STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G190	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICES CREEK ROAD HOME	3000 BRICES CREEK ROAD NEW BERN, NC 28562

(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 108	COMPLIANCE W FEDERAL, STATE & LOCAL LAWS CFR(s): 483.410(b) The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to safety, and This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure compliance with all applicable provisions of State law pertaining to safety. This affected 1 of 6 clients (#6) riding the facility van. The finding is: During afternoon observations at a local park on 11/4/24 at 11:55am, staff began assisting clients to load the facility van for departure. While checking seat belts for each of the six clients on the van, client #6's seat belt was noted to be stuck and would not stretch across the client. Staff A asked client #6 to move to another seat. The client ignored the question and continued to sit in the seat. Five other clients on the van were noted to have their seat belts secured. The van then exited the park with client #6 in the same seat and no secured seat belt. Immediate interview with Staff A revealed the seat belt had worked properly when they loaded the van to come to the park; however, it has somehow gotten stuck since then. Review on 11/5/24 of the facility's Transportation policy (last updated 8/8/24) noted, "North Carolina has two state laws that regulate seatbelt use, both of which declare seatbelt use to be mandatory. North Carolina Seat Belt Law...provides that all drivers, front seat passengers, and back seat passengers age 16	W 108		

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
	34G190	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICES CREEK ROAD HOME	**3000 BRICES CREEK ROAD NEW BERN, NC 28562**

(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 108	Continued From page 1 and over must wear seat belts." Interview on 11/5/24 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) confirmed staff are trained to follow State Laws concerning seat belt use and all clients should have their seat belts secured before the van leaves a location.	W 108		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure 1 of 4 audit clients (#6) were afforded privacy during personal care and toileting. The findings are: During observations in the home on 11/4/24 at 4:05pm, client #6 was in the back hallway bathroom sitting on the toilet with her pants down and the bathroom door open. Further observation in the home on 11/5/24 at 8:00am, client #6 was sitting on the toilet with her pants down with the bathroom door open. Review on 11/5/24 of client #6's Skills Assessment (dated 9/24/24) revealed client #6 requires verbal cues for closing doors when toileting. Interview on 11/5/24 with staff A revealed client #6 independently uses the bathroom and staff was not always aware of when she goes to the bathroom. Staff A confirmed client #6 does need verbal cues to close the door when using the	W 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G190	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICES CREEK ROAD HOME	3000 BRICES CREEK ROAD NEW BERN, NC 28562

(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 130	Continued From page 2 bathroom	W 130		
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 document review and interview, the facility failed to ensure all allegations were thoroughly investigated. The finding is: Review on 11/5/24 of an incident report dated 11/25/23 revealed on 11/25/23 client #4 eloped from the home undetected by staff. The report noted, "Staff was passing out meds. Staff called for [Client #4]. [Client #4] did not answer. Staff open [Client #4] door and seen that [Client #4] was not in his room. Staff notice that [Client #4] bedroom window was open, and the screen was broken. Staff then called House manager, to report the incident. Staff go into vehicle to look for [Client #4]. Staff found [Client #4] at store near the Group Home. Staff brought [Client #4] back to the Group Home..." No other information regarding the incident was available. Interview on 11/5/24 with the Statewide ICF Director indicated they do not investigate elopements; therefore, this incident was not investigated. During an interview, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged that the incident should have been investigated due to potential neglect.	W 154		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G190	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICES CREEK ROAD HOME	3000 BRICES CREEK ROAD NEW BERN, NC 28562

(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 249	Continued From page 3 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 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, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of objective implementation. This affected 2 of 4 audit clients (#3 and #4). The findings are: A. During observations in the home throughout the survey on 11/4 - 11/5/24, no chimes or alarms were activated on client #4's bedroom window or his bedroom door. Interview on 11/5/24 with the Home Manager (HM) revealed client #4 has elopement behaviors and should have the alarm on his door activated throughout the shift and a chime should also be mounted on his window. The HM indicated the client may have removed it. Review on 11/5/24 of client #4's Behavior Support Plan (BSP) dated 7/23/24 revealed an objective to exhibit 10 or less challenging behaviors per month for 12 consecutive months. Additional review of the plan included target behaviors of actual elopement, attempted elopement, failure to	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G190	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICES CREEK ROAD HOME	3000 BRICES CREEK ROAD NEW BERN, NC 28562

