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	MHL026-857	A. BUILDING: _____ B. WING _____	R 03/15/2018

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V 000	INITIAL COMMENTS A complaint and follow-up survey was completed on March 15, 2018. The complaint was substantiated (intake #NC 00135569). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to implement strategies to meet the needs of the client affecting 1 of 3 clients (#3). The findings are: Review on 3/14/18 and 3/15/18 of client #3's record revealed: - 31-year-old male. - Date of admission: 2/28/17. - Diagnoses: Schizophrenia, Psychoactive Substance Dependence, Depression, and History of Asperger's Syndrome. - No unsupervised time identified on plan. Treatment plan dated 3/1/17 and 3/1/18 revealed: - "How best to support [client #3] section: make every effort to ensure that [client #3] has choices and is encouraged to make decisions regarding his preferences as long as the decisions do not violate the group home rules and or jeopardizes his health and safety or the health and safety of others. - Redirect [client #3] when he talks about eloping from the facility and assist him in resolving the concerns he expresses." - "What is not working section: [Client #3] has tried to leave the facility without notifying staff and would be at risk for homelessness due to living in a group home for the first time. ...[Client #3] requires supervision and training to increase functional living skills." - "Action plan: [Client #3] meets the medical necessity for Group Living High DHHS (Department of Health and Human Services service definition) which includes one to one	V 112		

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support, integrated home, day program support services, and individualized interventions and strategies. [Client #3] continues to report paranoid thought about others plotting to harm him and other symptoms include frequently changing his mind about his mind about participating in day activities(PSR) (Psycho Social Rehabilitation), his physicians, whether he wants to stay in the facility and take his medications properly. Additional staff support is required daily to ensure that he is supported and can be redirected when he is unpredictable."

- "Crisis Prevention and Intervention Plan : ensure staff is available to provide one to one support ... if [client #3] elopes, walk with him and encourage his return. If he refused to accept staff's support and is away from the facility for 3 hours, call 911 to report him as missing."

Review on 3/15/18 of the facility's staff communication logs from January 2018 to March 15, 2018 revealed:
- 1/13/18 third shift communication log, "[client #3] at 3:45 am was prompted not to go outside and he refused to stay in and walked out anyway."
- 1/14/18 first shift communication log, "[client #3] keeps asking to go to the store to buy soda. Staff told him that maybe 2nd shift can take him since it's 2 staff on duty."
- 1/18/18 first shift communication log, "[client #3] didn't get up until around 12:30 pm. He woke up with an attitude trying to tell staff how to do their job."
- 2/17/18 first shift communication log, "[client #3] went on a walk was back in about 3 hours."
- Date unknown second shift communication log, "[client #3] was missing from the start of shift. Made police report. Made incident report."

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V 112	Continued From page 3 - 2/20/18 third shift communication log," [client #3] found." - 2/20/18 second shift communication log, "[client #3] walked off for an hour and a half and also got upset because staff informed him to wash hands before touching fruit." - 3/04/18 second shift communication log, "[client #3] walked off. Staff communicated to [client #3] of the consequences and safety hazards of him walking off." - 3/05/18 third shift communication log, "[client #3] walked off when he asked staff #4 to take him somewhere when she got off and she couldn't do it when he came back he was very combative." Review on 3/15/18 of the facility's medical consultation forms revealed: - 10/26/17: "Purpose of visit ...[client #3] has been getting up at 2 and 3 in the morning and walking the streets without staff permission ..." - 11/27/17: "Purpose of visit ...[client #3] also stands on the street corner to panhandle and has received several warnings from police officers about panhandling ..." Review on 3/15/18 of Incident/Investigation report from the local police department revealed: - Report dated 2/19/18. - Client #3 reported missing from the facility by staff #2 at 4 pm. Review on 3/15/18 of North Carolina Incident Response Improvement System (IRIS) report revealed: - Date of incident: 2/19/18. - Completed by staff #2. - Consumer behavior, "unplanned consumer absence of more than 3 hours over time specified in the PCP or that requires police contact." - No narrative completed.	V 112		

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V 112	Continued From page 4 Observation on 3/14/18 at approximately 3:30 pm at the facility revealed: - One staff working with 4 clients (Clients #1, 2, 3, and 5) at the facility. (Staff #1) - Additional staff came on duty as scheduled 4 - 9 pm. (Staff #2) Observation on 3/15/18 at approximately 11:30 am at the facility revealed: - One staff working at the facility (staff #4). Client #3 and client #1 were present at the facility. Interview on 3/14/18 with client #3 revealed: - He had lived at the facility for about one year. - Some days the facility was alright, but he needed time away from the facility. - He wanted his therapist to say he could have "time away" from the facility. - He would walk without staff to the nearby factory and the road next to the facility. - Client #3 denied he asked for money from strangers in passing cars at the road or at the factory. - He walked away from the facility "the other day and staff had made a big report of it," he saw the police and asked them for a ride to his mother's house. Interview on 3/14/18 with client # 1 revealed: - "[Client #3] would walk over to the street and when we called him, he would run into the woods." - He had witnessed client #3 walk away from the facility and go into the woods. - "We did not know which way he went." Interview on 3/14/18 at approximately 3:30 pm with client #2 revealed: - He had seen client #3 walk to stop sign at the	V 112		

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end of road next to the facility and to the other end of the road.
- Client #2 gestured toward the factory located less than half a mile from the facility.
- He did not know if client #3 could leave the facility site without staff, but "he guessed it was okay."

