STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040006	A. BUILDING: _____ B. WING _____	R-C 08/01/2018

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HOPEWELL	292 DOGWOOD LANE SNOW HILL, NC 28580

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on August 1, 2018. One complaint was substantiated (intake #NC00141220) and one complaint was unsubstantiated (intake #NC00140333). Deficiences were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children.	V 115		

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V 115	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide supervision to ensure the safety and welfare for three of four audited clients (#3,#4, #5). The findings are: Review on 8/01/18 of client #3's record revealed: - 22 year old male. - Admission date of 10/06/17. - Diagnoses of Schizoaffective Disorder, Bipolar Type, Mild Intellectual Disability, Cannabis Use, Attention-Deficit/Hyperactivity Disorder, and Explosive Behaviors. Review on 8/01/18 of Individual Support Plan for client #3 dated 1/30/18 revealed the following: - He "needs monitoring while interacting with peers." - He requires assistance to help avoid "inappropriate actions to include invading others space, interrupting, sexual actions or conversation, personally intrusive conversation and explicit language." Review on 07/31/18 of client #4's record revealed: - 36 year old male. - Admission date of 10/11/11. - Diagnoses of Schizoaffective Disorder-Bipolar Type, Insomnia, Seizure Disorder, Mild Intellectual Developmental Disability, Gastroesophageal Reflux Disease and Vitamin D Deficiency. Review on 08/01/18 of Individual Support Plan for client #4 dated 03/01/18 revealed the following:	V 115		

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V 115	Continued From page 2 - He "takes meds for behaviors and agitation" - He has "history of elopement and frequent agitation." - He requires "24 hour monitoring to assist him with maintaining his health/safety due to history of vehicle thefts, self-injurious behaviors, and frequent elopement attempts." - He will "attempt to elope, refuse to work, make false statements against others/staff, attempt to harm himself" and can be"very oppositional defiant when he cannot have what he requests." - He may be "agitated by others which may result in assault and increased attempts of elopement." - He requires assistance with managing "health concerns due to schizophrenia." - He requires support to "prevent/manage behaviors or conditions that could harm himself or others." - He requires support due to "history of frequent elopement attempts, threats to harm himself when he cannot get his requests, as well as vehicle theft." - He requires support for "safety" and "medications." - He has made minimal progress over past year coping with behaviors, remaining on task, reduced elopement, not taking keys and reducing episodes of paranoia. - He continues to "need individual support to reduce episodes of paranoia and frequent hallucinations." Review on 8/01/18 of client #5's record revealed: - 39 year old male. - Admission date of 10/11/11. - Diagnoses of Intermittent Explosive Disorder, Moderate Intellectual Developmental Disability and Seizure Disorder. Review on 8/01/18 of Individual Support Plan for	V 115		

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V 115	Continued From page 3 client #5 dated 4/01/18 revealed the following: - He "can be extremely impulsive" and his "judgement is somewhat impaired at times." - He requires "monitoring support to participate in desired activities because of past difficulties with anger control and anxiety." - He has a history of "extreme expressions of anger, often to the point of uncontrollable rage, that are disproportionate to the situation at hand." - He has a "history of throwing or breaking objects." - He has a "history of aggressive verbal and physical behavior." - He has "difficulties with following directions and rules without assistance or reminders." - He has a "history of poor impulse control, insight, and judgement." - He requires "support to prevent, manage or provide therapy for behaviors that can potentially cause physical harm." - He has a history of assault on two residential staff in which he pulled a knife and proceeded to "choke another staff by wrapping my hands around the staff neck." - He will "sometimes cuss, make threats, throw objects, and flip over tables when becoming angry." - He has been admitted to the hospital in the past for violent behaviors." Review on 8/01/18 of the facility staff schedule for July and August 2018 revealed: - Monday thru Friday - 2 staff were scheduled to be in the facility until 9pm. From 9pm until 7am only 1 staff was present at the facility. - Saturday and Sunday - 1 staff was scheduled from 3pm until 11pm. Interview on 08/01/18 the Facility Scheduler stated:	V 115		

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V 115	Continued From page 4 - She had recently taken over the scheduling duties. - She had kept the staffing pattern the same at the facility, 1 staff after 9pm Monday thru Friday. - She had 1 staff scheduled from 3pm until 11pm on Saturdays and Sundays. Interview on 08/01/18 the Director of Operations stated: - There should be 2 staff during awake hours at the facility. - He would follow up to ensure enough staff were at the facility for adequate supervision.	V 115		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (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. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (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. (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: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug;	V 118		

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V 118	Continued From page 5 (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications on the written order of a physician affecting one of four audited clients (#4). The findings are: Review on 07/31/18 of client #4's record revealed: - 36 year old male. - Admission date of 10/11/11. - Diagnoses of Schizoaffective Disorder-Bipolar Type, Insomnia, Seizure Disorder, Mild Intellectual Developmental Disability, Gastroesophageal Reflux Disease and Vitamin D Deficiency. - The last available lab work was completed on 06/13/18. Review on 08/01/18 of Individual Support Plan for client #4 dated 03/01/18 revealed the following: - He "takes meds for behaviors and agitation" - He has "history of elopement and frequent agitation." - He requires "24 hour monitoring to assist him with maintaining his health/safety due to history of vehicle thefts, self-injurious behaviors, and frequent elopement attempts." - He will "attempt to elope, refuse to work, make	V 118		