(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 249	Continued From page 4 make responsible choices, and inappropriate toileting. The BSP noted, "Due to [Client #4's] elopement his team feels chimes are needed on bedroom window...and the exit doors to the group home." Interview on 11/5/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 should have working chimes on his window to address elopement behaviors. B. During observations in the community and home throughout the survey on 11/4-11/5/24, client #3 ran around the community park, further than arm length from all staff. Client #3 ran outside of the home without staff in arm's length and several times running back of forth from the family area to his bedroom out of the arm's length of staff. Review on 11/4/24 of client #3's IPP dated 8/16/24 revealed being a fall risk and interventions to be utilized. The IPP reveals staff should closely monitor client #3 and be within arm's reach. Interview on 11/5/24 with the QIDP confirmed client #3 was a fall risk and should be within arm's length of staff to monitor if it looks as if the onset of a seizure.	W 249		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G190	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICES CREEK ROAD HOME	**3000 BRICES CREEK ROAD NEW BERN, NC 28562**

(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 288	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure techniques to manage client #4's behavior was included in a formal active treatment program. This affected 1 of 4 audit clients. The finding is: Observations in the home throughout the survey on 11/4 - 11/5/24 revealed an chime/alarm was placed over client #4's bedroom door. Additional observations just outside of client #4's bedroom window revealed a motion detector was mounted above the window. Interview on 11/5/24 with the Home Manager revealed the door alarm and motion detector had been placed in order to address client #4's elopement behavior. Review on 11/5/24 of client #4's Behavior Support Plan (BSP) dated 7/23/24 revealed an objective to exhibit 10 or less challenging behaviors per month for 12 consecutive months. Additional review of the plan included target behaviors of actual elopement, attempted elopement, failure to make responsible choices, and inappropriate toileting. The BSP noted, "Due to [Client #4's] elopement his team feels chimes are needed on bedroom window...and the exit doors to the group home." Further review of the plan did not indicate an interior bedroom door alarm or motion detector should be utilized to address client #4's elopement behavior. Interview on 11/5/24 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed only exterior door chimes and a window chimes have been included in client #4's BSP.	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G190	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICES CREEK ROAD HOME	3000 BRICES CREEK ROAD NEW BERN, NC 28562

(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 382	Continued From page 6	W 382		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure all medications remained locked except when being administered. The finding is: During observations in the home on 11/5/24 at 7:00am, staff F went out of the house door behind a client who ran out of the house. Staff F was in the medication room when the client ran out of the house and left the medication door open and the medication cart unlocked when he went behind the client. Further observation in the home at 8:00am staff B left the medication closet door unlocked when she walked to get client for medication pass. Interview on 11/5/24 with the home manager revealed that the medication closet should be kept locked at all time. Home manager also revealed that staff should have closed and locked the medication closet before going after the client.	W 382		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G190	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICES CREEK ROAD HOME	**3000 BRICES CREEK ROAD NEW BERN, NC 28562**

(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 436	Continued From page 7 interview, the facility failed to ensure client #4 was furnished eye glasses as indicated. This affected 1 of 4 audit clients. The finding is: During observations in the home throughout the survey on 11/4 - 11/5/24, client #4 did not wear eye glasses. The client was not prompted or encouraged to wear eye glasses. Review on 11/4/24 of client #4's vision examination report dated 9/18/24 revealed a diagnosis of myopia. The report noted eye glasses were "optional". Interview on 11/5/24 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) indicated client #4 does not have a pair of eye glasses to wear as an option.	W 436		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the prescribed and modified diets for 2 of 4 clients (#2 and #3) were provided as indicated. The findings are: A. Review on 11/4/24 of client #2's Individual Program Plan (IPP) dated 1/24/24 revealed 1800 calorie diet, regular texture with low calorie snacks. Further review of the home's menu book indicated No sugar added ice cream 1/2 cup for	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G190	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICES CREEK ROAD HOME	**3000 BRICES CREEK ROAD NEW BERN, NC 28562**

(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 460	Continued From page 8 dinner. For breakfast 1800 calorie diet should receive 1/2 cup of hot cereal with 1 cup of skim milk and 1/2 of seasonal fruit. During dinner observation in the home on 11/4/24 at 5:03pm, client #2 received a bowl and regular ice cream. Further observation client #2 received 1 cup of oatmeal, 1 cup of whole milk and 1 cup of pears (seasonal fruit). Client #2 consumed all of her food. Interview on 11/5/24 with the home manager confirmed client #2 should be on 1800 calorie diet and they should be going by the menu. Interview on 11/5/24 the qualified intellectual disabilities professional (QIDP) confirmed the menu with the portion sizes were not present in the home. B. Review on 11/4/24 of client #3's IPP dated 8/16/24 revealed on a regular diet with cut meats prior to coming to the table. During dinner observation in the home on 11/04/24 at 5:03, client #3 gestured for more chicken tenders. The chicken was not precut or cut at all when client #3 started eating the chicken tenders. Interview on 11/5/24 with the home supervisor confirmed client #3 should have extra precut meats in case he asked for more.	W 460		