Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-257	A. BUILDING: _____ B. WING _____ DHSR - Mental Health	C 08/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON	215 DARRELL ROAD LA GRANGE, NC 28551

AUG 14 2018
Lic. & Cert. Section

(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 000	INITIAL COMMENTS A follow up and complaint survey was completed on August 1, 2018. The complaints were unsubstantiated (intake # NC00141472 and NC00141475). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities. This Statement of Deficiencies was amended on August 6, 2018, due to a revision to the initial comments to reflect a follow up and complaint survey.	V 000	V112 This ~~issue~~ deficiency Should have been handled by the previous Clinical Director, however he dropped the ball. Because Ambleside believes in Community living for all individuals. We Serve many Individuals who exhibit severe behaviors. Oftentimes. In their initial ISP/treatment plan they often have the 1:1 staff recommendation, which we provide. Too often. as years go by and behavioral frequency reduces, or Clinicians over look the need to revise the ISP so that the 1:1 need is no longer reflected in the plan. This is one of those instances. Cont→	10/1/18
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	V 112		

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V 112	Continued From page 1 provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement strategies based on assessment for 1 of 3 clients (#1). The findings are: Review on 7/31/18 of client #1's record revealed: - 27 year old male admitted to the facility 10/2/15. - Diagnoses included Pervasive Developmental Disorder, not otherwise specified, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder, combined presentation, Bipolar 1 Disorder by history, Borderline Intellectual Functioning, history of medication induced seizures. - "Individual Support Plan" (ISP) effective 10/1/17 included "What Others Need to Know to Best Support Me . . . Life Situation . . . (client #1) engages in self injurious and aggressive behaviors towards other people. . . . He requires one on one staff at all times due to his impulsivity. . . (client #1's) behaviors pose a safety risk to himself and others and therefore he requires one on one support . . . Medical/Behavioral . . . because of his ability to engage in serious maladaptive behaviors and requires one on one supports at all times." - Person Centered Plan effective 10/1/17 included no strategies for 1:1 staffing at the residential facility. - Behavior Plan implemented 10/1/17 included	V 112	In his intensive Review Meeting held on 8/2/18, the Request was made to Client #1's Care Coordinator that the 1:1 Language be removed from his treatment Plan. Client #1's ISP is Scheduled for 8/15/18 (Although this date is tenative). the desire to have the Language edited will be brought up again during this ISP. ~~This~~ We will ensure that this Revision is made no later than 10/1/18, the start of his new plan year. This Project will be completed by the QP who oversees Client #1's Case.	10/1/18

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V 112	Continued From page 2 "Target Behaviors Defined: (Client #1's) behaviors include the following: verbal and physical aggression, biting others, hitting walls, kicking others, yelling using profanity, peer teasing, spitting and property destruction." - No strategy for 1:1 staffing in the residential facility. During interview on 8/1/18 client #1 stated there was usually one staff at the facility with him and two other clients. During interview on 8/1/18 client #3 stated there was one staff at the group home most of the time. Review on 7/31/18 of the Group Home Leader's personnel record revealed he was hired as a paraprofessional 1/19/16. During interview on 8/1/18 the Group Home Leader stated: - He had been the "House Lead" for about a year and a half. - There was usually one staff per shift at the group home. - He was at the group home for a short time in the mornings, would fill in for staff as needed, and if he was called to assist in the event of client behaviors. Review on 7/31/18 staff #1's personnel record revealed title of paraprofessional with a hire date of 7/6/16. During interview on 8/1/18 staff #1 stated: - He had worked at the facility for about two and a half years. - He usually worked third shift and was the only staff present on his shift. - Some of his duties were to wake the clients in	V 112		

