STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G245	A. BUILDING _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINHOOD GROUP HOME	1507 ROBINHOOD RD WILMINGTON, NC 28401

(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 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure the interdisciplinary team completed preliminary assessments within 30 days after admission. This affected 1 of 3 audit clients (#4). The finding is: Review on 6/17/24 of client #4's individual program plan (IPP) dated 3/5/24 revealed he was admitted to the facility on 1/31/24. Further review of client #4's record revealed no nutritional assessment was obtained within 30 days of admission. Interview on 6/18/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #4 had not had a nutritional evaluation since admission and the facility is currently in the process of finding a new dietician.	W 210		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) 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 record review and interview, the facility failed to ensure the restrictive behavior techniques for 3 of 3 audit clients (#3, #4 and #5) was reviewed and monitored by the human rights	W 262		

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
	34G245	A. BUILDING _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINHOOD GROUP HOME	1507 ROBINHOOD RD WILMINGTON, NC 28401

(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 262	Continued From page 1 committee (HRC). The findings are: Observations in the home throughout 6/17/24 and 6/18/24 revealed alarms on the exit doors. A. Review on 6/17/24 of client #3's Behavior Support Plan (BSP) dated 5/4/23 revealed no written HRC consent for door alarms. B. Review on 6/17/24 of client #4's BSP dated 1/24/24 revealed no written HRC consent for door alarms. C. Review on 6/17/24 of client #5's record revealed there is no formal BSP in place nor written HRC consent for door alarms. Interview on 6/18/24 with the qualified intellectual disabilities professional (QIDP) revealed that none of the 3 client's have HRC consent for exit alarms. The QIDP confirmed that the facility should have obtained HRC consent for all of the clients in the home.	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 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 interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 3 out of 3 audit clients (#3, #4 and #5). The findings are:	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G245	A. BUILDING _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINHOOD GROUP HOME	1507 ROBINHOOD RD WILMINGTON, NC 28401

(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 263	Continued From page 2 Observations in the home throughout 6/17/24 and 6/18/24 revealed alarms on the exit doors. A. Review on 6/17/24 of client #3's Behavior Support Plan (BSP) dated 5/4/23 revealed no written informed consent of a legal guardian for door alarms. B. Review on 6/17/24 of client #4's BSP dated 1/24/24 revealed no written informed consent of a legal guardian for door alarms. C. Review on 6/17/24 of client #5's record revealed there is no formal BSP in place nor written informed consent of a legal guardian for door alarms. Interview on 6/18/24 with the qualified intellectual disabilities professional (QIDP) revealed that none of the 3 client's have written consent for exit alarms. The QIDP confirmed that the facility should have obtained written informed consent for all of the clients in the home.	W 263		