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V 118	Continued From page 6 false statements against others/staff, attempt to harm himself" and can be"very oppositional defiant when he cannot have what he requests." - He may be "agitated by others which may result in assault and increased attempts of elopement." - He requires assistance with managing "health concerns due to schizophrenia." - He requires support to "prevent/manage behaviors or conditions that could harm himself or others." - He requires support due to "history of frequent elopement attempts, threats to harm himself when he cannot get his requests, as well as vehicle theft." - He requires support for "safety" and "medications." - He has made minimal progress over past year coping with behaviors, remaining on task, reduced elopement, not taking keys and reducing episodes of paranoia. - He continues to "need individual support to reduce episodes of paranoia and frequent hallucinations." Review on 08/01/18 of client #4's electronically signed physician orders dated 06/28/18 revealed: - Clozapine (used to treat severe schizophrenia, or to reduce the risk of suicidal behavior in people with severe schizophrenia or similar disorders) 25 milligrams (mg) - take 2 tablets (50mg) twice daily. - Clozapine 100mg - take 2 tablets (200mg) twice daily. Review on 08/01/18 of client #4's July 2018 MAR revealed the following: - Clozapine 25mg - take 2 tablets (50mg) twice daily (8am and 6pm). - Clozapine 100mg - take 2 tablets (200mg) twice daily (8am and 6pm).	V 118		

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V 118	Continued From page 7 - The transcribed Clozapine entries had "D/C (discontinue)" handwritten and a line drawn on the MAR from 07/15/18 thru 07/31/18 for 8am and 6pm. No staff initials to indicate the Clozapine was administered as ordered. Review on 08/01/18 of a facility pharmacy transmittal for client #4 dated 06/28/18 revealed: - "We can not fill Colzapine until lab work is provided so it can be logged into the REMS program (A REMS is a strategy to manage known or potential risks associated with a drug or group of drugs, and is required by the FDA (Food and Drug Administration) for clozapine to ensure that the benefits of the drug outweigh the risk of severe neutropenia (low white blood cells)." Interview on 07/31/18 client #4 stated: - He had resided at the facility for many years. - He had been treated for seizures a couple of months ago. - He had no concerns at the facility. Interview on 08/01/18 Staff #12 stated: - He had worked for the agency for over 4 years. - He had been the lead staff at the facility for the past 3 or 4 days. - He had taken client #4 to a neurological appointment recently and did not think client #4 was getting his medications properly. - Client #4 seemed to act differently and he was concerned about his well-being. - He had transported the clients from the facility to the day program on 07/31/18 and client #4 ran away from the van. This is a normal behavior for client #4. Interview on 08/01/18 the Medical Assistant stated:	V 118		

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V 118	Continued From page 8 - Client #4 was currently out of his Clozapine due to no current lab work. - The pharmacy staff had indicated client #4 needed a neurological test and lab work before the Clozapine could be dispensed. - She was not sure why client #4 had not had lab work completed prior to running out of the Clozapine. - Client #4 was at the doctor today to get a neurological test and lab work. This would allow the pharmacy to continue the medication. - The previous medication assistant would have been the person to ensure labs were scheduled and completed. - She had contacted client #4's Psychiatrist and he did not want the Clozapine discontinued. Interview on 08/01/18 the Qualified Professional stated: - She had worked at the facility for approximately two months. - She was not aware of any missed medications at the facility. - The Medical Assistant handled the medications and MARs. Interview on 08/01/18 the Director of Operations stated: - He was concerned about client #4 missing his medication. - There had been a similar episode at a sister facility. - He was in the process of hiring some medical professional to assist with medication issues. - Client #4 was at a doctor appointment today and Clozapine would be restarted. - He would follow up on the identified medication issue. Review on 08/01/18 of the Plan of Protection	V 118		

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V 118	Continued From page 9 dated 08/01/18 and completed by the Director of Operations revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? Our Agency Identified this deficiency yesterday and Immediately began working to get the med (medication) filled. We found this through internal audit. In that audit it was identified all other standing orders in the house are filled [and] present. We will immediately go onsite for another review to ensure this is the case. - Describe your plans to make sure the above happens. 2 Admin (Administrative) staff will go onsite at Hopewell to ensure all standing orders are filled [and] present in the home. A report will be submitted to the Director of Operations after the audit is conducted." Client #4 had a diagnosis of Schizoaffective Disorder-Bipolar Type for which he was prescribed Clozapine by his psychiatrist. This required monthly lab work to monitor for white blood count. His behaviors included elopement, frequent agitation, self injurious behaviors, and vehicle theft. Facility staff did not schedule him to have lab work in July which resulted in the pharmacy being unable to fill his order on 7/14/18. Because of the above failures, client #4 was without his prescribed Clozapine for 17 days, placing him at a substantial risk of serious harm. This deficiency constitutes a Type A2 rule and must be corrected within 23 days. No administrative penalty has been assessed. If the violation is not corrected within 23 days, an administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		

