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 _____	08/27/2025

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
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015	This deficiency will be corrected by the following actions A. Emergency food supply area will be thoroughly cleaned and disinfected. Afterwards, sealed items will be replenished, and a quarterly rotation schedule of when items in the disaster closet are to be replaced (3 months, 6 months, 9 months,1 year). B. Emergency food supplies will be purchased based on the needs of the people living in the home. C. All food will be secured, all expired food will be removed, and replaced D. Emergency food supply areas will be examined weekly by the 3rd shift DSP staff to ensure it has not been compromised by any type of pest. E. Terminix, pest control provider, will examine the home identified and provide additional treatment to resolve pest issue. F. Terminix will provide additional screening to all homes (#1, #3, #4, and #5) to ensure they are free from pests. G. During disaster relief training or during emergencies, additional relief supplies, including water, will be brought into the homes. H. Home Manager, Emergency Preparedness Coordinator and Safety Coordinator will monitor and document this monthly while conducting site review RECEIVED SEP 25 2025	08/30/25 09/03/25 08/27/25 09/21/25 09/15/25 09/17/25 10/01/25 10/28/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra G Grause
TITLE: Executive Director
(X6) DATE: DHSR-MH Licensure Sect 09/15/25

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. FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 015	Continued From page 1 hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure subsistence needs for staff and clients were maintained and adequately stored in house #2. The finding is: Observations during the recertification survey 8/26-27/25 in house #2 revealed the emergency food supplies to be stored in a locked closet. Further observations revealed the the canned foods stored on the shelf to have an expiration date of 8/2024. Continued observations of the emergency food supplies revealed several mouse traps on the floor with mouse feces scattered on the floor. Subsequent observations of emergency food supplies revealed a large plastic sealed container stored on the floor with an assortment of boxed snacks that had been breached by rodents leaving the contents with a large amount of mouse feces. Additional observation of the food supplies revealed only one 24 bottle case of waters that sat on top of the plastic container.	E 015		

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E 015	Continued From page 2 Review of records on 8/27/25 revealed a facility's Infectious/Communicable Disease Management policy dated 8/1/22. Further review of the 8/2022 policy revealed "all emergency food supplies will be assessed every three months to ensure quality and compliance with the disaster kit guidelines and established best practices. All emergency food will be stored in a secure location and monitored regularly to maintain inventory integrity and readiness for use". Continued review of the 8/2022 policy revealed the organized storage should "be stored at lease six inches off the floor to prevent contamination and pest access". Interview with the qualified intellectual disabilities professional (QIDP) on 8/27/25 revealed the emergency supplies are supposed to be checked at least every three months. Further interview with the QIDP revealed the home is located near a wooded area and does have an existing mouse problem which they are addressing. Continued interview with the QIDP revealed that the emergency foods should have been checked more regularly to ensure no expired foods, adequate water and no breach from the rodents.	E 015		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the exterior of the facility was safe and orderly relative to House #2. The finding is: Observations during the recertification survey from 8/26/25-8/27/25 revealed a fence behind	W 104		

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W 104	Continued From page 3 House #2 that was broken and on the ground in two places. Further observations also revealed a fallen tree on top of the fence. Continued observations revealed the two open areas to expose a steep, uneven area with a significant drop of several feet. Observations did not reveal the two open areas to secure the steep, uneven area. Interview with the Assistant Qualified Intellectual Disabilities Professional (QIDP) on 8/27/25 revealed the fence has been down since the beginning of the summer. Further interview with the Assistant QIDP revealed the tree fell down after a storm came through the area. Continued interview with the Assistant QIDP revealed management has been discussing the need to secure the fence and cut the tree. Additional interview with the Assistant QIDP agreed the fence should be repaired especially since there are several clients that have elopement behaviors. Interview with the Facility Administrator on 8/27/25 revealed she was aware of the need to cut the tree and repair the fence. Further interview with the Facility Administrator verified the fence will be repaired and secured.	W 104	Rouses will ensure that the exterior of the home #2 and other RGH homes are safe and maintained in good repair. A. The fence behind home #2 will be repaired and maintained to ensure the safety of the clients served. B. A Local Tree Service is scheduled to remove the tree from the fence area behind house 2. C. Monthly, the fence and other exterior areas will be checked to ensure they are safe, functional, and in good repair. D. RGH DSP Staff and House Manager will monitor and report any damage to the fence, area behind House 2, or the facility exterior. E. Maintenance personnel will repair or replace any exterior in need of repair.	10/16/25 10/09/25 10/23/25 09/17/25 10/23/25
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure clients had the right to retain and	W 137		

