

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL067-157</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/21/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GUARDIAN CARE 2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 CRISSY DRIVE</b> <b>JACKSONVILLE, NC 28541</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual and follow up survey was completed on March 21, 2018. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 112	<p><b>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</b></p> <p><b>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</b></p> <p>(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.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p>	V 112		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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V 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies to address the behaviors of one of two audited clients (#1). The findings are:</p> <p>Review on 3/20/18 of Client #1's record revealed: - 26 year old male, admitted to the facility June 2009. - Diagnoses of Moderate Intellectual/Developmental Disability, Intermittent Explosive Disorder, Mood Disorder, not otherwise specified, Oppositional Defiant Disorder. - Individual Support Plan by the Local Management Entity (LME) was updated 3/01/18, and included the following: - "What Others Need to Know to Best Support Me . . . Life Situation . . . Although last year [Client #1] was doing better with his behaviors, this past year his behaviors increased again. The police were called as he allegedly touched his niece while at his mother's home. Charges were not pressed on [Client #1] however this is a possibly for [Client #1]. He has also attacked female staff and has cornered female staff on multiple occasions masturbating in front of female staff. This has continued and has gotten worse. He is masturbating in front of others more often. . . . [Client #1] requires constant redirection, role modeling, and supervision throughout the day to ensure his safety. [Client #1] requires one on one redirection to ensure the safety of his self as well as others in his home. . . [Client #1] also has a history of masturbating in public places. . . [Client #1] has broken things and has put holes in doors and walls. . . Behavioral: . . . [Client #1] is presently having issues with interactions with females, saying inappropriate comments to them and</p>	V 112		

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V 112	<p>Continued From page 2</p> <p>following them around, and not providing them with a comfortable amount of personal space. . . Also history of him masturbating in public. . . [Client #1] requires support to learn about and/or avoid actions that endanger self or others. . . [Client #1] requires support to prevent, manage or provide therapy for behaviors or conditions that can potentially cause physical harm to himself or others or that may be a misdemeanor. [Client #1] requires close supervision due to risk of wandering away. [Client #1] requires support due to inability to make safe choices when at home and in the community. . . Incident Reports: 1. March 7, 2017 (Level II) - Became upset after being confronted about masturbating in public . . . 2. March 28, 2017 (Level II) - Became upset after being confronted about masturbating in public . . . 5. August 8, 2017 (Level II) - [Client #1] left the (day program) facility and walked to his mother's house; his mother wasn't there; [Local Municipality] Sanitation workers witnessed [Client #1] masturbating while children were walking to the nearby elementary school. . . [Client #1] needs to have SCS (Specialized Consultative Services) for a behavioral support plan and training staff; however, currently there is not a provider in the area for this service. The team will be implementing this service as soon as a provider is available."</p> <p>- "Long Range Outcome: [Client #1] will learn how to interact with others in his home and in the community in a respectful manner. Where am I now in Relationship to the Outcome? . . . The team would like to continue this goal as [Client #1's] masturbating in public has increased in the past year. [Client #1] will learn how to masturbate in private and avoid masturbating in public places . . . Service/Support to Reach Outcome: Residential Support . . . Who will provide Support &amp; Location(s) Licensee . . . Estimated Frequency</p>	V 112		

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V 112	<p>Continued From page 3</p> <p>for Each Location 7 D/W (Days per Week) . . . "</p> <p>-Residential "Individual Support Plan Short Range Goals" had not been updated since 3/01/17.</p> <p>- No strategies to address Client #1's behaviors of public masturbation, property destruction, and elopement.</p> <p>- No updated Short Range Goals.</p> <p>- Undated "Behavior Support Plan": "Program Title: Decreasing Inappropriate touch and Public Masturbation, Physical and verbal aggression. . . . Antecedent manipulations: . . . At NO point, should [Client #1] be left unsupervised during community outings."</p> <p>Review on 3/21/18 of Licensee memoranda "Subject: Incident Report/[Client #1]" dated 12/23/17, 1/02/18, and 1/11/18, and signed by Staff #1 revealed:</p> <p>- "On Saturday December 23, 2017 at 11:00 am we went to the laundromat at [local shopping center] to do our weekly laundry. Along with [Client #1] was myself [Staff #1] and another consumer. We were all inside the laundromat washing their clothes in the machines. . . We all went to the laundromat attendant to get some change for the dryer. We left our dryer sheets in the truck, [Client #1] said that he would go and get them out of the truck. While he went to the truck, we continued putting the clothes into the dryer. After a few moments, the laundry attendant approached us and stated that [Client #1] was in the truck masturbating in front of a little girl. I immediately rushed out of the truck to [Client #1] and to find out what was going on. The little girl told her mother and her mother in turn told the laundry attendant. The laundry attendant told me that the little's girl mother wanted to contact the police department. I informed the attendant we are truly sorry and will never return back to the establishment again.</p>	V 112		