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V 112	Continued From page 3 the mornings, prepare their breakfast and make sure they were ready to go to the day program. - Client #1 and client #2 sometimes had behaviors in the mornings. Review on 7/31/18 of staff #3's personnel record revealed title of paraprofessional with a hire date of 6/29/17. During interview on 8/1/18 staff #3 stated: - He usually worked second shift (3:00 pm - 11:00 pm) at the facility. - There was only one staff at the facility for most of the shift; another staff would drop the clients off after the day program and would usually leave after about 30 minutes. - Client #1 was "destructive" and had no specific triggers for his behaviors, "he just goes off." During interview on 8/1/18 the Qualified Professional stated: - She had worked for the Licensee for about a month and a half. - Some of her duties included clinical oversight of the facility, developing short range goals, facilitating person centered planning meetings, and managing the home "as best as possible." - Staffing pattern at the facility was based on the needs of the home and the individuals who lived there. - The "Scheduler" was responsible for ensuring staff coverage at the facility. - She did not develop the current ISPs or the current person centered plans (PCP). - No client required 1:1 supervision at the residential facility. - 1:1 supervision was based on the clients' Supports Intensity Scale (SIS) scores. - A representative from the Local Management Entity completed the SIS.	V 112		

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V 112	Continued From page 4 - "We can't get extra staffing at the home for him because of the SIS score." During interview on 8/1/18 the Director of Operations stated client #1's ISP/PCP meeting was scheduled for 8/2/18 and his behaviors and need for 1:1 supervision in the facility would certainly be discussed.	V 112	V118 In order to ensure all Huntington staff are Competent in medication Admin, all Current Huntington staff will need to re-take the med Admin Course with the new instructor to ensure competency. Additionally, a new section will be added to the employee orientation Process to ensure all new employees have been trained in the proper procedure to let the CMA know about the need for med Refills. In my mind there is no reason an individual should run out of a medication, and we will work diligently to ensure that this does not persist into the future. At this point, the missing (unfilled) medications are present in the Huntington house Cont->	8/30/18
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; (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	V 118		

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V 118	Continued From page 5 file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews the facility failed to ensure medications were administered as ordered by the physician and that medications administered were recorded on each client's MAR immediately after administration affecting 3 of 3 clients (#1, #2, and #3). The findings are: Review on 7/31/18 of client #1's record revealed: - 27 year old male admitted to the facility 10/2/15. - Diagnoses included Pervasive Developmental Disorder, not otherwise specified, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder, combined presentation, Bipolar 1 Disorder by history, Borderline Intellectual Functioning, history of medication induced seizures. - Physicians orders signed 2/21/18 for Peridex .12% Mouth Rinse (used to treat gum disease), swish and spit 10 milliliters (ml) by mouth twice daily, Risperdal (antipsychotic) 2 mg 1 tablet by mouth three times daily, Cogentin (used to treat tremors) 2 mg 1 tablet by mouth twice daily, Klonopin (used to prevent and treat seizures) .5 mg 1 tablet by mouth three times daily in the morning, at noon and at 6 pm, Desyrel 100 mg 1 tablet by mouth at bedtime. - Physician's orders signed 5/8/18 for Thorazine (antipsychotic) 100 mgs (milligrams) 2 tablets by mouth every morning and noon, and Thorazine 100 mgs 3 tablets by mouth at 6 pm. - No physician's order to discontinue or increase	V 118	And are being ~~[illegible]~~ Administered as Written by the ~~Dest~~ physician. The Medication Administration training will be conducted by an RN, the Update to new staff orientation will be developed by the director of Operations and will be implemented by the Ambleside CMA or a QP (If CMA is unavailable). Additionally as an extra measure of prevention, monthly med closet Checks will be done to ensure all prescribed meds are present in the Huntington home. This will be conducted by the Ambleside CMA 8/30/18	