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W 137	Continued From page 4 use appropriate personal possessions affecting 6 of 6 clients (#18, #19, #20, #21, #22, #23) residing in House #3. The finding is: Observations throughout the recertification survey from 8/26/25-8/27/25 revealed two electric razors to sit on a small table in the kitchen area. Further observations revealed the two electric razors to be plugged up to an outlet and charging. Continued observations revealed the two electric razors to not be labeled. Interview with staff H on 8/27/25 revealed three of six clients use the electric razors for shaving during the morning personal care. Further interview with staff H revealed the electric razors are usually charging in the living room area on the bookshelf. Interview with the Assistant Qualified Intellectual Disabilities Professional (QIDP) on 8/27/25 revealed all six clients have their own personal razors. Further interview with the Assistant QIDP revealed the electric razors should be labeled and in the client's rooms. Continued interview with the Assistant QIDP revealed staff and clients should not share razors to maintain healthy hygiene habits.	W 137	Rouses will ensure the rights of the clients served: A. After completion of an Internal Review, it was determined that all 6 of the persons served had their own personal electric razors in the home. It was also determined that 3 of the 6 persons served are independent with shaving and store their razors in their bedrooms, B. The person served guardian/lrp, and the HRC will assess if the person served can safely store their razors in their rooms. C. Rights will be reviewed for the 3 clients whose razors were charged outside their rooms. D. All individuals served will have access to their personal grooming items, pending any restrictions imposed by HRC and the guardian. E. Home Manager, AQPs, and QPs will monitor and document this monthly while conducting their site review.	08/28/25 09/17/25 09/15/25 09/18/25 10/10/25
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 and frequency to support the achievement of the objectives identified in the individual program	W 249		

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W 249	Continued From page 5 plan. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that a continuous active treatment program consisting of needed interventions were implemented as identified in the individual support plan (ISP) for 2 of 8 audited clients (#17 and #20). The findings are: A. The facility failed to use client #17's lift vest as prescribed in House #4. For example: Observations in the facility on 8/27/25 at 6:51 AM revealed client #17 to sit at the dining room table eating the breakfast meal. Further observations at 7:10 AM revealed that staff L provided the client with an additional cup of juice to consume. Continued observations at 7:15 AM revealed that staff L turned client #17's armless chair around to face the living room to transfer the client. Subsequent observations revealed that staff L stood in front of the client and removed the client from the chair holding the client's hands while the staff walked backwards to the living room. The client was placed in a living room chair. At no time during the observation was the staff observed to utilize the client's lift vest that was in place. Review of client #17's records on 8/27/25 revealed an ISP dated 8/6/25. Further review of the ISP revealed that client #17 is prescribed a lift vest to wear daily. Continued review of the ISP revealed a physical therapy assessment dated 10/5/24 which indicates the client ambulates with	W 249		