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V 112	<p>Continued From page 4</p> <p>The attendant didn't contact the police. I gathered all of our clothes and we left the laundromat immediately." - "Date: January 02, 2018 . . . On Tuesday night at 8:30 pm, I received a phone call from the staff at the group home that [Client #1] left the facility. The staff stated that [Client #1] was watching television in the common are and was caught masturbating. He was told to stop in that area and that he could do so in his bedroom. [Client #1] became agigated and told the staff that he was leaving. I advised the staff to stay with the other consumer in the home and I will go assist with [Client #1]. I located [Client #1] on [nearby road], pulled over and asked him why he left the group home. He told me that he became upset. I advised [Client #1] I knew what happened and he had the option of going to his bedroom but in the common areas he can't masturbate. [Client #1] stated he knew that he was wrong and the staff was right but he didn't want to stop at the time. I discussed with [Client #1] the reasons why he can't masturbate in public/common areas and the consequences of such behavior. . . ." - "Date: January 11, 2018 . . . At 6:30 pm I received a phone call from the group home staff that [Client #1] had left the group home. I informed the staff that I would come out and attempt to locate [Client #1]. . . . I found [Client #1] near the corner of [nearby roads]. I asked him why he left the group home, he told me that he was upset because I had promised him that I would pick him up at five' o clock and I didn't. . . . Upon returning to the group home [Client #1] again became agitated and started breaking things in the kitchen area. He broke some kitchen ornaments and tried to bust the kitchen windows. At that point were able to calm him down and get him to go to his bedroom."</p>	V 112		

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V 112	<p>Continued From page 5</p> <p>Interviews on 3/21/18 representatives from the local City Police Department and the local County Sheriff's Department stated there were no records of calls to dispatch or police reports for the incident of 12/23/17. There was no documentation of calls or reports for incidents involving Client #1 since April 2017.</p> <p>Interview on 3/21/18 Client #1 stated:</p> <ul style="list-style-type: none"> <li>- He had walked away from the facility before.</li> <li>- When he walked away from the facility, staff called his mother.</li> <li>- He remembered the incident at the laundromat; the police were called and gave him a warning; he did not go to the police station.</li> <li>- A little girl was there, but he didn't know how old she was but thought she was too young to go to school.</li> <li>- Staff told him "that wasn't right."</li> <li>- He and Client #2 got along "pretty good" but sometimes argued about the television.</li> <li>- When they argued, staff told them to go to their bedrooms.</li> <li>- Client #2 got upset about his behaviors; staff told him to go to his room to masturbate.</li> </ul> <p>Interview on 3/21/18 Client #2 stated:</p> <ul style="list-style-type: none"> <li>- She and Client #1 didn't get along very well.</li> <li>- Client #1 had tried to touch her.</li> <li>- She didn't like "what he does."</li> <li>- Client #1 masturbated in front of her, "everywhere he can and every day."</li> <li>- She remembered the incident at the laundromat but did not see the little girl; the police were called.</li> <li>- Police had responded to the facility "3 or 4 times" because of Client #1's behaviors, but she couldn't remember when.</li> </ul> <p>Interview on 3/21/18 Staff #1 stated:</p>	V 112		

