STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G020	A. BUILDING ______ B. WING ______	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUSE'S GROUP HOME	5949 NC 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 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure the individual support plan (ISP) for client #14 included training objectives relative to an identified need with wearing eyeglasses as prescribed. The finding is: Observations throughout the recertification survey from 8/21/23 - 8/22/23 revealed client #14 to participate in leisure activities, play video games, participate in the dinner meal, clean up his area, put the dishes in the dishwasher and interact with his housemates. At no point during observations was client #14 wearing eyeglasses. Review of client #14's record on 8/22/23 revealed an ISP dated 6/3/23. Continued review of the ISP revealed the following training objectives: oral care routine, flossing teeth, clean his bedroom, follow work routine, laundry goal, state name of medication and medication routine (am). Further review of the record for client #14 revealed adaptive equipment to include eyeglasses. Subsequent review of client #14's record revealed an eye exam consult dated 11/12/22 verified the client wears eyeglasses. Additional record review revealed a medical consult dated 5/24/23 which indicated the client complained about having blurred vision. "The blurred vision is at a distance. Mild in severity, left eye is worse than the right eye. Blurred vision had been present for years. Astigmatism can be corrected with eyeglasses or	W 227		

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 227	Continued From page 1 contact lenses." Review of the vision consult also revealed a new prescription for eyeglasses was provided and recommendations are to return in one year. Interview with the assistant qualified intellectual disabilities professional (QIDP) on 8/22/23 revealed the client (#14) refuses to wear eye glasses because it messes up his hair. Continued interview revealed the client's eyeglasses were ordered; however when the eyeglasses arrived, the client stated "that's not what I ordered" and he didn't like them. Further interview with the QIDP confirmed client #14 would benefit from a program to tolerate wearing his eyeglasses as prescribed.	W 227		
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 were provided opportunities for choice and self-management and not for the convenience of staff relative to menu selection during mealtimes. The finding is: Observations in house #4 facility on 8/22/23 at 6:00 PM revealed clients to transition to the dining table to prepare for the dinner meal. The dinner meal consisted of the following menu items: macaroni & cheese, greens, black eye peas, cornbread, juice and water. Continued observations revealed clients #7 and #16 to request seconds of macaroni & cheese. Further	W 247		

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W 247	Continued From page 2 observation revealed staff H to take client #7's plate to the kitchen and add a second serving of macaroni & cheese and vegetables. Additional observation revealed staff H to state to clients "you won't be able to have more seconds. We need enough food to make lunch tomorrow". Review of the clients records on 8/22/23 revealed prescribed diets for all clients. Continued review of prescribed diets revealed client #7 has a low fat, low cholesterol diet. Further review of records revealed client #16 has a 1500 calorie diet, encourage liquids between meals, sugar free beverages and desserts, no added salt, no spicy food, no caffeine, no garlic bread, and no spaghetti sauce due to GERD diagnosis. Review of the records for clients in house #4 did not reveal clients could not have second servings during mealtimes. Interview with the program manager (PM) on 8/22/23 revealed all clients are allowed a second serving of food as long as their diets will allow it. Continued interview with the PM revealed that all facilities have fully stocked refrigerators so there should be no reason to restrict clients from seconds during the dinner meal. Further interview with the PM revealed clients should not be restricted from menu selections and seconds in order to preserve leftovers for another meal.	W 247		
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	W 249		

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W 249	Continued From page 3	W 249		

and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:
Based on observations, interview and record review, the facility failed to ensure a continuous active treatment program consisting of needed interventions were implemented as identified in the individual support plan (ISP) for 1 of 8 sampled clients (#1) relative to boundaries and personal space.

Observations in the facility on 8/22/23 at 8:00AM revealed client #1 to transition to the day program for day activities. Continued observation at 8:10 AM revealed client #1 to be seated at a desk and to hit several clients and this surveyor as they walked by him. Further observation revealed client #1 to hit this surveyor on the buttocks as they walked by the client. Observations also revealed client #1 to turn around and stick up his middle finger at this surveyor. Additional observation did not reveal staff to prompt client #1 to respect the personal space of others.

Review of the record for client #1 on 8/22/23 revealed an ISP dated 1/15/23 which included the following program goals: wash hands, clean bathroom sink, bathing goal, identify community survival signs, apply lotion to entire body, brush his tongue and perform a task. Continued review of the record for client #1 revealed a behavior support plan (BSP) dated 1/14/22 which indicated the following target behaviors: aggression, self-injurious behaviors (SIBs) and disruptive behavior. Further review of the 1/2022 BSP for

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W 249	Continued From page 4 client #1 revealed the following "other challenging behaviors": property destruction, inappropriate verbal behavior, inappropriate sexual behavior, stealing/taking things, and elopement. Subsequent review of the BSP for client #1 revealed if aggression occurs, staff should separate the client from the other individual and prompt him to resume the ongoing activity. Additional review of the BSP for client #1 also indicates if the client touches staff or another individual in private areas (e.g. breasts, buttocks, genital area), staff should support the person in moving away from the client and prompt him to resume with the ongoing activity. "This incident should be reported to the supervisor or supervisor on-call immediately". Review of the BSP for client #1 did not reveal behavioral interventions relative to respecting personal space and boundaries. Interview with the Assistant Qualified Intellectual Disabilities Professional (QIDP) on 8/22/23 revealed she has never known of client #1 sticking up his middle finger at others or intentionally hitting someone in an inappropriate area. Interview with the program manager (PM) on 8/22/23 revealed that it has not been reported to her that client #1 exhibits inappropriate sexual behavior or hitting others. Interview with the PM also revealed staff should have followed client #1's BSP to address his behaviors. Continued interview with the PM and Assistant QIDP revealed client #1 could benefit from formal interventions and techniques to address client behaviors relative to personal space and boundaries.	W 249		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i)	W 262		

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W 262	Continued From page 5 The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 20 of 20 clients in (House #1, #2, #3 and #4). The finding is: Observations throughout the recertification survey period from 8/21/23-8/22/23 in House #1, #2, #3 and #4 revealed mounted video cameras in the homes. Continued observations revealed exterior door alarms to chime loudly as staff, clients and surveyors entered and exited the facilities. Review of client records on 8/22/23 for all clients in House #1, #2, #3 and #4 did not reveal signed consents from HRC relative to video cameras or alarms on exterior doors. Interview with the assistant qualified intellectual disabilities professional (QIDP) and program manager (PM) on 8/22/23 revealed that signed consent forms could not be located during the survey. Continued interview with the QIDP and PM verified HRC limitation consent forms for all clients should be updated and signed by the HRC annually.	W 262		
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	W 263		

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consent of the client, parents (if the client is a minor) or legal guardian.
This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure restrictive techniques were reviewed and approved by the legal guardians for 15 of 20 clients in (House #1, #2, #3 and #4). The finding is:

Observations throughout the recertification survey from 8/21/23-8/22/23 revealed in House #1, #2, #3 and #4 mounted cameras in the homes. Continued observations revealed exterior door alarms to chime loudly as staff, clients and surveyors entered and exited the facilities.

Review of client records on 8/22/23 for all clients in House #1, #2, #3 and #4 revealed seven consents were signedm however two of the seven consents were expired. Continued review revealed no signed consents from legal guardians for 13 of 20 clients relative to video cameras or alarms on exterior doors.

Interview with the assistant qualified intellectual disabilities professional (QIDP) and program manager (PM) on 8/22/23 revealed that updated signed consent forms for 15 of 20 clients could not be located during the survey. Continued interview with the QIDP and PM verified consent forms for all clients should be updated and signed by the legal guardian annually.