities) on 1/18/23 revealed there is client #1 because he has not priate behaviors until last d to address structure and ctivities of daily living. For ghout the group home on ient #1 to constantly pace and for staff to attempt multiple sit and engage in a puzzle or inued observations revealed verbal and respond to verbal vn then quickly get up and bund the house. Further led no visual aids present in client #1 with making choices	W 2	227			

If continuation sheet Page 2 of 9

		AND HUMAN SERVICES				FORM	01/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G345	B. WING _			01/1	8/2023
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
ROUSE'S	S GROUP HOME #6			5820 NC HIGHWAY 135 STONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
W 227	Observation in the g AM revealed client the house. Continue to 7:55 AM revealed room table with stat different block build Review of client #11 he was admitted to Continued review of diagnosis of Severe Autism Spectrum D support plan (ISP) of of client #1's record Assessment dated TEACCH Assessm recommendations t supports such as vi schedules and activ client to move throu flexibility in routines for verbal prompting Interview with the C client #1 lived perm mother prior to bein 10/6/21. Continued revealed they are a behaviors since mo further revealed the #1's TEACCH Asses the QIDP confirmed a formal training pro activities of daily liv DRUG ADMINISTR CFR(s): 483.460(k)	group home on 1/18/23 at 6:47 #1 to engage in pacing around ed observation from 6:58 AM d client #1 to sit at the living ff and engage 1:1 in several ling and matching activities. s record on 1/18/23 revealed the facility on 10/6/21. f the record revealed a e Intellectual Disability and bisorder, and an individual dated 10/27/22. Further review I revealed a TEACCH 4/22/21. Review of the ent revealed to include incorporating visual sual checklists, object-based vity systems that may allow the ughout the day with more and lessen the requirement g. DIDP on 1/18/23 revealed anently at home with his ag admitted to the facility on interview with the QIDP ware of changes in client #1's oving to the group home and ey have not reviewed client assment. Further interview with d client #1 would benefit form ogram to support him with ing. ATION	W 22	27			

If continuation sheet Page 3 of 9

		AND HUMAN SERVICES				FORM	01/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G345	B. WING	i		01/ [,]	18/2023
NAME OF	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROUSE'	S GROUP HOME #6				820 NC HIGHWAY 135 TONEVILLE, NC 27048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 369	that all drugs, includ self-administered, a This STANDARD is Based on observati interview, the facility were administered (#1, #2, and #3) observations administration. The A. The facility failed without error for clies Observations in the 7:03 AM revealed s medications into a b administration. Constaff E to hand clier medications and the medications into his revealed client #1 to mouth and take all Review of records f revealed physician Review of the 12/20 medications to adm alfuzosin HCL ER 1 10 mg tab, lorsartar vitamin D3 1,000-ur megestrol 40 mg ta review of physician be prescribed alfuzo mouth daily for enla 1,000 unit SOF (2 c in the winter, and B daily with meals. D staff E was not observations of the staff E was not observations of the staff E was not observations of the staff E was not observations of the staff E was not observations of the staff E was not observations of the staff E was not observations of the staff E was not observations of the staff E was not observations of	ding those that are are administered without error. s not met as evidenced by: tion, record review and y failed to assure all drugs without error for 3 of 4 clients served during medication e findings are: d to administer medications ent #1. For example: e group home on 1/18/23 at thatff E to punch client #1's bowl for medication ntinued observation revealed at #1 the bowl with e client to pour the s hand. Further observation o put the medications into his medications whole with water. for client #1 on 1/18/23 orders dated 12/2022. D22 physician orders revealed hinister at 8:00 AM to be 10 mg tab, amlodipine besylate n-hctz 100-12.5 mg tab, nit SOF (2 capsules), ab, and Boost drink. Further orders revealed client #1 to osin HCL ER 10 mg tab by arged prostate, vitamin D3 capsules) by mouth once daily oost drink 1 bottle 3 times furing the survey observation erved to administer alfuzosin , vitamin D3 1,000-unit SOF (2	W	369			