			DEFICIENCY)	
W 249	Continued From page 6 B genuvalgum, wide base support, assistance (as needed)/close supervision during ambulation and prescribed a lift vest. Interview on 8/27/25 with the qualified intellectual disabilities professional (QIDP) confirmed that client #17 is prescribed a lift vest. Further interview with the QIDP confirmed that staff transferred the client improperly. Staff should use the lift vest appropriately to move the client from one area to another and to get the client out of bed. B. The facility failed to provide client #20's eyeglasses in House #3. For example: Observations throughout the recertification survey from 8/26/25-8/27/25 revealed client #20 to participate in various activities such as watching television, personal care, participating in mealtimes, and medication administration without his eyeglasses. At no point during the observation did staff prompt client #20 to wear his eyeglasses. Review of the record for client #20 on 8/27/25 revealed an individual support plan (ISP) dated 10/4/24 and a vision consult dated 9/16/24 which indicates the client should wear his eyeglasses full time. Interview with the Assistant QIDP on 8/27/25 revealed client #20 does not like to wear his eyeglasses. Further interview with the Assistant QIDP verified that client #20 should wear his eyeglasses as prescribed.	W 249	This deficiency will be corrected by the following actions: A. House and Day Program staff will be in-serviced on the function and use of the gait vest/ belt. B. House and Day Program staff will be in-serviced on following the client's ISP guidelines and provided consultations on the use of adaptive equipment as ordered. C. Client will be baselined to wear eyeglasses as prescribed. A formal objective will be implemented to ensure the client wears his eyeglasses as prescribed. D. PT will reassess all clients' use of adaptive equipment and provide guidelines for its use. E. QP will submit a recommendation for any adaptive equipment deemed restrictive to the HRC and guardian/lrp for approval and written consent. F. QPs and AQPs will ensure that the PT's recommendations and/or guidelines for the use of adaptive equipment are included in the client's ISP Plan. G. Program Manager, QPS, AQPs and House Manager will monitor adaptive equipment use and document during monthly site reviews.	09/17/25 09/17/25 09/19/25 09/19/25 09/22/25 10/01/25 10/20/25
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2)	W 369		

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W 369	Continued From page 7 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all drugs were administered without error for 1 of 8 audited clients (#16) observed during medication administration. The finding is: Observations in the home on 8/27/25 at 7:07 AM revealed client #16 to sit at the dining room table eating her breakfast meal which consisted of French toast, scrambled eggs, water, and juice. Further observations at 7:28 AM revealed the client entered the medication administration area with a cup of water. Continued observations revealed client #16 to identify and to punch all morning medications into a medication cup and take all medications whole with a cup of water. Review of records for client #16 on 8/27/25 revealed physician's orders (PO) dated 7/18/25. Review of the PO's revealed medications prescribed at 8:00 AM to be Atenolol 25MG, Furosemide 20MG, Metformin HCL 500MG, Portia-28, Potassium CL ER 10MEQ, Sertraline HCL 100MG, Vitamin D3 1,000 Unit, Bupropion HCL 100MG, Divalproex SOD ER 500MG, and Dicyclomine 20MG. Further review of PO's revealed that client #16 is prescribed at 7:00 AM Levothyroxine 50 MCG take one tablet by mouth once daily on an Empty Stomach in the morning. Staff L was observed to have administered client #16's Levothyroxine 50 MCG after the client consumed her breakfast meal and all 8:00 AM medications.	W 369	This deficiency will be corrected by the following actions: A. RN will assess all orders. B. All physician orders will be reviewed for accuracy. C. DSP staff provided in-service on assuring all medications are administered w/o error. D. All staff will be in-serviced on medication procedure and following the guidelines for measuring and dispensing all medications. E. All RN assessments will be reviewed and discussed during monthly clinicals, core team meetings, quarterly reviews, and/or ISP meetings. F. RN, AQP, QPs, and Program Manager will observe and review drug administration monthly while conducting site reviews.	09/15/25 08/29/25 09/17/25 10/15/25 10/26/25

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W 369	Continued From page 8 Interview with the facility nurse on 8/27/25 confirmed that client #16's PO's are current. Continued interview with the facility nurse confirmed that the staff should have administered the client's Levothyroxine 50 MCG on an empty stomach.	W 369		
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 observation and interviews, the facility failed to assure the medication closet remained locked except when preparing for medication administration for 6 of 6 clients (#18, #19, #20, #21, #22, #23) in House #3. The finding is: Observations on 8/26/25 from 4:45PM to 5:45PM revealed the medication closet and cabinets to remain unlocked while not being used. Further observations at 5:45PM revealed clients and staff to prepare to leave the facility for an outing in the community. Continued observations revealed this surveyor to make staff F aware that the medication closet and cabinets were unlocked. Observations on 8/27/25 at 6:45AM revealed the medication closet and cabinets to again remain unlocked while not being used. Further observations at 7:00AM revealed this surveyor to make staff H aware that medication close and cabinets were unlocked. Interview with the facility nurse and Assistant Qualified Intellectual Disabilities Professional (QIDP) on 8/27/25 verified that medications	W 382	This deficiency will be corrected by the following actions: A. All staff will be trained on the medication administration procedures, adhering to the guidelines for medication storage B. Staff will also be in-serviced on the importance of never leaving medication unsecured. C. Home Manager, RN, AQPs, QPs, and Program Manager will monitor and document during their monthly site review.	09/30/25 09/17/25 10/25/25