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V 112	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>- He had worked at the facility for a long time, but he could not remember exactly how long.</li> <li>- He usually worked day shift on the weekends and afternoon and night shifts during the week.</li> <li>- The Licensee had provided "redirection training."</li> <li>- He took Client #1 and Client #2 to the laundromat, usually on Saturdays.</li> <li>- He would park the truck so that he could watch Client #2 through the window of the laundromat while he waited in the truck with Client #1.</li> <li>- He tried to keep Client #1 "close to his hip" due to his behaviors.</li> <li>- On December 23, he was assisting Client #2 with her laundry when Client #1 went outside alone.</li> <li>- The laundry attendant told him Client #1 was "having one of his episodes."</li> <li>- He went to the truck and redirected Client #1 and did not let Client #1 go back inside the laundromat.</li> <li>- The laundry attendant reported that Client #1 had masturbated in front of a "little girl."</li> <li>- The girl's parents contacted the laundry attendant.</li> <li>- He never spoke to the child's parents.</li> <li>- He did not ask how old the child was.</li> <li>- The attendant said if he (Staff #1) would take care of the situation and if they agreed to never return to the laundromat, he would not contact the police.</li> <li>- He estimated Client #1 had exposed himself in public 3 or 4 times while he was working in the last 6 months.</li> <li>- Client #1's behaviors determined where they could go in the community.</li> <li>- He was not aware of any special precautions or restrictions regarding Client #1 being around children.</li> <li>- Client #1's behavior plan was to redirect him</li> </ul>	V 112		

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V 112	<p>Continued From page 7</p> <p>and focus on the positives.</p> <ul style="list-style-type: none"> <li>- Client #1 did not like to participate in activities like books, games or counting money; he was not interested in video games.</li> <li>- Client #1 had walked away from the facility; he would walk away when he was upset.</li> <li>- He estimated the longest Client #1 had been away from the facility was about 1 1/2 hours.</li> <li>- When Client #1 walked away from the facility, he called another staff and either he or the other staff would go look for Client #1.</li> <li>- In the last 90 days, Client #1 may have walked away from the facility once while Staff #1 was on duty.</li> <li>- He always completed incident reports when Client #1 walked away.</li> <li>- There had been no calls to the police since December 2017.</li> </ul> <p>Interview on 3/20/18 Staff #2 stated:</p> <ul style="list-style-type: none"> <li>- There was usually one staff present at the facility.</li> <li>- If Client #1 left the facility, "we just let him walk" and staff stay at the facility with Client #2, watching Client #1 while calling another staff who lived nearby.</li> <li>- Client #1 would "walk to the corner" and sometimes would not get into the car to return to the facility.</li> <li>- Client #1 had not exhibited any violent behaviors towards others, only property destruction.</li> <li>- Client #1 hit the wall when he couldn't get his way.</li> <li>- Client #1 hit something and injured himself in December or January and was taken to the doctor.</li> <li>- To her knowledge Client #1 had not threatened Client #2.</li> <li>- Client #1 had a behavior plan; staff talked to him to calm him down.</li> </ul>	V 112		



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V 112	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>- Client #1 had a medication he could take for agitation as needed, but he had not needed it "in a while."</li> </ul> <p>Interview on 3/21/18 Staff #8 stated:</p> <ul style="list-style-type: none"> <li>- He worked overnight about 4 weekends a month at the facility.</li> <li>- Client #1 liked to stay up during the night masturbating.</li> <li>- Client #1 might get 3 hours of sleep per night.</li> <li>- Staff were awake all night.</li> <li>- Client #1 was not usually agitated at night; he stayed in his bedroom and sometimes was restless.</li> <li>- Client #1 had hit and damaged walls and one time lost his balance and fell into the wall causing a hole.</li> <li>- He had seen no other property destruction by Client #1.</li> <li>- Client #1 had attempted to go into Client #2's bedroom once, but staff stopped him.</li> <li>- Client #1 did not masturbate in front of Client #2; Client #2 had never complained to him about Client #1.</li> <li>- Client #1 had not attempted to elope while he was on duty.</li> <li>- Client #1 had 1:1 staffing while at the day program.</li> <li>- Client #1 had to have "eyes on supervision at all times because of his behaviors."</li> <li>- Staff had received follow up training following the incident at the laundromat; staff were to keep Client #1 "at arm's length while in the community."</li> <li>- The training did not include new techniques or strategies, but reinforced what was already in place.</li> <li>- If Client #1 eloped, masturbated in public, or was physically aggressive, the police would be called to keep the public safe.</li> </ul>	V 112		

