STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G069	A. BUILDING _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIE G. SMITH GROUP HOME	1921 PALMETTO DRIVE 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 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure clients (#1, #2, #3, #4, #5, #6) were provided opportunities for choice and self-management and not for the convenience of staff relative to locked bedroom doors. The finding is: Observations throughout the 1/31/23-2/1/23 survey revealed all clients to have locked bedroom doors and door chimes outside of each door. Continued observations revealed six keys to hang on a wall in the hallway labeled by the clients' (#1, #2, #3, #4, #5, #6) names. Further observations revealed staff to unlock all clients' doors upon entry to their bedrooms. Additional observations revealed staff to lock various clients' doors with a key and the clients to remain inside of their rooms. Review of records for client #1 on 2/1/23 revealed an individual support plan (ISP) dated 9/28/22. Continued review of the ISP for client #1 revealed the following program goals: clean his room, get dressed, table manners, oral hygiene goal, refrain from interrupting others, participate in medication administration, complete a household chore, engage in an activity in the common area and an exercise goal. Review of the ISP did not include a program goal to use a key to unlock bedroom door. Additional review of the record for client #1 revealed a behavior support plan (BSP) dated 10/1/22. Review of the BSP for client #1 revealed the following target behaviors: darting/running	W 247		

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 247	Continued From page 1 away, social aggression, property aggression, inappropriate toileting, refusal, self-injurious behaviors (SIBs) and tantrums. Interview with the qualified intellectual disabilities professional (QIDP) and Chief Regulatory Officer (CRO) on 2/1/23 revealed the locks on the bedroom doors are to prevent clients from going into each other's rooms and taking other's belongings. Continued interview with the QIDP and CRO revealed there is no plan in place should client #1 have SIBs in his room with the door closed and the bedroom door is locked from the outside. Further interview with the CRO revealed there are multiple copies of the bedroom keys for all clients (#1, #2, #3, #4, #5, #6) in the group home should a key is lost or misplaced or in the event of an emergency that would require evacuation of the group home.	W 247		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that updated, written informed consent of the legal guardian and human rights committee (HRC) was approved and received relative to interior bedroom doors for 6 of 6 clients (#1, #2, #3, #4 #5 and #6). The finding is: Observations throughout the 1/31/23-2/1/23 survey revealed all clients to have locked bedroom doors and door chimes outside of each	W 263		

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 263	Continued From page 2 door. Continued observations revealed six keys to hang on a wall in the hallway labeled by the clients' names. Further observations revealed staff to unlock the clients' doors upon entry and exiting their bedrooms. Review of client records on 2/1/23 for clients (#1, #2, #3, #4 #5 and #6) revealed consents relative to the exterior locked entry system. Review of the documentation did not reveal written informed consent from the human rights committee (HRC) and legal guardians relative to interior bedroom door locks. Interview with the qualified intellectual disabilities professional (QIDP) and Chief Regulatory Officer (CRO) on 2/1/23 revealed that human rights consent limitation forms for the interior bedroom doors for clients #1, #2, #3, #4 #5 and #6 have not been reviewed and signed by the HRC and legal guardians. Continued interview with the CRO and QIDP revealed all HRC limitation consent forms for all clients should be updated and signed by the HRC and legal guardians annually.	W 263		