If continuation sheet Page 4 of 9

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G345	B. WING			01/'	18/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROUSE'S	GROUP HOME #6				820 NC HIGHWAY 135 STONEVILLE, NC 27048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 369	Continued From pa	ge 4	Wa	369			
	the physician orders Continued interview revealed staff E did medications were n	acility nurse on 1/18/23 verified s dated 12/2022 to be current. with the facility nurse not notify nursing that ot administered to client #1.					
		d to administer medications ent #2. For example:					
	7:07 AM revealed c medication area wit medications from th medication adminis observation reveale medications into his	h a water cup and to remove he medication cabinet for tration. Continued ed client #2 to punch hand and put into his mouth. revealed the client to take all					
	revealed physician Review of the 12/20 medications to adm fluticasone 50 mcg 17 grams, sertraline clonidine HCL 0.1 m physician orders rev prescribed Miralax grams in 8 0z. of jui constipation. Durin E was not observed 17 grams.	or client #2 on 1/18/23 orders dated 12/2022. 022 physician orders revealed inister at 8:00 AM to be nasal spray, Miralax powder e HCL 100 mg tab and ng tab. Further review of vealed client #2 to be powder mix (1 capful) 17 ice or water once daily for g the survey observation staff t to administer Miralax powder					
	the physician orders Continued Interview revealed staff E did	acility nurse on 1/18/23 verified s dated 12/2022 to be current. / with the facility nurse not notify nursing that ot administered to client #2.					

If continuation sheet Page 5 of 9

		AND HUMAN SERVICES				FORM	01/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	E SURVEY PLETED	
		34G345	B. WING			01/ [.]	18/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROUSE'S	S GROUP HOME #6				820 NC HIGHWAY 135 STONEVILLE, NC 27048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 369	Continued From pa	ige 5	wa	369			
		d to administer medications ent #3. For example:					
	7:11 AM revealed c medication area an the medication cabi administration. Con staff E to take client observation revealed over hand punch m staff E to place the cup. Subsequent of to take all medication Review of records f revealed physician Review of the 12/20 medications to adm drink, Miralax powd 50-, pazeo 0.7% ey tabs), topiramate 20 1,000-unit SOF, and Further review of pl #3 to be prescribed 17 grams in 8 0z. o constipation, pazeo both eyes every mo 0.12% rinse for clie 1-2 minutes and ex every night after bro observation staff E administer Miralax p	ntinued observation revealed t #3's temperature. Further ed staff E and client #3 to hand nedications into a bowl and medications into a medicine observation revealed the client ons whole with water. for client #3 on 1/18/23 orders dated 12/2022. 022 physician orders revealed hinister at 8:00 AM to be Boost ler, multi vitamin tablet (QC) we drops, rufinamide 200 mg (2 00 mg tab, vitamin D3 d chlorohexidine 0.12% rinse. hysician orders revealed client I Miralax powder mix (1 capful) f juice or water once daily for 0.7% eye drops 1 drop in orning, and chlorhexidine int to swish 15 ml in mouth for spectorate every morning and ushing. During the survey was not observed to powder, pazeo 0.7% eye xidine 0.12% rinse.					
	the physician orders	acility nurse on 1/18/23 verified s dated 12/2022 to be current. v with the facility nurse					

If continuation sheet Page 6 of 9

	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		A. BUILDING	i		COMPLETED		
IAME OF PROVIDER OR SUPPLIER		B. WING		•	/18/2023		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 5820 NC HIGHWAY 135	DE			
ROUSE'S	S GROUP HOME #6			STONEVILLE, NC 27048			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
W 369	Continued From pa	ige 6	W 369				
		not notify nursing that					
W 436	SPACE AND EQUI CFR(s): 483.470(g)		W 436				
		rnish, maintain in good repair, o use and to make informed					
		use of dentures, eyeglasses,					
	hearing and other of and other devices i	communications aids, braces,					
		m as needed by the client.					
		s not met as evidenced by:					
		tions, record review, and ity failed to furnish and teach 1					
	of 4 clients (#4) to u	use and make informed lasses. The finding is:					
		-					
		ns in the group home on ient #4 to engage in various					
		group snack, a review of his					
	day, hygiene, laund	lry, television, a block activity,					
		stration, and dinner. Continued led client #4 to be without his					
	eyeglasses and rev	ealed no prompts from staff					
	for the client to wea	ar his eyeglasses.					
		ns in the group home on					
		ient #4 to engage in various breakfast and clean up,					
	hygiene, television,						
		tinued observations revealed					
		out his eyeglasses and ts from staff for the client to					
	wear his eyeglasse	s. Interview with staff E at 7:35					
		It #4 wear's eyeglasses and he n due to him losing them.					
		ith staff E revealed the					
	eventeses to be in	a locked cabinet in the locked					