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V 118	Continued From page 6 dosage of Thorazine. - Physician's order for Penlac 8% solution (used to treat fungal infections of fingernails and toenails) apply to nail as directed. - Physician's order dated 7/29/18 for Prilosec (treats reflux) 20 mg 1 tablet by mouth daily. - Physician's order dated 7/5/17 for Miralax (laxative) mix 17 grams in 8 ounces of beverage and drink by mouth every day. Review on 7/31/18 and 8/1/18 of client #1's MARs for May, June, and July 2018 revealed: - Printed transcriptions for Peridex .12% Mouth Rinse, swish and spit 10 ml by mouth twice daily; Risperdal 2 mg 1 tablet by mouth three times daily; Cogentin 2 mg 1 tablet by mouth twice daily, Klonopin .5 mg 1 tablet by mouth three times daily in the morning, at noon, Desyrel 100 mg 1 tablet by mouth at bedtime and at 6 pm; Miralax Powder mix 17 grams in 8 ounces of beverage and take by mouth every day. - Printed transcriptions for Thorazine 100 mg 2 tablets by mouth every morning and at noon, and Thorazine 100 mg 3 tablets by mouth at 6 pm; these entries were highlighted yellow with handwritten notation of "D/C See new order." - Handwritten transcriptions for Thorazine 200 mg 1 tablet by mouth each morning and noon; Thorazine 200 mg 2 tablets by mouth at 6 pm; and omeprazole (generic for Prilosec) 20 mg 1 cap by mouth daily. - Circled staff initials and documentation that Peridex .12% Mouth Rinse was not administered 7/3/18 - 7/30/18, "needs to be refilled." - Circled staff initials and documentation that Miralax was not administered 6/16/18 and 6/17/18, "refused." - No staff initials that the following were administered: - Risperdal 2 pm 7/27/18 and 7/30/18.	V 118		

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V 118	Continued From page 7 - Cogentin 8 pm 7/27/18 - Klonopin 12 noon 7/27/18 and 7/30/18. - Desyrel 7/27/18 and 7/29/18. - Thorazine (200 mg 1 tablet by mouth each morning and noon) 8 am 7/30/18 and 7/31/18, and 12 noon 7/27/18, 7/30/18. - Thorazine (200 mg 2 tablets by mouth at 6 pm) 7/27/18. - Penlac 8% Solution 8 pm 7/29/18. - Prilosec 7/30/18 and 7/31/18. Review on 8/1/18 of client #1's July MAR revealed staff initials had been entered in some of the previously blank date boxes. Observations at approximately 2:20 pm 8/1/18 of client #1's medications revealed: - No Peridex Mouth Rinse available for administration. - Risperdal 2 mg 1 tablet by mouth three times daily, dispensed 7/15/18. - Cogentin 2 mg 1 tablet by mouth twice daily, dispensed 7/15/18. - Klonopin .5 mg 1 tablet by mouth three times daily in the morning, at noon, and at 6 pm, dispensed 7/16/18. - Thorazine 200 mg 1 tablet by mouth every morning and at noon, dispensed 7/15/18. - Thorazine 200 mg 2 tablets by mouth daily at 6 pm, dispensed 7/15/18. - Penlac 8% solution apply topically to affected nail as directed, dispensed 5/29/18. - Prilosec 20 mg 1 tablet by mouth daily, dispensed 7/30/18. - Miralax 3350 powder, mix 1 capful (17 grams) in 8 ounces of beverage and drink as needed, dispensed 2/27/18. During interview on 8/1/18 client #1 stated staff helped him take his medications daily and he had	V 118		

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V 118	Continued From page 8 not missed any medications. Review on 7/31/18 of client #2's record revealed: - 33 year old male admitted to the facility 10/2/15. - Diagnoses included Attention Deficit Hyperactivity Disorder, Delusional Disorder, Intermittent Explosive Disorder, Paranoid Schizophrenia, Moderate Intellectual /Developmental Disability, Seizure Disorder. - Physician's order dated 12/28/17 for Haldol (antipsychotic) 10 mg 1 tablet by mouth three times daily. Review on 7/31/18 of client #2's MARs for May, June, and July 2018 revealed: - Printed transcription for Haldol 10 mg 1 tablet by mouth three times daily. - No staff initials that Haldol was administered 7/27/18 or 5/30/18 at 2 pm, with no explanation documented for the omission. During interview on 8/1/18 client #2 stated staff gave him his medications and he took them every day. Review on 7/31/18 of client #3's record revealed: - 56 year old male admitted to the facility 1/15/97. - Diagnoses included Autism Spectrum Disorder with accompanying language and intellectual impairments, Intermittent Explosive Disorder, Borderline Intellectual Functioning, Hypertension, Obesity, Hyperlipidemia, Sleep Apnea. - Physician's order dated 3/20/18 for Calcium Carbonate (relieves heartburn and acid indigestion) 500 mg 3 tablets by mouth daily "to make 1500 mg." - No physician's order to reduce the dosage or discontinue the Calcium Carbonate. Review on 7/31/18 of client #3's MARs for May,	V 118		

