DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G268	A. BUILDING _____ B. WING _____	C 01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORE COUNTY HOME FOR AUTISTIC ADULTS	1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315

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W 000	INITIAL COMMENTS A complaint survey was conducted on 1/9/23 for intake NC00196594. There were no deficiencies cited as a result of the specific allegation; however, three standard level deficiencies were cited during the 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 record review and interviews, the facility failed to ensure all allegations were thoroughly investigated. The finding is: Review of a inquiry into an allegation of abuse dated 12/7/22 revealed, "On November 29, 2022 I attended facility ICF/IID meeting for Devonshire group home. [Former facility nurse] discussed she believed that the [Client #5's family member] was sexually abusing the consumer." The report noted the facility's owner, "...would go out and interview staff and consumer and make phone calls with staff that were not on shift and that [Qualified Intellectual Disabilities Professional (QIDP)] would contact the mother for interview." Additional review of the report revealed four staff working at the home and client #5's mother were contacted and questioned regarding the allegation with no concerns noted. However, review of a staff roster provided by the facility indicated two additional staff had not been interviewed and the Home Manager's response to her interview was not provided. Further review of the report noted, "Our investigation concluded there is NO presenting	W 154	All allegations of abuse will be investigated thoroughly. The process will include interviews of all staff. All staff interviews will be included in the report. The investigation procedure will be monitored by the QA/QI, Program Director and QIDP as they occur.	2/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: June Rhone TITLE: QIDP MA (X6) DATE: 1/19/23

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 evidence [Client #5] has been abused in any manner by her [Client #5's family member]." Interview on 1/9/23 with the QIDP confirmed a weekend staff person had not been interviewed; however, the QIDP offered no explanation as to why the other staff had not been interviewed and why the Home Manager's response was not included within the report.	W 154		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure sufficient staff were provided to supervise clients and provide services in accordance with their Individual Program Plan (IPP). This potentially affected all clients residing in the home (#1, #2, #3, #4, #5, and #6). The finding is: Observations upon arrival at the group home on 1/9/23 at 9:00am, the home manager (HM) was working in the home alone with six clients. The HM stated that the third shift worker had left because she worked all night. At 9:10am, the HM attempted to call for additional assistance by phoning the Qualified Intellectual Disabilities Professional (QIDP) multiple times with no answer from the QIDP. At 9:20am, Staff A, the third shift worker, returned to the home. At	W 186	The agency will ensure the provision of adequate staff is available. Staff coverage for each shift will be monitored by Home Manager and reported as assistance is needed to Hab Spec, QIDP and program director. Sufficient staff coverage will also be monitored by QIDP daily.	2/10/23

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W 186	Continued From page 2 10:00am, Staff A left the home for duty, leaving the HM as the only staff. Further observations on 1/9/23 from 10:00am - 11:50am revealed the HM as the only staff with six clients. From 10:00am - 11:10am, one client was observed interacting with the HM at the den table. One client slept on the couch in the den, three clients sat in the den as the television played, and one client sat in a separate room with no activity or interaction. At 11:10am, the HM went to the kitchen with two clients to open frozen chicken pot pies to be placed in the oven for lunch. All other clients remained in the same locations with no interaction. From 11:20am-11:45am, the HM went from the kitchen to the den area to both prepare lunch and take clients in turn to the bathroom. At 11:50am, the QIDP arrived at the home. Interview on 1/9/23 with the HM revealed that the home was short of staff on a consistent basis with some staff working 12 to 24 hour shifts. When asked what the expected staff coverage ratio should be, the HM stated that there should be two staff for six clients, per shift. The HM stated that they should be able to call the QIDP if they cannot get sufficient staff to come into work. The HM stated that activities and training could not occur sufficiently with only one staff because meals had to be prepared and toileting had to be ensured. Interview on 1/9/23 with the QIDP revealed that the home should have two staff for six clients, per shift. The QIDP stated that she did not receive any phone calls from the HM earlier in the morning. The QIDP then stated that she did not have her phone earlier in the morning when the HM attempted to call her. When asked who the,	W 186		

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W 186	Continued From page 3 staff should contact for emergencies and to ensure staff coverage for the home, the QIDP stated there is no "on-call" person and that they should be able to contact the QIDP. Review on 1/9/23 of the facility staffing policy, dated 12/13/22, revealed that direct care staff minimum ratios for facilities serving "children under the age of 12, severely and profoundly clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior" should be a ratio of 1 staff per 3 clients. Further interview on 1/9/23 with the QIDP revealed that the facility minimum staffing policy also included adults. The QIDP provided a written edit by adding the word "adults" to the policy and initialing and dating the policy.	W 186		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #5's Behavior Intervention Plan (BIP) was reviewed and/or revised after she failed to progress towards an identified objective. This affected 1 of 2 audit clients. The finding is: Review on 1/9/23 of client #5's BIP dated 3/6/21	W 257	All clients' BIPs will be reviewed an updated as needed. More specifically client #5 BIP will be revised as warented to address progress or lack of progress. All behavior plans will be reviewed monthly by the team and revised as needed. The process will be monitored by the QIDP and psychologist.	2/10/23

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W 257	Continued From page 4 revealed an objective to decrease the frequency of defined Inappropriate Touching to 5 or fewer incidents per month for 10 out of 12 consecutive months. Additional review of available behavior data sheets for February '22 - December '22 revealed the following incidents of inappropriate touching: 02/22 - 11 03/22 - 11 04/22 - 10 05/22 - 11 06/22 - 14 07/22 - 16 08/22 - No data available 09/22 - No data available 10/22 - 5 11/22 - 1 12/22 - No data available Review of nursing notes (January '22 - December '22) revealed the following: February '22 - "...now she is attempting to touch another female client and has been redirected on several occasions for this." March '22 - "...It appears that her inappropriate touching has increased." August '22 - "...continues to show inappropriate behaviors of touching others..." November '22 - "...There has been an increase in her inappropriate sexual behaviors as evidenced by her attempts to grab the genetial areas of staff and other clients..." Additional review on 1/9/23 of client #5's behavior	W 257		

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W 257	Continued From page 5 progress notes revealed the last note was written on 10/4/21. No current progress notes were available for review. Interview on 1/9/23 with the Home Manager confirmed she and staff have observed an increase in inappropriate touching behaviors being exhibited by client #5 over the past several months. Interview on 1/9/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed no current behavior progress notes could be located and team members, including the Psychologist, have not reviewed client #5's BIP after concerns of an increase in her inappropriate touching behaviors.	W 257		