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V 112	<p>Continued From page 9</p> <ul style="list-style-type: none"> <li>- He had been trained regarding Client #1's behavior plan.</li> <li>- The behavior plan included modeling appropriate coping and social skills, getting client #1's input into activities and talking to him about public masturbation.</li> <li>- Police would be called if Client #1 eloped, masturbated in public, or was physically aggressive in the community.</li> </ul> <p>Interview on 3/21/18 the Qualified Professional stated:</p> <ul style="list-style-type: none"> <li>- Some of his responsibilities were to create and update person centered plans, complete incident reports, and staff training.</li> <li>- The frequency of Client #1's behaviors had decreased in the last year; his behavior plan was helpful.</li> <li>- Client #1 did not receive behavioral consultation services because the LME did not have a provider on contract.</li> <li>- He could not remember specific details about the incident that occurred at the laundromat on 12/23/17, but there had been several similar incidents.</li> <li>- Client #1 had eloped recently but he didn't have his notes in front of him so he didn't know any specific details.</li> <li>- If Client #1 eloped from the facility, staff would let him walk and would call another staff who lived nearby.</li> <li>- "We can't restrict someone's rights."</li> <li>- Client #1 had walked to a local grocery store about 2 miles from the facility, "but I don't think he's done that in the past year."</li> <li>- Client #2 had complained about Client #1's behaviors and her guardian had expressed concern a couple of years ago, but Client #1's behaviors had decreased in the last 2 years.</li> <li>- Interventions staff should implement included</li> </ul>	V 112		

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V 112	<p>Continued From page 10</p> <p>looking for his triggers and watching for signs/symptoms of him getting agitated.</p> <ul style="list-style-type: none"> <li>- Client #1 would get upset if his mother didn't call him as planned; staff had asked her to let them know if she was not going to call so they could engage Client #1 in an activity to divert his attention.</li> <li>- Client #1's property destruction behaviors had decreased, but still occurred.</li> </ul> <p>Review on 3/21/18 of the Plan of Protection, completed and signed by the Office Manager 3/21/18 revealed:</p> <ul style="list-style-type: none"> <li>- "What immediate action will the facility take to ensure the safety of the consumers in your care?               <ol style="list-style-type: none"> <li>1. Our agency, Spirit of Excellence Community Outreach, Inc. DBA Guardian Care will ensure that we have two staff members present with the consumers at all times during community outings.</li> <li>2. Our agency, Spirit of Excellence Community Outreach, Inc. will ensure that all staff receives a refresher course on maintaining the Health and Safety of the consumers in our care, especially as it pertains to community outings. During this refresher course staff will also review supervision requirements for all of our consumers during community outings and activities. The Qualified Professional will ensure that these trainings are implemented and are addressed during staff Monthly Supervision."</li> </ol> </li> <li>- "Describe your plans to make sure the above happens.               <ol style="list-style-type: none"> <li>1. Residential Facility Schedules will be modified to reflect two staff members for community outings.</li> <li>2. We will Schedule Immediate Refresher Course for Health, Safety, and Supervision of the consumers in our care.</li> <li>3. Any staff that will be found non-compliant with maintaining the Health and Safety of the consumers in our care and by not providing adequate supervision will receive immediate</li> </ol> </li> </ul>	V 112		

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V 112	<p>Continued From page 11</p> <p>disciplinary actions, and could be reviewed for termination."</p> <p>Client #1 is a 26 year old male with a known pattern of inappropriate behaviors, including public masturbation, inappropriately touching young children, intimidation of females, elopement, property destruction and physical aggression. On the morning of December 23, 2017, Client #1 was at the local laundromat with Staff #1 and a peer when he was asked to go outside unsupervised to retrieve needed supplies from the facility vehicle. While he was outside, a young girl witnessed Client #1 masturbating. Staff report Client #1's behaviors of public masturbation and elopement have occurred several times in the last six months, though there is no documentation to support their reports. Statements included in Client #1's Individual Support Plan dated 3/01/18 indicate that his behaviors have increased in last year. The failure to develop and implement strategies to address (1) increasing episodes of public masturbation; (2) precautions when in the community where children may be present, and the failure to supervise Client #1 at all times when in the community, put Client #1 at risk to commit criminal acts, and subsequently subject Client #1 to serious legal consequences. This deficiency constitutes a type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$2000 is imposed. If the violation is not corrected within 23 days, an additional penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.</p>	V 112		
V 118	27G .0209 (C) Medication Requirements	V 118		

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V 118	<p>Continued From page 12</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to follow the written order of a physician and failed to keep the MARs current affecting 1 of 2 audited clients (#2). The</p>	V 118		