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V 118	Continued From page 9 June, and July 2018 revealed: - Printed transcription for Calcium Carbonate 1250 mg/5 ml take 15 ml (3750 mg) by mouth daily. - No staff initials that Calcium Carbonate was administered 7/28/18 or 7/29/18. Observation at approximately 2:35 pm on 8/1/18 of client #3's medications revealed no Calcium Carbonate available for administration. During interview on 8/1/18 client #3 stated he took his medications daily with staff assistance and he had never missed any medications. During interview on 8/1/18 staff #4 stated the pharmacy was expected to deliver client #1's Peridex that evening. During interview on 8/1/18 the Qualified Professional stated: - She was aware that there had been medication errors prior to her employment. - When she visited the facility she checked the medication closet to make sure the medications were actually given and that the MARs were completed. - She did not have a set schedule to visit the facility and check medications, but was going to develop one. - If she saw inconsistencies or indications of missed medications on the MARs, she would report them to the team lead and to the Program Manager to ensure that they tracked what happened. - The person who did not document medication administration would be contacted and asked if they did give the medication; if they said they did, she would check the bubble card to ensure the medication had been punched out.	V 118		

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V 118	Continued From page 10 - Typically if a medication administration was not documented on the MAR it was because the staff person responsible just neglected to put their initials on the MAR. - There had been "issues" with the previous Certified Medication Assistant; it was "evident that things were not being done correctly." - Because there had been medication errors, the pharmacy had been "brought in to do some heavy duty training for staff." - The pharmacy's nurse trainer was doing observations of medication administration, "that's how we are correcting some of these issues." During interview on 8/1/18 the Director of Operations stated "We are finding out about a lot of things that haven't been done properly in the past and we want to do things correctly and according to the rules. We are making changes." Due to failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted.	V 123		

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V 123	Continued From page 11 . This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to notify the physician or pharmacist of medication errors and refusals for 2 of 3 clients (#1 and #3). The findings are: Review on 7/31/18 of client #1's record revealed: - 27 year old male admitted to the facility 10/2/15. - Diagnoses included Pervasive Developmental Disorder, not otherwise specified, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder, combined presentation, Bipolar 1 Disorder by history, Borderline Intellectual Functioning, history of medication induced seizures. - Physicians orders signed 2/21/18 for Peridex .12% Mouth Rinse (used to treat gum disease), swish and spit 10 milliliters (ml) by mouth twice daily. - Physician's order dated 7/5/17 for Miralax (laxative) mix 17 grams in 8 ounces of beverage and drink by mouth every day. Review on 7/31/18 and 8/1/18 of client #1's MARs for May, June, and July 2018 revealed: - Printed transcriptions for Peridex .12% Mouth Rinse, swish and spit 10 ml by mouth twice daily, Miralax Powder mix 17 grams in 8 ounces of beverage and take by mouth every day. - Circled staff initials and documentation that Peridex .12% Mouth Rinse was not administered 7/3/18 - 7/30/18, "needs to be refilled." - Circled staff initials and documentation that Miralax was not administered 6/16/18 and 6/17/18, "refused."	V 123	V 123 The requirement to notify ~~the~~ the pharmacist of any medication error is currently in written Policy @ Ambleside. It is important our staff are adhering to this Policy. To ensure they do, the following actions will take place. 1) The Ambleside Director of Operations will request the RN (who teaches Med Admin) teach new/existing Staff about the need to call pharmacy when a med error occurs. 8/30/18 2) Poster will be placed on outside ? inside of med Closet Door Alerting Staff to "Call Pharmacy with any/every med error. the number is ..." 3) In the "CMA" Section of the Orientation form, "Understanding of Med error Policy" Must be Signed cont'd →	

