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
	MHL092-795	A. BUILDING: _____ B. WING _____	R 07/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE SKILLS INDEPENDENT CARE #1	800 PERRY HOWARD ROAD FUQUAY VARINA, NC 27526

(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 An Annual, Follow Up and Complaint Survey was completed July 30, 2018. The Complaints were substantiated (Intake #NC00138981 and #NC00139632) Deficieincies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and	V 108	V 108 27G. 0202 Personnel Requirements CPR/ First Aid instructors assisting Director in getting cards through the new verification system within the next 30 days. DHSR-Mental Health AUG 2 7 2018 Lic. & Cert. Section	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rene Whitehead TITLE Director (X6) DATE 8/24/18

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V 108	Continued From page 1 implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 4 of 4 audited staff (#1, #2, #5, #8) had training to meet the needs of the clients. The findings are: Review on 05/22/18 of the facility's personnel records revealed: -Staff #1- hired 09/02/14 -Staff #2- hired 05/04/18 -Staff #5- hired 09/26/14 -Staff #8- hired 09/27/13 A. Review on 05/22/18 of the facility's personnel records for staff #1, #2, #5 and #8 revealed: -No documentation of training regarding gangs (Note: Refer to tag V112 for specific details regarding the treatment plan not addressing gang association for the clients #1, #2 and DC #3 and incident of eyebrow slits during a visit to the Barber.) During interview on 07/06/18, the Director reported: -Years prior, a training had been completed for gangs by a local company...within the past few years, no training on gangs had been completed B. Review on 05/22/18 of the facility's personnel	V 108	*	

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V 108	Continued From page 2 records for staff #1 and #2 revealed: -A filled in test for (cardiopulmonary resuscitationcardiopulmonary resuscitation) CPR/First Aid, however, no scoring noted -No certificates or evidence to support if staff passed training for CPR/First Aid During interview on 06/07/18, staff #1 and staff #2 indicated they worked together the night of 05/13/18 During interview on 07/22/18, the Qualified Professional reported: -A nurse served as instructor for CPR/First Aid...she had not provided the certificates or cards for completion of CPR/First Aid	V 108		
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	V 112	V112 27G. 0205 (C-D) Director and Licensed Professional are exploring risk assessment tools that will all LCI to determine challenging behaviors of potential clients. This tool will be identified within the next 30 days. QP will educate staff on new consumers as they enter the program and follow up with a staff meeting to assure understanding of the clients identified behaviors. On-going LP and QP will review the clients' PCP plan to assure there are adequate goals to address the client's needs and update plans in the next CFT meeting with team. On-going Director and QP will contact local law enforcement to set up a training on gang awareness within the next 30 days.	

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V 112	Continued From page 3 (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. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to develop and implement strategies in the treatment plans of two of two clients (#1-#2) and deceased client (DC #3). The findings are: Review on 05/22/18 of client #1's record revealed: -Admitted: 03/29/18 -Diagnoses: Conduct Disorder, Adolescent Onset type, Cannabis Use Disorder (Mild) and Intellectual Developmental Disability (Mild) -Age 14 -Admission Assessment dated 03/29/18 completed by the group home indicated charged with felony breaking & entering, possession of stolen property (01/27/16 & 02/04/16)...2012 for injury to real property..involvement in the juvenile justice system for probation...more than 25 juvenile detention lock ups -Treatment plan dated 03/07/18: Goals-develop appropriate coping skills in order to decrease aggressive behaviors, decrease use of substances, comply with rules and expectations of the group home and reduce issues at school by maintaining passing grades Review on 05/22/18 of client #2's record	V 112	*	

