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	34G020	A. BUILDING ______ B. WING ______	08/20/2024

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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that client (#8) in House #2 was treated with dignity and respect regarding the use of incontinence padding. The finding is: During observations in House #2 on 8/20/24 at 7:00 AM, client #8 was observed sitting in a chair in the living room of the group home with an incontinence pad clearly visible under the client's body. Interview with staff F on 8/20/24 revealed that the purpose of the incontinence pad is to prevent damage to furniture from client #8's toileting accidents. Continued interview with the qualified intellectual disabilities professional (QIDP) and QIDP assistant on 8/20/24 confirmed that use of the incontinence pads violates the clients' right to dignity.	W 125		
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 and interview, the facility failed to provide opportunities for choice and self management for 2 clients (#5 and #7) in House #2 relative to medication administration. The	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 findings are: A. Observations in the group home on 8/20/24 at 7:30 AM revealed client #7 to participate in the breakfast meal. Continued observation at 7:37 AM revealed staff E to request client #7 to the hallway for medication administration. Further observation revealed client #7 to leave her breakfast meal and to go take morning medications in the hallway. Subsequent observation at 7:41 AM revealed client #7 to return to the dining room to finish her breakfast meal that remained on the table. At no time during the observation was client #7 allowed the opportunity to finish her breakfast meal prior to taking medications. B. Observations in the group home on 8/20/24 at 7:30 AM revealed client #5 to participate in the breakfast meal. Continued observation at 7:41 AM revealed staff E to request client #5 to the hallway for medication administration. Further observation revealed client #5 to leave her breakfast meal and to go take morning medications in the hallway. Subsequent observation at 7:45 AM revealed client #5 to return to the dining room to finish her breakfast meal that remained on the table. At no time during the observation was client #5 allowed the opportunity to finish her breakfast meal prior to taking medications. Interview with the qualified intellectual disabilities professional (QIDP) and QIDP assistant revealed that it is not the practice of the facility to interrupt meals for medications. Continued interview with the QIDP assistant revealed that staff will require further training in providing choices.	W 247		

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W 448	Continued From page 2	W 448		
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to investigate all problems relative to fire evacuation drills including the justification for extended times needed for facility evacuation for House #1, #2, #3, and #4. The finding is: Review on 8/19/24 of facility's fire evacuation drill reports revealed 48 fire drill reports conducted over the survey 2023-2024 review year. Continued review of the facility fire drills revealed 32 out of 48 drills with extended evacuation times to evacuate the facility. Further review of the fire drill reports revealed the 32 drills evacuation times ranged from 4 minutes to 12 minutes in length. A. Review on 8/20/24 of facility fire evacuation drills for House #1-Aster revealed 8 of 12 drills exceeded 3 minutes. Continued review of House #1 evacuation drills revealed the 8 drills that exceeded 3 minutes were conducted on the following dates: 7/17/24 (5 minutes), 6/18/24 (7 minutes), 03/10/24 (8 minutes), 12/23/23 (8 minutes), 11/15/23 (5 minutes), 10/21/23 (5 minutes), 9/12/23 (6 minutes), and 8/18/23 (5 minutes). Further review of the evacuation drills exceeding 5 minutes revealed no explanation or cause for the extended time. B. Review on 8/20/24 of facility fire evacuation drills for House #2-Balway revealed 7 of 12 drills exceeded 3 minutes. Continue review of House #2 evacuation drills revealed that the 7 drills	W 448		

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W 448	Continued From page 3	W 448		

exceeding 3 minutes were conducted on the following dates: 6/15/24 (8 minutes), 3/10/24 (10 minutes, 12/23/23 (6 minutes), 11/13/23 (9 minutes), 10/21/23 (7 minutes), 9/12/23 (8 minutes) and 8/10/23 (7 minutes). Further review of the evacuation drills exceeding 5 minutes revealed no explanation or cause for the extended time.

C. Review on 8/20/24 of facility fire evacuation drills for House #3-Clover Place revealed 8 of 12 drills exceeded 3 minutes. Continue review of House #3 evacuation drills revealed that the 8 drills exceeding 3 minutes were conducted on the following dates: 7/19/23 (5 minutes), 6/18/24 (9 minutes), 5/17/24 (4 minutes), 3/10/24 (8 minutes), 12/23/23 (4 minutes), 11/15/23 (8 minutes), 10/21/23 (6 minutes), and 9/12/23 (7 minutes). Further review of the evacuation drills exceeding 5 minutes revealed no explanation or cause for the extended time.

D. Review on 8/20/24 of facility fire evacuation drills for House #4-Dogwood Manner revealed 9 of 12 drills exceeded 3 minutes. Continue review of House #4 evacuation drills revealed that the 9 drills exceeding 3 minutes were conducted on the following dates: 7/17/24 (5 minutes), 6/18/24 (12 minutes), 02/15/24 (5 minutes), 1/11/24 (8 minutes), 12/23/23 (10 minutes), 11/15/23 (8 minutes), 9/12/23 (7 minutes), 8/18/23 (7 minutes) and 7/19/24 (5 minutes). Further review of the evacuation drills exceeding 5 minutes revealed no explanation or cause for the extended time.