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V 123	Continued From page 12 Observations at approximately 2:20 pm 8/1/18 of client #1's medications revealed: - No Peridex Mouth Rinse available for administration. - Miralax 3350 powder, mix 1 capful (17 grams) in 8 ounces of beverage and drink as needed, dispensed 2/27/18. During interview on 8/1/18 client #1 stated staff helped him take his medications daily and he had not missed any medications. Review on 7/31/18 of client #3's record revealed: - 56 year old male admitted to the facility 1/15/97. - Diagnoses included Autism Spectrum Disorder with accompanying language and intellectual impairments, Intermittent Explosive Disorder, Borderline Intellectual Functioning, Hypertension, Obesity, Hyperlipidemia, Sleep Apnea. - Physician's order dated 3/20/18 for Calcium Carbonate (relieves heartburn and acid indigestion and promotes bone health) 500 mg 3 tablets by mouth daily "to make 1500 mg." - No physician's order to reduce the dosage or discontinue the Calcium Carbonate. Review on 7/31/18 of client #3's MARs for May, June, and July 2018 revealed: - Printed transcription for Calcium Carbonate 1250 mg/5 ml take 15 ml (3750 mg) by mouth daily. - No staff initials that Calcium Carbonate was administered 7/28/18 or 7/29/18. Observation at approximately 2:35 pm on 8/1/18 of client #3's medications revealed no Calcium Carbonate available for administration. During interview on 8/1/18 client #3 stated he	V 123	off by the CMA before Staff are able to start working. We believe these procedure Changes will Assist in Ensuring the pharmacist is Called, and it is documented anytime a med error occurs. The next med Admin Class is 8/9/18, and the Director of Operations will Speak to The RN before ~~staff~~ Class to Mention the Ambleside med error policy. The CMA Will ensure the posters are Hung on the door by weeks end, and the Director of Ops. will implement the new orientation Procedure for Staff before the end of August.	8/30/18

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V 123	Continued From page 13 took his medications daily with staff assistance and he had never missed any medications. During interview on 8/1/18 staff #4 stated the pharmacy was expected to deliver client #1's Peridex that evening. No documentation regarding physician or pharmacist notification of medication errors or refusals was available for review. During interview on 8/1/18 the Qualified Professional stated: - She was aware that there had been medication errors prior to her employment. - When she visited the facility she checked the medication closet to make sure the medications were actually given and that the MARs were completed. - She did not have a set schedule to visit the facility and check medications, but was going to develop one. - If she saw inconsistencies or indications of missed medications on the MARs, she would report them to the team lead and to the Program Manager to ensure that they tracked what happened. - The staff who failed to document medication administration would be contacted and asked if they gave the medication; if they said they did, she would check the bubble card to ensure the medication had been punched out. - Typically if a medication administration was not documented on the MAR it was because the staff person responsible just neglected to put their initials on the MAR. - There had been "issues" with the former Certified Medication Assistant; it was "evident that things were not being done correctly." - Because there had been medication errors, the	V 123		

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V 123	Continued From page 14 pharmacy had been "brought in to do some heavy duty training for staff." - The pharmacy's nurse trainer was doing observations of medication administration, "that's how we are correcting some of these issues." - The staff who was administering the medication was responsible for reporting medication errors and refusals to the physician or pharmacist; the staff was also supposed to notify the QP of the medication error or refusal. During interviews on 7/31/18 and 8/1/18 the Director of Operations stated: - He was certain the physician or pharmacist had been contacted regarding medication errors and refusals. - "We are finding out about a lot of things that haven't been done properly in the past and we want to do things correctly and according to the rules. We are making changes."	V 123	V318 Simply put, this will not happen again. At this point, all QPs have been made aware any abuse allegation must be reported to the HCPR through the IRIS System. Failure to report allegations within this time frame Could result in termination. Additionally, all Abuse, neglect. and/or exploitation allegations must be reported to the Director of Operations. He/she will ensure the HCPR has been notified within 24 hours. This Acknowledgement & Additional Layer of Supervision should prevent any future deficiencies in this area.	8/10/18
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).	V 318		