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V 112	Continued From page 4 revealed: -Admitted: 03/15/18 -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder and Substance Use (Severe) -Age 15 -Treatment plan last updated 05/09/18: Goals-display improved control of impulsive behavior, recognize and verbalize how feelings are connected to behaviors, develop appropriate coping skills, remain sober and maintain abstinence, comply with rules and expectation of residential placement, take responsibility & be accountable for actions Review on 05/22/18 of DC #3's record revealed: -Admitted: 03/16/18 -Deceased: 05/14/18 -Diagnoses: Cannabis Use Disorder, Conduct Disorder, ADHD and Anxiety Disorder -Age 16 -Treatment plan last updated 05/11/18: Goals- display improve control of impulsive behavior, recognize and verbalize how feelings are connected to behaviors, comply with rules and expectations of residential treatment and take responsibility as well as be accountable for actions I. Examples no strategies for behaviors of runaway. Review on 07/05/18 of the facility's "AWOL (absent without official leave) policy" revealed: -Screening procedures for admission into the home included number of AWOL attempts within the last year. If the client had more than one AWOL attempt in the past 60 days, this client would not be admitted into the program	V 112		

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V 112	Continued From page 5 Review on 05/22/18 of client #1's, client #2's and DC #3's records revealed: -Client #1's Psychological Assessment dated 08/21/17 by another agency listed additional concerns: Runaway, Substance Use and Crime delinquency...Psychological Assessment dated 04/17/18 by a different agency listed runaway...no date of the last AWOL -Client #2's Admission Assessment by Juvenile Court system last amended 12/22/17 client had to go to court for running away and ran away four times since June 2016...no date of the last AWOL -DC #3's Admission Assessment dated 03/16/18 indicated on probation...history of skipping school, suspensions (in and out of school), THC (Tetrahydrocannabinol), Marijuana, Hash. Increasing use of drugs in last few months..history of robbing people...no history of runaway noted - Treatment plans listed no specific strategies to address history of runaway During interview on 06/27/18, client #2's Probation Officer reported: -Client #2 had a history of runaway... previously ran away from a PRTF (Psychiatric Residential Treatment Facility) prior to admission to the group home. During interview on 06/28/18, DC #3's Department of Social Service appointed Guardian reported: -He did not complete the initial paperwork for DC #3 to enter the group home...he was at the group home the first day DC #3 was admitted...upon admission to the group home, history of runaway was discussed with management of the group home...group home relterated their no tolerance policy for runaway	V 112		

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V 112	Continued From page 6 with DC #3 and the guardian. During interviews between 05/25/18 and 06/18/18 with 4 of 4 audited facility staff regarding client runaway behavior reported: -Staff #1-worked at the facility a few years...not aware runaway history for client #1, #2 or DC #3 -Staff #2- only worked at this location twice...not aware of clients runaway histories but described clients as criminals because of their histories of robbery and other illegal activities -Staff #6- worked at the facility at least twice a month...last worked in April 2018...not aware of a lot of information about clients because he didn't work there too often...not aware of any history of runaway -Staff #7-worked for the company for an estimated four years...primarily worked weekend shift and as needed during the week...last worked at this location two weeks prior to this interview...only DC #3 had a history of runaway...none of the other clients had runaway history. During interview on 07/05/18, the Qualified Professional reported: -To her knowledge only DC #3 had a history of runaway...he had one incident in which he left his aunt's home in an attempt to run to another state to be with his biological father. -If a client came from a PRTF, she would use the treatment plan developed by the agency, maintain goals that were applicable to the group home and review effectiveness at the Child and Family meeting. During interview on 07/05/18, the Director reported: - Client #1, #2 and DC #3 had no history of	V 112		