If continuation sheet Page 7 of 9

					FORM	01/20/2023 APPROVED 0938-0391
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	34G345	B. WING			01/	18/2023
PROVIDER OR SUPPLIER						
GROUP HOME #6						
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
medication closest. AM revealed staff E eyeglasses and for then place them in I observation at 8:10 leave for the day pre- his coat pocket. Review of client #4" a vision assessment assessment reveale eyeglasses with a for scheduled for one y client #4's record re eyeglasses being d Interview with the q professional (QIDP) #4 is prescribed eyes should not be locke Continued interview #4 had a formal trait to support him weat was discontinued d Further interview wi #4 would benefit fro and support wearing	Further observation at 7:41 to provide client #4 with his the client to wear them briefly his pocket. Subsequent AM revealed client #4 to orgram with his eyeglasses in 's record on 1/18/23 revealed at dated 3/22/21. Review of the ed client #4 was prescribed ollow-up appointment year. Continued review of evealed no evidence of the iscontinued. ualified intellectual disabilities) on 1/18/23 confirmed client eglasses and revealed they ed in the medication closest. with the QIDP revealed client ining program three years ago ring his eyeglasses, however it ue to refusal behaviors. ith the QIDP confirmed client on a formal program to teach g eyeglasses.			DEFICIENCY)		
CFR(s): 483.470(l)(There must be an a prevention, control, and communicable This STANDARD is Based on observat facility failed to impl the prevention and	 (1) active program for the and investigation of infection diseases. s not met as evidenced by: tions, and interviews, the lement an active program for control of infection and 					
	RS FOR MEDICARE OF DEFICIENCIES FORRECTION PROVIDER OR SUPPLIER GROUP HOME #6 SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa medication closest. AM revealed staff E eyeglasses and for then place them in l observation at 8:10 leave for the day pr his coat pocket. Review of client #4' a vision assessment assessment reveale eyeglasses with a for scheduled for one y client #4's record re eyeglasses being d Interview with the q professional (QIDP #4 is prescribed eye should not be locke Continued interview #4 had a formal trait to support him weat was discontinued d Further interview wi #4 would benefit fro and support wearing INFECTION CONT CFR(s): 483.470(I)(There must be an a prevention, control, and communicable This STANDARD is Based on observat facility failed to implithe prevention and	IDENTIFICATION NUMBER: 34G345 PROVIDER OR SUPPLIER SGROUP HOME #6 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 medication closest. Further observation at 7:41 AM revealed staff E to provide client #4 with his eyeglasses and for the client to wear them briefly then place them in his pocket. Subsequent observation at 8:10 AM revealed client #4 to leave for the day program with his eyeglasses in his coat pocket. Review of client #4's record on 1/18/23 revealed a vision assessment dated 3/22/21. Review of the assessment revealed client #4 was prescribed eyeglasses with a follow-up appointment scheduled for one year. Continued review of client #4's record revealed no evidence of the eyeglasses being discontinued. Interview with the qualified intellectual disabilities professional (QIDP) on 1/18/23 confirmed client #4 is prescribed eyeglasses and revealed they should not be locked in the medication closest. Continued interview with the QIDP revealed client #4 had a formal training program three years ago to support him wearing his eyeglasses, however it was discontinued due to refusal behaviors. Further interview with the QIDP confirmed client #4 would benefit from a formal program to teach and support wearing eyeglasses.	RES FOR MEDICARE & MEDICAID SERVICES IOF DEFICIENCIES FCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILE 34G345 B. WING PROVIDER OR SUPPLIER 34G345 B. WING SCOUP HOME #6 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 4 Continued From page 7 medication closest. Further observation at 7:41 AM revealed staff E to provide client #4 with his eyeglasses and for the client to wear them briefly then place them in his pocket. Subsequent observation at 8:10 AM revealed client #4 to leave for the day program with his eyeglasses in his coat pocket. W 4 Review of client #4's record on 1/18/23 revealed a vision assessment dated 3/22/21. Review of the assessment revealed client #4 was prescribed eyeglasses with a follow-up appointment scheduled for one year. Continued review of client #4's record revealed no evidence of the eyeglasses being discontinued. Interview with the qualified intellectual disabilities professional (QIDP) on 1/18/23 confirmed client #4 had a formal training program three years ago to support him wearing his eyeglasses. However it was discontinued due to refusal behaviors. W 4 Chrine interview with the QIDP confirmed client #4 would benefit from a formal program to teach and support wearing his eyeglasses. INFECTION CONTROL CFR(s): 483.470(I)(1) W 4 There must be an active program for the prevention, control, and investigation of	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES FORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING. 34G345 B. WING	MENT OF HEALTH AND HUMAN SERVICES O SFOR MEDICARE & MEDICAID SERVICES O OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING ROVIDER OR SUPPLIER 34G345 B. WING SGOUP HOME #6 STREET ADDRESS, CITY, STATE, ZIP CODE (EACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) D Continued From page 7 W 436 DEPICIENCY (EACH DEPICIENCY MIST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFING INFORMATION) W 436 Continued From page 7 W 436 W 436 redication closest. Further observation at 7.41 AM revealed staff E to provide client #4 with his eyeglasses and for the client to wart them briefly then place them in his pocket. Subsequent observation at 8:10 AM revealed client #4 with his eyeglasses with a follow-up appointment scheduled for one year. Continued review of client #4's record ro eyeal. Continued review of client #4's record ro eyeal continued review of client #4's record ro eyeals continued. Interview with the qualified intellectual disabilities professional (QIDP) on 1/18/23 confirmed client #4 had a formal training program three years ago to support him wearing his eyeglasses, however it was discontinued due to refusa behaviors. INFECTION CONTROL W 455 CFR(S): 483 470(I)(1) There must be an active program for the prevention, control, and investigation of infection and communicable di	MENT OF HEALTH AND HUMAN SERVICES FORM SF COR MEDICARE & MEDICAID SERVICES OMB NO. OF DEFICIENCIES OMB NO. OF DEFICIENCIES ImprovidensupPuterRicLia. IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATA COMM 34G345 B. WING 01/7 PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 582 ONCE HIGHWAY 135 STONEVILLE, NC 27048 01/7 SIGNUP HOME #6 STREET ADDRESS, CITY, STATE, ZIP CODE 582 ONCE HIGHWAY 135 STONEVILLE, NC 27048 01/7 Continued From page 7 FORVIDER STONEVILLE, NC 27048 CRONS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 7 W 436 (EACH CORRECTIVE ACTION PAULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 7 W 436 (EACH CORRECTIVE ACTION PAULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued Isoft To the roward client #4 to leave for the day program with his eyeglasses in his coat pocket. W 436 Review of Client #4's record revealed Client #4 to leave for the day program with his eyeglasses in professional (20DP) on 1/18/23 confirmed client #4 ha formal training program three years ago to support the qualified intellectual disabilities professional (20DP) on 1/18/23 confirmed client #4 ha a formal training program to teach and support waining keyeglasses. This STANDARD is not met as evidenced by: Based on observations, and interviews, the facility failed to imp