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V 118	<p>Continued From page 13</p> <p>findings are:</p> <p>Review on 3/20/18 of client #2's record revealed: -57 year old female admitted 1/2/13. -Diagnoses included schizoaffective disorder, unspecified; mild intellectual disabilities; diabetes type 2; and, disorder of the kidney and ureters, unspecified. -Order dated 7/26/17 and 3/16/18 for Flonase 50 mcg (micrograms) nasal spray, 2 sprays daily. (Used to treat seasonal and year-round allergy symptoms such as stuffy/runny nose, itching, and sneezing.) -Order dated 7/26/17 for Trazodone 50 mg (milligrams), take 1 to 2 tablets at bedtime. (Used to treat depression. It may help to improve your mood, appetite, and energy level as well as decrease anxiety and insomnia related to depression.) -No order to clarify when to administer 1 or 2 tablets of Trazodone 50 mgs at bedtime. -Trazodone order was increased on 1/11/18 to 150 mg at bedtime.</p> <p>Review on 3/20/18 of client #2's MARs from 12/1/17-3/19/18 revealed: -Trazodone 50 mg was documented from 12/1/17 - 1/11/18. There was no documentation if 1 or 2 tablets had been administered. -Flonase 2 sprays was documented daily.</p> <p>Observations on 3/20/18 at 12:30pm of client #2's medications on hand revealed: -3 bottles of Flonase on hand. -The label on the Flonase bottle currently in use read it had been dispensed 11/14/16 and should have been discarded by 11/14/17. The bottle was approximately 2/3 full. The label read it contained 120 metered sprays, which would equal the number of sprays administered every 60 days if</p>	V 118		

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V 118	<p>Continued From page 14</p> <p>administering 2 sprays daily. -There were 2 unused bottles of Flonase on hand with dispense dates 9/5/17 and 11/21/17. Each appeared to be full.</p> <p>Interview on 3/20/18 Staff #2 stated: -They had been told to give 2 Trazodone 50mg tablets to client #2 if she had a restless day, and 1 Trazodone 50 mg tablet if she had a normal day. They did not record if they gave 1 or 2 tablets. -She could not explain why they were still using a bottle of Flonase that had been dispensed more than a year prior.</p> <p>Due to the failure to accurately document medication administrations it could not be determined if clients received their medications as ordered by the physician.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 118		
V 366	<p>27G .0603 Incident Response Requirments</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures</p>	V 366		

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V 366	<p>Continued From page 15</p> <p>to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as</p>	V 366		



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V 366	Continued From page 16  follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and	V 366		

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V 366	<p>Continued From page 17</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement a policy governing their response to Level II incidents, including developing and implementing corrective measures and measures to prevent similar incidents. The findings are:</p> <p>Review on 3/21/18 of the Licensee's "Critical Incident Reporting" policy, revised/reviewed and approved on 7/09/15 revealed:</p> <ul style="list-style-type: none"> <li>- "Purpose: To assure immediate documentation and reporting to proper supervisors when an overwhelming, abnormal incident occurs. This policy and procedure will assure immediate response to critical incidents."</li> <li>- "Policy: 1. The agency will maintain a system for reporting and follow-up of incidents. The incident report serves to: a. Prevent Critical Incidents from occurring b. Detect problems early c. Provide a mechanism to prevent future problems d. Provide for trending of incidents. 1. All unusual events must be reported as well as any other occurrences presenting risks to Consumers."</li> <li>- "Definition A critical Incident* is defined as a stress experienced due to an event, which overwhelms the individual's normal coping mechanism, rendering the person ineffectual. some examples of critical incidents include abuse and neglect, death of a Consumer, attempted suicide or suicide, injury/illness, sexual assault,</li> </ul>	V 366		

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V 366	<p>Continued From page 18</p> <p>mental health crisis, drug/alcohol overdose, medication errors, use of seclusion and restraint, aggressive/violent behaviors, sentinel events, use or possession of weapons, elopement or wandering, vehicular accidents, biohazard accidents, use or possession of illicit or licit substances, fire/explosion with injuries or significant damage, natural disasters, infectious diseases/control, communicable diseases, and any other designated emergencies."</p> <p>- "Type I incidents: are to be documented on an Incident Response form (that can be printed from the website <a href="https://iris.dhhs.state.nc.us">https://iris.dhhs.state.nc.us</a>). Once completed the form is maintained at the [Licensee's] office and is not submitted in IRIS [Incident Response Improvement System]. A written summary of the Incident may also serve as documentation for the incident that occurred."</p> <p>- "2. The Clinical Supervisor and the reporting staff member will review and sign the Incident Report Form and follow-up with the Consumer or his or her legal representative for debriefing within (48) hours. Remedial education may be required to prevent repeated incidents."</p> <p>- ". . . 5. Providers should also notify all other appropriate agencies (such as any accrediting or regulatory agencies) as required by all governing rules or statues, including federal requirements."</p> <p>- "6. A summary of the Incident Reports should go to the Board of Directors who will review the report recommendations and make any adjustments necessary to prevent the issue from recurring in the future."</p> <p>- "Type II and III incidents are to be submitted in IRIS (Incident Response and Reporting System)."</p> <p>Review on 3/21/18 of Licensee memoranda "Subject: Incident Report/[Client #1]" dated 12/23/17, 1/02/18, and 1/11/18, and signed by Staff #1 revealed:</p>	V 366		