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V 521	Continued From page 10	V 521		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further	V 521		

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V 521	Continued From page 11 authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the necessary documentation was in the client record when a restrictive intervention was utilized affecting one of four audited clients (#2). The findings are: Review on 08/01/18 of client #2's record revealed: - 26 year old male. - Admission date of 05/04/12. - Diagnoses of Intermittent Explosive Disorder, Impulse Control Disorder, Moderate Intellectual Disabilities, Hypertension, Hyperlipidemia, Tachycardia, Hypothyroidism, Obesity, and Vitamin D Deficiency. Review on 08/01/18 of a North Carolina Incident Response Improvement System (IRIS) report for client #2 revealed: - Date of incident: 06/06/18. - Time of incident: 5:46pm. - Report documented a restrictive intervention was implemented. - Provider Comments: "On 6.6.18 around 5:46 pm during or alittle after supper, the member (client #2) begin attacking other peers for no apparent reason. One of the higher functioning members intervened to prevent him from attacking others when the member attempted to attack another peer when the peer struck him in the face several times to keep him from attacking. Staff were able to intervene and separate everyone while getting the member to his room (one attacking others). Once in his room he did attempt to hit staff and was blocked as staff stepped away from the member and closed the door to his room. No	V 521		

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V 521	Continued From page 12	V 521		

other incident was reported for the remainder of the evening. It should be noted that he also engage in periods of head banging along with his physical aggression directed towards peers. The next morning on 6.7.2018 the member got up and was agitated again with the House manager. But he was redirected without further incident then. Upon arrival at the Day program staff noticed member was lethargic slight puffiness around his jaw area. EMS (Emergency Medical Services) was contacted and checked his blood pressure and expressed concerns regarding his low blood pressure count. The member was taken to [Local Hospital] for further assessment whereby it was discovered that the member has a dislocated jaw. Clinical Director spoke with hospital personnel and provided them with information regarding his behavioral outburst and attacking other members. Clinical Director also spoke with Guardian and Care Coordinator regarding the incident and provided them with information as well. As a result of the discovery, the medical personnel sought approval from the guardian to perform surgery. Hospital personnel reached out to the Clinical Director and inquired if he would be returning to Licensee (Ambleside) upon recovery which the response was yes."
- "Describe the cause of this incident, (the details of what led to this incident). Member attacked other peers without provocation and one of the peers struck him on the side of his face several times to prevent form being attacked."
- "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Consultation with psychiatrist while recovery from injury. Continue staffing pattern of 2 staff in the home during the day and evening shifts. Staff person must be positioned in all

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V 521	Continued From page 13	V 521		

areas of the home while member is present and awake to intervene as needed."
- No documentation of type of restrictive intervention, the length of intervention or debriefing with staff and client #2.

Review on 8/01/18 of hand-written shift log by staff #11 revealed:
- Date of incident: 6/06/18
- Report documented a restrictive intervention was implemented.
- "On June 6, 2018 upon coming inside from smoking a cigarette, I noticed (client #2) having a behavior. I to the other individuals involved to remove their selves from the situation. I then restrained [Client #2] while he keep trying to assault staff and individuals. I then put [Client #2] in his room with help from staff. [Client #2] was left in his room per the housing manager."

Review on 8/01/18 of facility incident reporting form by former Clinical Director revealed:
- Date of report: 6/07/18
- Report documented preventive actions and recomended follow up to incident on 6/07/18.
- "QP reminded staff importance of documenting the type of intervention used when client was acting out. Even if the technique is blocking it needs to be documented and not just describing the behavior alone."

Interview on 08/01/18 the Director of Operations stated:
- He understood the staff should complete the required documentation after a restrictive intervention was utilized.
- He would follow up to ensure the proper documentation was completed if a restrictive intervention was implemented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040006	A. BUILDING: _____ B. WING _____	R-C 08/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWELL	292 DOGWOOD LANE SNOW HILL, NC 28580

(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) COMPLETE DATE
V 736	Continued From page 14	V 736		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 07/31/18 at approximately 10:30 am revealed the following: - The side storm door entering facility was damaged and would not close properly. - A resin chair under the carport had a broken right arm rest. - The kitchen stove had a broken handle and one of the four burners did not work. - The door handle latch of door entering Client #4's room was broken. The night stand in Client #4's room had two broken drawers. Client #4's dresser was missing 3 knobs. - The door handle latch of door entering Client #5's room was broken - There was brown discoloration around baseboard of tub and behind toilet in bathroom #1. Discoloration extended approximately 36 inches along tub and approximately 48 inches behind toilet. - The window frame of a window in Client #1's room had crack in top of frame extending approximately 36 inches. There was daylight protruding through the crack.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 736	Continued From page 15 -The lower cabinet door was broken off and missing from Entertainment Center/TV stand of Client #6's room. Interview on 08/01/18 with Director of Residential Services stated: - He would follow up with the repairs needed for the facility. - He had no additional information regarding the repair items discussed at exit. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		