STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G055	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FANJOY HOME #1	**235 FANJOY ROAD STATESVILLE, NC 28625**

(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 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to notify a parent or guardian of an allegation of abuse against 1 of 6 clients in the group home (#3). The finding is: Review of records on 7/17/24 revealed an internal facility investigation which was opened on 7/8/24 and completed on 7/9/24. The investigation was initiated following a complaint by staff that client #3 had been physically abused by a staff member. Continued review revealed a 5-day report to the Division of Health Service Regulation which stated that client #3's guardian had been notified of the allegations and the fact that an investigation was opened. Upon request, the facility was unable to produce any record of having notified the guardian. Interview on 7/17/24 with the guardian of client #3 revealed that he had no knowledge of the allegation or the opening or outcome of the investigation. Interview with the qualified intellectual disabilities professional (QIDP) revealed that she had left a message for client #3's guardian to call her but had not indicated the nature of the call and had not followed up by any method when the call was not returned.	W 148		
W 157	STAFF TREATMENT OF CLIENTS	W 157		

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 157	Continued From page 1 CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to show evidence of appropriate corrective action for an allegation of abuse of a client by staff members involving 1 of 6 clients (#3). The finding is: Review of facility documentation on 7/17/24 revealed an internal investigation summary dated 6/10/24 regarding an allegation that client #3 had been physically and verbally abused by several staff members. Upon learning of the allegations, the facility placed all staff named in the complaint on leave. The internal investigation substantiated the allegations of physical and verbal abuse and noted the following corrective actions: termination of all staff named in the complaint; in-service training for all direct care staff on quality of life, timely reporting, and reporting abuse, neglect and exploitation; and routine and unannounced visits to the group home by the clinical team at least twice per week to ensure the safety of the clients and that the clients are freely moving within their home. Review of facility documentation did not reveal evidence of interaction/engagement assessments by the clinical staff or in-service training with all facility staff after the incident (6/5/24). Therefore, corrective actions were not provided or completed as indicated in the internal investigation summary. Interview with the qualified intellectual disabilities professional (QIDP) on 7/17/24 verified that the facility had not completed all of the corrective actions called for in the internal investigation	W 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G055	A. BUILDING _____ B. WING _____	C 07/17/2024

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W 157	Continued From page 2 summary. The QIDP further indicated that she was not aware of the need for those corrective actions as the previous quality manager had left the agency.	W 157		