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V 318	Continued From page 15 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report to the Health Care Personnel Registry (HCPR) an allegation of abuse against health care personnel within 24 hours of becoming aware of the allegation. The findings are: Review on 7/31/18 of client #1's record revealed: - 27 year old male admitted to the facility 10/2/15. - Diagnoses included Pervasive Developmental Disorder, not otherwise specified, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder, combined presentation, Bipolar 1 Disorder by history, Borderline Intellectual Functioning, history of medication induced seizures. - "Individual Support Plan" (ISP) effective 10/1/17 included "What Others Need to Know to Best Support Me . . . Life Situation . . . (client #1) engages in self injurious and aggressive behaviors towards other people. . . . He requires one on one staff at all times due to his impulsivity. . . (client #1's) behaviors pose a safety risk to himself and others and therefore he requires one on one support . . . - Behavior Plan implemented 10/1/17 included "Target Behaviors Defined: (Client #1's) behaviors include the following: verbal and physical aggression, biting others, hitting walls, kicking others, yelling using profanity, peer teasing, spitting and property destruction." During interview on 8/1/18 client #1 stated: - He and staff #3 did not get along and they got into a fight "the other night"; he could not remember the date of the incident. - He kicked out a window in his bedroom. - Staff #3 put him in a therapeutic hold. - Client #1 did not give any details of the "fight"	V 318		

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V 318	Continued From page 16 with staff #3. - He did not feel safe at the facility. - Staff accused him of lying and stealing. - He was not known to lie or steal. - A meeting was held but he could not remember what day. - After the meeting he decided to give staff #3 a second chance because he didn't want staff #3 to be fired. - A quarter sized green bruise on his upper right arm was from recent lab work. - Staff #2 took him shopping recently and he got new clothes, they also went to lunch at his favorite Chinese restaurant. - When at the day program staff would take him outside behind the fence and kick him and beat him up. - He reported the staff to the Qualified Professional (QP) and the former Clinical Director. Client #1 was observed to hold his head down and to speak very softly during interview, particularly when asked about the "fight" with staff #3. Review on 7/31/18 of staff #1's personnel record revealed: - Title of paraprofessional, hire date of 7/6/16. - North Carolina Interventions+ (plus) (NCI+)-Restrictive training (parts A & B) 6/8/18. - Training on the Licensee's Abuse/Neglect/Exploitation policy, Abuse/Neglect Reporting Procedure, and Clients Rights 7/6/16. During interview on 8/1/18 staff #1 stated: - He usually worked third shift and was the only staff on shift. - He had not used a restrictive intervention on client #1 in about a year.	V 318		

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V 318	Continued From page 17 - Client #1 reported mistreatment by other staff to him, "but he does that." - Client #1's main complaint about staff was that he was not treated the same as other clients. - Client #1 "will come at us if he doesn't get his way." - The House Lead told him that client #1 alleged that other staff had hit and kicked him and client #1 confirmed the allegation. - He didn't put hands on any client unless he absolutely had no other choice. Review on 7/31/18 of staff #3's personnel record revealed: - Title of paraprofessional, hire date of 6/29/17. - NCI+ Interventions - Restrictive training (parts A & B) 7/2/18. - Training on the Licensee's Abuse/Neglect Policy, Abuse/Neglect Reporting Procedure, and Clients Rights 6/29/17. Interview on 8/1/18 staff #3 stated: - He usually worked second shift (3:00 pm - 11:00 pm) and was the only staff on shift. - Client #1 was "destructive" and had no real triggers, he would "just go off", especially if told to do something he didn't want to do. - He used a restrictive intervention on client #1 on 7/20/18 after he became agitated, physically aggressive and destructive in his bedroom. - He thought the incident occurred because he tried to "enforce the rules" and "provide more structure" than other staff. - Client #1 had reported allegations of abuse to him and he reported them to his House Lead. Review on 7/31/18 of the Group Home Leader's (House Lead) personnel record revealed: - Title of Group Home Leader, hire date of 1/19/16 as a paraprofessional.	V 318		

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V 318	Continued From page 18 - Crisis Prevention Institute (CPI) training 1/10/18. - Training on the Licensee's Abuse/Neglect Policy, Abuse/Neglect Reporting Procedure, and Clients Rights 1/19/16. During interview on 8/1/18 the Group Home Leader stated: - He had been the "House Lead" at the facility for about a year and a half. - He was not present when client #1's most recent incident occurred. - Client #1 "alleges abuse every time he's put in a hold and I always follow up." - His follow up included speaking with staff involved and reviewing incident reports. - The QP did the debriefing after allegations were made. - Allegations against staff occurred frequently, "anytime (client #1) doesn't get his way." - All allegations of abuse were reported to the QP. Review on 8/1/18 of the QP's personnel record revealed: - Hire date of 6/19/18. - NCI Interventions - core + Training (parts A & B + designated optional techniques) 4/16/18. - Training on the Licensee's Abuse/Neglect Policy, Abuse/Neglect Reporting Procedure, and Clients Rights 6/29/18. During interview on 8/1/18 the QP stated: - One of her job responsibilities was to investigate all allegations of abuse. - She made sure the staff named in the allegation was "removed" from the facility. - She was not the person responsible for notifying the HCPR of allegations. - The Director of Operations or the Human Resources Manager would make the notification.	V 318		