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V 112	Continued From page 7 elopement...."That's why we had the elopement policy and its signed upon admission. We don't always have accurate information provided" by the Managed Care Organization or other referral sources. II. Example no implementation of strategies for gang association A. Review on 05/22/18 of client #1's record revealed treatment plan listed no association with gangs. Observation and interview between 4:00-5:30 PM on 05/29/18 was held with client #1 while he was in juvenile detention. Two eyebrow slits noted on both eyebrows. During interview on 05/29/18, client #1 reported: -He had the eyebrow slits (slits put in eyebrows usually associated with gangs as a sign of how many people one raped, drugged or killed) done while in the group home...eyebrows slits done because he saw the other clients get it and he decided to have the eyebrow slits done. During interview on 05/25/18, staff #7 reported: -Client #1 was "not in a gang" that he knew of but would always get into trouble with having bandanas...described client #1 as a spoiled kid B. Review on 05/22/18 of client #2's record revealed: -Treatment plan updated 04/05/18 with notes from monthly CFT (Child Family Team) Meeting-client had been in the home 3 weeks...has been involved with doing gang handshakes and making gang signs...very impulsive and will do things to gain the attention of peers in the home...No specific strategies noted to address gang	V 112		

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V 112	Continued From page 8 association or affixation Review on 07/09/18 of client #2's Juvenile Commitment/Release form order entered 05/08/18 provided by the Probation Officer revealed: -On 05/09/18 released to group home with under these conditions: shall not wear anything red and not associate with any other gang members Observation and interview between 4:30-5:30 PM on 06/06/18 was held with client #2 while he was in juvenile detention. Two eyebrow slits noted on both eyebrows During interview on 06/06/18, client #2 reported he: -Obtained the eyebrow slits while taken to the Barber for haircuts with staff...did not ask staff but asked the Barber to put the slits in his eyebrows...heard staff tell other clients told no to the slits because they had to go to court....did not think he would be going to court...observed peers obtain the eyebrow slits and thought it would be okay During interview on 06/06/18, client #2 and his grandmother/guardian reported: -He was not in a gang...when he went to court (05/31/18), the judge thought he was in a gang because he had the eyebrow slits and made mention During interviews on 06/07/18 & 07/05/18, the Quallfied Professional reported: -Client #2 was court ordered not wear a specific color per the judge during a May 8, 2018 court case when he was released from detention back to the group home...prior to the court	V 112		

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V 112	Continued From page 9 hearing, she was not aware of any issues with gangs related to client #2 C. Review on 05/22/18 of DC #3's record revealed: -Psychological Assessment dated 04/17/18 listed gang involvement -Treatment plan listed no specific strategies noted to address gang association or affixation During interview on 05/25/18, staff #7 reported: -Not aware of any clients affiliated with or had issues with gangs During interview on 06/07/18, the Residential Support Specialist reported: -Prior to this interview, he was not aware the eyebrow slits were correlated with gangs -All the clients (#1, #2 and DC #3) wanted to be affiliated with gangs but he doubted any of the clients from this home were actually in a gang During interviews on 06/07/18 & 07/05/18, the Quallfied Professional reported: -She found out clients had eyebrow slits after staff had taken clients to the Barber for hair cuts...did not recall which specific staff took the clients and had that done...spoke with those staff afterwards...was aware the association of eyebrow slits and gang association -She was not aware of any of the other clients with a history of gang involvement During interview on 07/05/18, the Director reported: - Previously had clients with gang association...believed DC #3 was associated with gangs based on staff talk about pictures of signs on social media..Prior to his death, she was not aware DC #3 was gang associated	V 112		

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V 112	Continued From page 10 -She "skimmed through the assessments" when clients were admitted..the Qualified Professional and Licensed Professional looked through the assessments in more detail to assure the group home could meet their needs. This deficiency is cross referenced into 10A NCAC 27G.1701 Residential Treatment for Children (V293) for a Type A1 rule violation.	V 112		
V 139	27G .0404 (F-L) Operations During Licensed Period 10A NCAC 27G .0404 OPERATIONS DURING LICENSED PERIOD (f) DHSR shall conduct inspections of facilities without advance notice. (g) Licenses for facilities that have not served any clients during the previous 12 months shall not be renewed. (h) DHSR shall conduct inspections of all 24-hour facilities an average of once every 12 months, to occur no later than 15 months as of July 1, 2007. (i) Written requests shall be submitted to DHSR a minimum of 30 days prior to any of the following changes: (1) Construction of a new facility or any renovation of an existing facility; (2) Increase or decrease in capacity by program service type; (3) Change in program service; or (4) Change in location of facility. (j) Written notification must be submitted to DHSR a minimum of 30 days prior to any of the following changes: (1) Change in ownership including any change in partnership; or (2) Change in name of facility.	V 139	V139 27 G. 0404 (F-L) Operations During Licensed Period DHSR worker was notified by Residential Support staff of the move to the hotel. Director will be using required notification form if a client has to be moved from the residence in the future. On-going	