Review on 8/20/24 of the facility's Evacuation Fire Drill Procedures dated 3/1/2010 revealed "if evacuation time exceeded 3 minutes, the reporter

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W 448	Continued From page 4 will state the reasons for the delay". Continued review of the fire evacuation drills did not reveal a corrective action or additional drill within the current month for the extended evacuation times. Interview on 8/20/24 with the qualified intellectual disabilities professional (QIDP) and QIDP assistant revealed the facility's policy is a three-minute maximum time to evaluate the facility. Continued interview with the QIDP's revealed they could not verify if corrective action, or additional drills had been completed relative to extended evacuation times.	W 448		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review, and interview the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This potentially affected all clients (#1, #2, and #3) in House #1 and clients (#5, #6, #7, #8, #9 and #10) living in House #2. The findings are: A. Observations on 8/19/24 in House #1 at 5:30 PM revealed client #2 to exit his bedroom and walk into the kitchen to retrieve the utensils to set his place and peers at the dining table. Continued observations revealed client #3 to exit the living room into the kitchen to make a salad, juice and place the pitchers on the table. Further observations at 5:34 PM revealed client #1, #2	W 454		

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W 454	Continued From page 5 and #3 to sit at the dining table to participate in the dinner meal. At no point during observations did staff A prompt clients #2 and #3 to wash their hands prior to setting the dining table or participate in the dinner meal. Interview with the facility qualified intellectual disabilities professional (QIDP), QIDP assistant and medical technician (MT) on 8/20/24 revealed that staff should have prompted all clients to wash their hands. Continued interview with the QIDP's revealed prior to meal preparation, setting the table and participation in meals, all clients and staff should wash their hands. B. Observations on 8/19/24 in House #2 at 6:00 PM revealed client #5 to exit the living room and walk into the kitchen with her walker to retrieve the dinnerware to set the dining table. Continued observations revealed client #5 to touch her face, arms, and the counter in the dining room. Further observations revealed client #5 take the utensils from the dishwasher and cups by the mouth area and placed them on the table without washing her hands. At no point during observations did staff B prompt client #5 to wash her hands prior to setting the dining table. Interview with the QIDP's and MT on 8/20/24 revealed that staff should have prompted client #5 to wash her hands prior to setting the table.	W 454		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review, and	W 474		

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W 474	Continued From page 6 interview the facility failed to ensure food for 1 client (#8) in House #2 was served in a form consistent with their developmental level. The finding is: Observations in the group home on 8/20/24 at 6:00 AM revealed the breakfast meal to be oatmeal, apple cider donut, bacon, margarine, 2% skim milk, juice and coffee. Continued observations at 7:30 AM revealed client #8 to sit at the dining table and staff E to cut the donut and bacon into 1/4 size pieces. Further observations revealed client #8 to consume her oatmeal, donut and bacon. Review of client #8's record on 8/20/24 revealed a nutritional evaluation (NA) dated 7/3/24. Review of the NA indicated client #8's diet order is 1800 calories, NAS, low cholesterol. Continued review of the NA revealed all foods for client #8 must be put into a chopper before serving for safe p/o intake. Interview with the facility QIDP's and medical technician (MT) on 8/20/24 confirmed client #8's diet orders are current. Continued interview with the QIDP's and MT confirmed client #8's food was not prepared to the specifications of the diet order. Further interview with the QIDP's and MT confirmed the diet order should be followed as prescribed at all times.	W 474		
W 477	MENUS CFR(s): 483.480(c)(1)(i) Menus must be prepared in advance. This STANDARD is not met as evidenced by:	W 477		

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W 477	Continued From page 7	W 477		

Based on observations, record review, and interviews, the facility failed to produce a copy of client menus prospectively to verify that planning is done in advance for House #1, #2, #3 and #4. The findings are:

Observation of all group homes during the 8/19/24- 8/20/24 survey revealed typed menu for the meals as follows: Dinner - chicken pies, salad, fruit cups; Breakfast-oatmeal of choice, bacon, apple cider donut, and Lunch-sandwich of choice, chips and fruit. Continued review of the typed menu revealed no prescribed serving or portion sizes, no type or choice of beverage, and, no type or choice of salad dressings. Further observation revealed the breakfast meal had no prescribed serving or portion size for the oatmeal, no listed type or choice of oatmeal available, no choice or type of beverage and no alternative option available for those not wanting the apple cider donut.

Review of records on 8/20/24 revealed no seasonal menu available for review when requested. Continued review of records revealed all clients to have a Nutritional Assessment completed by a registered dietitian. Further review of records revealed the typed menu to be the menu used by staff in all homes.

Interview with the qualified intellectual disabilities professional (QIDP) and assistant QIDP confirmed the facility does employ a dietitian. Contained interview of the QIDP's verified the nutritional assessments for all clients are current. Further interview with the QIDP revealed all clients diet orders should be followed as prescribed.