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V 318	Continued From page 19 - She felt certain the Director of Operations had notified the HCPR of the allegations client #1 made against staff. - The only allegation of abuse she was aware of was made "last week when we sat down with DSS (Department of Social Services)." - "Staff here haven't always been trained appropriately." During interviews on 7/31/18 and 8/1/18 the Director of Operations stated: - They found out about the allegation of abuse on 7/27/18 when DSS came to do an investigation. - The initial report from DSS was that the Group Home Leader was the staff who allegedly abused client #1, but through the interview process, they learned that client #1 stated it was staff #3. - The QP did a revised Incident Response Improvement System (IRIS) report and notified HCPR of the allegation on 7/31/18. - They did not notify HCPR of any allegation until they had completed their internal investigation. - He was not aware of the requirement to notify HCPR of allegations of abuse/neglect/exploitation within 24 hours of learning of the allegation. - Any future allegations would be reported as required.	V 318		
V 366	27G .0603 Incident Response Requirments 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;	V 366		

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V 366	Continued From page 20 (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 to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (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 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (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. (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: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals	V 366		

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V 366	Continued From page 21 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 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	V 366		

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V 366	Continued From page 22 treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document their response to level 1 incidents. The findings are: Refer to Tag v123 for specific details. No level 1 incident reports were available for review on 7/31/18 or 8/1/18. During interview on 8/1/18 the Qualified Professional (QP) stated: - She was aware that there had been medication errors prior to her employment. - When she visited the facility she checked the medication closet to make sure the medications were actually given and that the MARs were completed. - If she saw inconsistencies or indications of missed medications on the MARs, she would report them to the team lead and to the Program Manager to ensure that they tracked what happened. - The person who did not document medication administration would be contacted and asked if they did give the medication; if they said they did, she would check the bubble card to ensure the	V 366	V366 It is already written Policy that all medication errors are to be accompanied by a call to the pharmacist and a Level 1 Incident Report. Much of the procedure changes that will Solve this issue are addressed in the Corrective actions on pages R and B of this report. For example, the RN will be asked to touch base on this Policy During med admin training, Posters With instructions will be placed on the inside of the med Closet Door, and the orientation checklist will include this in the "CMA" Section. In addition to these areas, an additional Safeguard will be put in place. For 2 consecutive weeks Cont. →	

Division of Health Service Regulation

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V 366	Continued From page 23 medication had been punched out. - Typically if a medication administration was not documented on the MAR it was because the staff person responsible just neglected to put their initials on the MAR. - There had been "issues" with the previous Certified Medication Assistant; it was "evident that things were not being done correctly." - Because there had been medication errors the pharmacy had been "brought in to do some heavy duty training for staff." - The pharmacy's nurse trainer was doing observations of medication administration, "that's how we are correcting some of these issues." During interviews on 7/31/18 and 8/1/18 the Director of Operations stated: - He was certain level 1 incident reports had been completed and submitted to the former QP. - He was unable to locate any level 1 incident reports for the facility after extensive searching. - "We couldn't find any level 1 incident reports; I looked for them for 2 hours yesterday and couldn't find them." - "We are finding out about a lot of things that haven't been done properly in the past and we want to do things correctly and according to the rules. We are making changes."	V 366	the Huntington MARs will be Checked daily for med errors. If med errors exist, they must be accompanied by a Level 1 incident Report (call to pharmacy Included). If not Level 1 is sent in, the staff who violated the policy must Come in for ~~re~~ Med error policy training w/ the CMA and/or QP of Huntington. This will be Recorded on an inservice sheet. The offending staff will be removed from the schedule until they Come in for the training. ~~We feel this thought this procedure~~ Also, all Level 1 incidents will be Scanned into a Secured shared folder.	8/30/18