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V 366	<p>Continued From page 19</p> <p>- "On Saturday December 23, 2017 at 11:00 am we went to the laundromat at [local shopping center] to do our weekly laundry. Along with [Client #1] was myself [Staff #1] and another consumer. We were all inside the laundromat washing their clothes in the machines. . . We all went to the laundromat attendant to get some change for the dryer. We left our dryer sheets in the truck, [Client #1] said that he would go and get them out of the truck. while he went to the truck, we continued putting the clothes into the dryer. After a few moments, the laundry attendant approached us and stated that [Client #1] was in the truck masturbating in front of a little girl. I immediately rushed out of the truck to [Client #1] and to find out what was going on. The little girl told her mother and her mother in turn told the laundry attendant. The laundry attendant told me that the little's girl mother wanted to contact the police department. I informed the attendant we are truly sorry and will never return back to the establishment again. The attendant didn't contact the police. I gathered all of our clothes and we left the laundromat immediately."</p> <p>- "Date: January 02, 2018 . . . On Tuesday night at 8:30 pm, I received a phone call from the staff at the group home that [Client #1] left the facility. The staff stated that [Client #1] was watching television in the common are and was caught masturbating. He was told to stop in that area and that he could do so in his bedroom. [Client #1] became agitated and told the staff that he was leaving. I advised the staff to stay with the other consumer in the home and I will go assist with [Client #1]. I located [Client #1] on [nearby road], pulled over and asked him why he left the group home. He told me that he became upset. I advised [Client #1] I knew what happened and he had the option of going to his bedroom but in the</p>	V 366		

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V 366	<p>Continued From page 20</p> <p>common areas he can't masturbate. [Client #1] stated he knew that he was wrong and the staff was right but he didn't want to stop at the time. I discussed with [Client #1] the reasons why he can't masturbate in public/common areas and the consequences of such behavior. . . . "</p> <p>- "Date: January 11, 2018 . . . At 6:30 pm I received a phone call from the group home staff that [Client #1] had left the group home. I informed the staff that I would come out and attempt to locate [Client #1]. . . . I found [Client #1] near the corner of [nearby roads]. I asked him why he left the group home, he told me that he was upset because I had promised him that I would pick him up at five' o clock and I didn't. . . .</p> <p>. Upon returning to the group home [Client #1] again became agitated and started breaking things in the kitchen area. He broke some kitchen ornaments and tried to bust the kitchen windows. At that point were able to calm him down and get him to go to his bedroom."</p> <p>- No documentation of review by the Clinical Supervisor or the Board of Directors, no documentation of corrective measures or measures to prevent similar incidents in the future.</p> <p>Review on 3/20/18 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level II or Level III incidents submitted by the facility 12/01/17 - 3/19/18.</p> <p>Interview on 3/21/18 the Qualified Professional stated:</p> <p>- He and another staff were responsible for entering Level II and Level III incidents into IRIS.</p> <p>- He had not made any IRIS entries in the last 3 months.</p> <p>- He could not remember the specifics of the incidents that occurred on 12/23/17, 1/02/18, or</p>	V 366		

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V 366	Continued From page 21  1/11/18 because he didn't have his notes in front of him. - Client #1's behavior plan had been reinforced with staff following the incident that occurred on 12/23/17.	V 366		
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	V 367		

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V 367	<p>Continued From page 22</p> <p>day whenever:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(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:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in</p>	V 367		