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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
W 382	Continued From page 9 should be double locked when not being used for medication administration. Further interview with the Assistant QIDP verified staff have been trained to secure medications when they are not being administered to the clients.	W 382		
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 observations and record reviews, the facility failed to formally investigate all fire evacuation drills including the justification for extended times needed for facility evacuation in House #1, #2, #3 and #4. The findings are: Review on 8/26/25 of facility fire evacuation drill reports revealed 48 fire drill reports conducted over the survey 2024-2025 review year. Continued review of the facility fire drills revealed 41 out of 48 drills with extended evacuation times exceeding three minutes to evacuate the facility. Further review of the fire drill reports revealed the 7 drills evacuation times ranged from 4 minutes to 5 minutes in length without justification. A. Review on 8/26/25 of facility fire evacuation drills for House #1-Aster revealed 2 of 12 drills exceeded 3 minutes. Continued review of House #1 evacuation drills revealed the 2 drills that exceeded 3 minutes were conducted on the following dates:10/20/2024 (5 minutes) and 11/21/2024 (5 minutes). Further review of the evacuation drills exceeding 5 minutes revealed no explanation or cause for the extended timeframe.	W 448	This deficiency will be corrected by the following actions: A. Fire/evacuation drills will be conducted monthly with appropriate documentation at various times, including 1st, 2nd, and 3rd shifts, as well as weekends. B. All drills that are completed will have a justification if the time taken is within a 3-minute period. C. Recommendations and/or follow-up are required for drills that exceed 3 minutes. D. Client assessments and ratings will be completed for individuals who exhibit difficulty evacuating during fire/disaster drills. Formal goals and assistance to ensure safety will be incorporated into the person served's ISP as needed. E. The safety committee will review all drills for compliance F. Home Manager, AQPs, QPs, and Program Manager will monitor and document fire/evacuation drills to ensure any drill exceeding 3 minutes provides an explanation or cause during monthly site reviews.	09/11/25 09/15/25 09/15/25 10/02/25 1015/25 10/25/26

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W 448	Continued From page 10 B. Review on 8/26/25 of facility fire evacuation drills for House #2-Balway revealed 1 of 12 drills exceeded 3 minutes. Continued review of House #2 evacuation drills revealed that the evacuation drill exceeding 3 minutes was conducted on 11/21/2024 (4 minutes). Further review of the evacuation drill exceeding 5 minutes revealed no explanation or cause for the extended timeframe. C. Review on 8/26/25 of facility fire evacuation drills for House #3-Clover Place revealed 2 of 12 drills exceeded 3 minutes. Continued review of House #3 evacuation drills revealed that the evacuation drills exceeding 3 minutes were conducted on the following dates: 9/30/2024 (4 minutes) and 10/20/2024 (5 minutes). Further review of the evacuation drills exceeding 5 minutes revealed no explanation or cause for the extended timeframe. D. Review on 8/26/25 of facility fire evacuation drills for House #4-Dogwood Manner revealed 2 of 12 drills exceeding 3 minutes. Continued review of House #4 evacuation drills revealed that the evacuation drills exceeding 3 minutes were conducted on the following dates: 10/01/2024 (5 minutes) and 11/21/2024 (5 minutes), 11/15/24 (8 minutes), and 9/12/24. Further review of the evacuation drills exceeding 5 minutes revealed no explanation or cause for the extended timeframe. Review on 8/26/25 of the facility's Evacuation Fire Drill Procedures dated 3/1/2010 revealed "if evacuation time exceeded 3 minutes, the reporter 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.	W 448		

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W 448	Continued From page 11	W 448		

	Interview on 8/27/25 with the qualified intellectual disabilities professional (QIDP) revealed the facility's policy is a three-minute maximum time to evacuate the facility. Further interview with the QIDP revealed staff should have provided an explanation for any drill exceeding 3 minutes. Continued interview with QIDP revealed their quality assurance staff should have questioned the facility staff regarding lack of clarification for the drills exceeding 3 minutes. Subsequent interview with the QIDP verified their safety committee should also review for compliance but could not confirm if they had been reviewed.			