Interview on 3/14/18 with staff #1 revealed:
- He had worked at the facility for one and half years.
- He generally worked third shift and Wednesday 4 - 9 pm.
- He was unaware of any authorization for client #3 to have unsupervised time away from the facility.
- Client #3 had walked to the stop sign at the end of the road near the facility and at the other end of the road near a factory.
- Client #3 would use a trail in the woods to go to the factory nearby the facility.
- Client #3 had walked up the street and was not supposed to ask for money from strangers.
- He did know that client #3 could not return to his previous day program until he had a 1:1 support staff with him there.
- Staff #1 did not know when client #3 would get a 1:1 staff.

Interview on 3/14/18 with staff #2 revealed:
- He had worked for the facility for one and half years and this was his third time having worked for this company.
- He worked 4 pm to 12 am.
- He was not aware of unsupervised time for client #3.
- Staff #2 stated client #3 would walk away from the facility without money and return and request to go to the store, " 'cause he had money."
- He had completed a missing person report for

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client #3 with the local police department.
- He completed an IRIS report and he shared the number assigned to the report via an image on his phone.
- He was in correspondence with the Qualified Professional (QP) during the entire incident.
- He had heard from a coworker that the police had found client #3 and took him to his mother's house.

Interview on 3/15/18 with staff #4 revealed:
- Client #3 had only left one time as she could recall.
- She was not aware of any police coming to the facility.

Interview with the facility QP on 3/14/18 and 3/15/18 revealed:
- She was aware client #3 had walked away from the facility.
- She said that client #3 would stand out at the street and ask people in cars for money.
- She verbally provided a schedule for the staff at the facility: one staff worked first shift, 2 staff worked second shift, and one staff worked third shift Monday through Friday. Weekend schedule varied.
- She had received the "phone" approval from the MCO (Managed Care Organization) for the Group Home Living High and had not arranged for 1:1 staff for client #3.
- The staff are "not to touch the clients" and "redirect him" or "follow him" when he walks away from the facility.

Interview with the Licensee on 3/15/18 revealed:
- He was aware of the incidents where client #3 had walked away from the facility.
- He said that client #3 was a challenging case.
- The facility would work towards meeting client

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V 112	Continued From page 7 #3's treatment needs to address his elopement behaviors at the facility and the day program.	V 112		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be	V 367		

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V 367	Continued From page 8 erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and	V 367		

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V 367	Continued From page 9 (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are: Review on 3/14/18 of the facility records revealed: - No documented Level II incident reports for law enforcement involvement as a result of a consumer act from January 1, 2018 through March 14, 2018. Review on 3/14/18 of the North Carolina Incident Response Improvement System (IRIS) revealed: - No incident report had been submitted to the LME/MCO for client #3's absence from facility on 2/19/18 which resulted in law enforcement involvement. Review on 3/15/18 of the facility staff communication logs revealed: - Date unknown for second shift communication log, "[client #3] was missing from the start of shift. Made police report. Made incident report." - 2/20/18 third shift communication log, "[client #3] found." Review on 3/15/18 of Incident/Investigation report from the local police department revealed:	V 367		

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V 367	Continued From page 10 - Report dated 2/19/18. - Client #3 reported missing from the facility by staff #2 at 4 pm. Review on 3/15/18 of IRIS report revealed: - Date of incident: 2/19/18. - Completed by staff #2. - Consumer behavior, "unplanned consumer absence of more than 3 hours over time specified in the PCP (Person Centered Plan) or that requires police contact." - No narrative completed for client #3's absence. - No official date of submission to LME/MCO for incident. Interview on 3/14/18 with client #3 revealed: - He walked away from the facility "the other day and staff had made a big report of it." - He saw the police and asked them for a ride to his mother's house. Interview on 3/14/18 with staff #2 revealed: - He had called the police on 2/19/18 to report client #3 missing when he could not find him at the beginning of his shift. - He completed an incident report and police report. - He notified the Qualified Professional (QP) of the incident and the police reports. Interview on 3/13/18 and 3/14/18 with the QP revealed: - She reported no incident reports for the past three months. - She was aware client #3 had walked away from the facility and police had been involved with his return to the facility. - She revealed staff had submitted an incomplete incident report for client #3.	V 367		

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V 367	Continued From page 11 Interview with the Licensee on 3/15/18 revealed: - He was aware of the incident on 2/19/18 with client #3. - The facility will work to insure incident reports are completed in more timely manner.	V 367		