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V 367	<p>Continued From page 23</p> <p>the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to submit a Level II incident report on the form provided by the Secretary within 72 hours as required. The findings are:</p> <p>Review on 3/20/18 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level II or Level III incidents submitted by the facility 1/01/18 - 3/19/18.</p> <p>Review on 3/20/18 of Client #1's record revealed: - 26 year old male, admitted to the facility June 2009. - Diagnoses of Moderate Intellectual/Developmental Disability, Intermittent Explosive Disorder, Mood Disorder, not otherwise specified, Oppositional Defiant Disorder. - Documentation of behaviors including public masturbation, elopement, property destruction, inappropriate comments and intimidation of females, and physical aggression.</p> <p>Review on 3/21/18 of Licensee memoranda "Subject: Incident Report/[Client #1]" dated 12/23/17, 1/02/18, and 1/11/18, and signed by Staff #1 revealed:</p>	V 367		



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V 367	<p>Continued From page 24</p> <p>- "On Saturday December 23, 2017 at 11:00 am we went to the laundromat at [local shopping center] to do our weekly laundry. Along with [Client #1] was myself [Staff #1] and another consumer. We were all inside the laundromat washing their clothes in the machines. . . We all went to the laundromat attendant to get some change for the dryer. We left our dryer sheets in the truck, [Client #1] said that he would go and get them out of the truck. while he went to the truck, we continued putting the clothes into the dryer. After a few moments, the laundry attendant approached us and stated that [Client #1] was in the truck masturbating in front of a little girl. I immediately rushed out of the truck to [Client #1] and to find out what was going on. The little girl told her mother and her mother in turn told the laundry attendant. The laundry attendant told me that the little's girl mother wanted to contact the police department. I informed the attendant we are truly sorry and will never return back to the establishment again. The attendant didn't contact the police. I gathered all of our clothes and we left the laundromat immediately."</p> <p>- "Date: January 02, 2018 . . . On Tuesday night at 8:30 pm, I received a phone call from the staff at the group home that [Client #1] left the facility. The staff stated that [Client #1] was watching television in the common are and was caught masturbating. He was told to stop in that area and that he could do so in his bedroom. [Client #1] became agitated and told the staff that he was leaving. I advised the staff to stay with the other consumer in the home and I will go assist with [Client #1]. I located [Client #1] on [nearby road], pulled over and asked him why he left the group home. He told me that he became upset. I advised [Client #1] I knew what happened and he had the option of going to his bedroom but in the</p>	V 367		

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V 367	<p>Continued From page 25</p> <p>common areas he can't masturbate. [Client #1] stated he knew that he was wrong and the staff was right but he didn't want to stop at the time. I discussed with [Client #1] the reasons why he can't masturbate in public/common areas and the consequences of such behavior. . . . "</p> <p>- "Date: January 11, 2018 . . . At 6:30 pm I received a phone call from the group home staff that [Client #1] had left the group home. I informed the staff that I would come out and attempt to locate [Client #1]. . . . I found [Client #1] near the corner of [nearby roads]. I asked him why he left the group home, he told me that he was upset because I had promised him that I would pick him up at five' o clock and I didn't. . . . Upon returning to the group home [Client #1] again became agitated and started breaking things in the kitchen area. He broke some kitchen ornaments and tried to bust the kitchen windows. At that point were able to calm him down and get him to go to his bedroom."</p> <p>Interview on 3/21/18 the Qualified Professional stated:</p> <ul style="list-style-type: none"> <li>- He and another staff were responsible for entering Level II and Level III incidents into IRIS.</li> <li>- He had not made any IRIS entries in the last 3 months.</li> <li>- He could not remember the specifics of the incidents that occurred on 12/23/17, 1/02/18, or 1/11/18 because he didn't have his notes in front of him.</li> </ul>	V 367		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p> <p>(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly</p>	V 736		

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V 736	<p>Continued From page 26</p> <p>manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the Licensee failed to maintain the facility in a safe, clean and attractive manner. The findings are:</p> <p>Observation of the facility on 3/20/18 at approximately 10:40 am revealed:</p> <ul style="list-style-type: none"> <li>- Food particles and crumbs on the floor under and around the dining room table.</li> <li>- Dark splatter stains, that appeared to be a dried liquid, on the dining room blinds.</li> <li>- Painted wall surfaces in the dining room were scuffed.</li> <li>- Artificial plants and flowers and other decor on top of the dining room cornice was visibly dusty.</li> <li>- The outside of the trash can in the kitchen was dirty and had dried liquid streaks on the outside surface.</li> <li>- Dried food splatters inside the microwave.</li> <li>- Food splatters and stains on the wall behind the stove.</li> <li>- Dark spots on the ceiling above the sink and the stove.</li> <li>- The canisters beside the stove were sticky to the touch.</li> <li>- Water standing in the bottom of the dishwasher.</li> <li>- Objects that appeared to be dead insects inside the kitchen light fixture.</li> <li>- A hole, approximately 4 inches in diameter and a crack approximately 8 - 10 inches in diameter in Client #1's bedroom wall.</li> <li>- The drywall in Client #1's bedroom wall was scuffed and torn.</li> <li>- The wall at the head of Client #1's bed had a dark, greasy stain covering a large area.</li> </ul>	V 736		