Facility ID: 960838

If continuation sheet Page 8 of 9

		AND HUMAN SERVICES				FORM	01/20/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G345	B. WING			01/ [,]	18/2023
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROUSE'S	S GROUP HOME #6				820 NC HIGHWAY 135 STONEVILLE, NC 27048		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 455	Continued From pa	ge 8	W 4	155			
	PM revealed 2 staff and both staff to no observation in the g PM revealed staff A door and staff A to a with putting away g snack. Continued of not wear a face ma 1/17/23 revealed st enter the group hor shift and to assist of Subsequent observ 1/18/23 at 6:25 AM surveyors at the fro breakfast meal and wearing a mask wh the Centers for Mea (CMS) to limit the s Interview on 1/18/2 disabilities professio QIDP told staff that staff being fully vac with the QIDP revea	workshop on 1/17/23 at 1:00 to work directly with clients t wear a mask. Continued group home on 1/17/23 at 4:00 to meet surveyors at the front assist the clients in the kitchen roceries and preparing a observation revealed staff A to sk. Further observation on aff B, staff C and staff D to ne at various times to work the lients and to not wear a mask. vation at the group home on revealed staff E to meet nt door, to assist with medication administration not ich is a current requirement by dicare and Medicaid Services pread of the COVID-19 virus. 3 with the qualified intellectual onal (QIDP) revealed that the mask was optional due to cinated. Continued interview aled that the facility was not irements regarding wearing a					

Facility ID: 960838

If continuation sheet Page 9 of 9