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V 736	<p>Continued From page 27</p> <ul style="list-style-type: none"> <li>- The pillows on Client #1's bed were heavily stained and very dingy and dirty looking.</li> <li>- Client #1's mattress had visible dark stains.</li> <li>- The ceiling in Client #1's bedroom was visibly dusty.</li> <li>- The ceiling fan in Client #1's bedroom was visibly dusty.</li> <li>- There was no door on Client #1's closet.</li> <li>- The ceiling fan in Client #2's bedroom was visibly dusty.</li> <li>- Rails for a hospital bed were stored on the floor in Client #2's bedroom.</li> <li>- The toilet seat in Client #2's private bathroom was loose and moved freely.</li> <li>- The wallpaper in the hallway was peeling away from the walls at the seams.</li> <li>- The air filter in the ceiling register in the hallway was dirty and needed to be replaced.</li> <li>- The air register in the hallway ceiling was rusty.</li> <li>- Water standing on the floor in the hall bathroom.</li> <li>- Damage to the bathroom door at the doorknob.</li> <li>- Brown smeared stain on the molding inside the bathroom door.</li> <li>- Broken wooden magazine rack on the bathroom wall.</li> <li>- Broken wooden toothbrush rack on the bathroom wall by the sink.</li> <li>- Damage to the wall behind the toilet at the floor next to the bathtub.</li> <li>- A corner of the metal threshold in the living room, near the back door, was raised slightly and presented a safety hazard.</li> <li>- Unfolded clothing was piled haphazardly on a shelf in the laundry room.</li> <li>- A mattress was propped against the wall on the patio outside the living room.</li> </ul> <p>Interview on 3/20/18 Staff #2 stated:</p> <ul style="list-style-type: none"> <li>- Client #1 would hit his bedroom wall when he was angry or couldn't have his way.</li> </ul>	V 736		

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V 736	Continued From page 28 <ul style="list-style-type: none"> <li>- The hole in Client #1's bedroom wall had been there approximately 2 weeks.</li> <li>- A similar hole had been repaired, but Client #1 hit and damaged the wall again.</li> <li>- Client #1 had caused the stains to his bedroom wall by moving around in his bed.</li> <li>- Client #1 repeatedly masturbated into his pillows.</li> <li>- The bed rails in Client #2's bedroom went to her bed.</li> <li>- Client #1 used the hall bathroom.</li> <li>- The mattress was on the back porch because Client #1 had urinated on it; the stains on the mattress on his bed were caused by him urinating and masturbating.</li> <li>- The mattress on his bed had been purchased "6 or 7 months ago"; they alternated use of the two mattresses on Client #1's bed until the one on the patio got rained on.</li> <li>- They had purchased plastic covers for use on Client #1's mattress, but he tore them up.</li> <li>- All of Client #1's clothing was stored in the laundry room because he would tear it up and clog the toilet with it.</li> <li>- They did not use the dishwasher.</li> </ul>	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures  10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit.	V 752		

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V 752	<p>Continued From page 29</p> <p>This Rule is not met as evidenced by: Based on observations and interview, the facility failed to maintain water temperatures between 100 and 116 degrees Fahrenheit in areas where clients are exposed to hot water. The findings are:</p> <p>Observation on 3/20/18 at approximately 10:40 am revealed:</p> <ul style="list-style-type: none"> <li>- The temperature of the hot water in the kitchen sink was 120 degrees Fahrenheit.</li> <li>- The temperature of the hot water in the bath tub in Client #2's private bathroom was 120 degrees Fahrenheit.</li> </ul> <p>Interview on 3/20/18 Staff #2 stated she would make sure the facility's maintenance staff were notified of the hot water temperatures.</p>	V 752		