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V 139	Continued From page 11 (k) When a licensee plans to close a facility or discontinue a service, written notice at least 30 days in advance shall be provided to DHSR, to all affected clients, and when applicable, to the legally responsible persons of all affected clients. This notice shall address continuity of services to clients in the facility. (l) Licenses shall expire unless renewed by DHSR for an additional period. Prior to the expiration of a license, the licensee shall submit to DHSR the following information: (1) Annual Fee; (2) Description of any changes in the facility since the last written notification was submitted; (3) Local current fire inspection report; (4) Annual sanitation inspection report, with the exception of a day/night or periodic service that does not handle food for which a sanitation inspection report is not required; and (5) The names of individuals who are owner, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity. This Rule is not met as evidenced by: Based on record review and interview, the governing body failed to provide written request to Division of Health Service Regulation (DHSR) of change of location. The findings are: Review on 05/18/18 of the facility's public record maintained by DHSR revealed: -No evidence of notification of emergency change of address During interview on 05/18/18 and 07/25/18, the	V 139		

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V 139	Continued From page 12 Director reported: -05/18/18: Incident occurred on 05/14/18 in which a client from their group home was fatally ran over by a citizen..clients were moved to a hotel for four days...clients moved due to the news media driving by the group home as well as clients indicating they didn't feel comfortable staying at the group home -07/25/18: She was not aware of the emergency relocation process on the DHSR webpage prior to this interview...not aware she was required to notify DHSR of change of location	V 139		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to	V 293	V293 27G. 1701 Residential Tx Child/Adol- Scope Director will meet with QP twice a month to review each client's identified need and timely follow up to any recommendations. Residential Support Staff will complete a system test with the alarm company once a month to ensure that the alarm is working appropriately. On-going A training was conducted with staff on how to complete nightly bed checks. On-going	

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(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 293	Continued From page 13 facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide services designed to include individualized supervision, minimize the occurrence of behaviors related to functional deficits, and ensure safety of 2 of 2 current clients (clients #1 and #2) and 1 of 1 Deceased Client (DC #3). Additionally, the residential treatment agency failed to coordinate services with other agencies within the two of two	V 293		

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V 293	Continued From page 14 current client's (#2) system of care. The findings are: A. Cross reference: 10A NCAC 27G.0203 Treatment and Habilitation plans. (V112) Based on observation, record review and interview, the facility failed to develop and implement strategies in the treatment plans of two of two clients (#1-#2) and Deceased Client (DC #3). B. Example facility failed to coordinate services with Probation requirements regarding client #2. Review on 05/22/18 of client #2's treatment plan updated 05/09/18 revealed: -"[Client #2] and two peers (a former client and DC #3) robbed a student at school in the bathroom. [Client #2's] peers had ski masks. [Client #2] was the look out person. They had attempted to rob another student earlier that day without the ski mask and were unsuccessful. In both incidents, [client #2] was the look out person and in one case lured the student into the bathroom. [Client #2] was suspended for 10 days with recommendation of long term suspension. [Client #2] attended Juvenile Delinquent Court...was detained in detention center on 4-24-18 by the Judge due to his involvement...[Client #2] was released on 5-9-18 from detention and returned to the group home." *Note: robbery was of a cell phone During interview 06/06/18, client #2 and his guardian reported: -Client #2 was released from detention to the group home with the understanding from the group home that he would be enrolled in a day program for school. That should have been established prior to his release from the detention center. The group home told them the programs	V 293		

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V 293	Continued From page 15 were for middle school not high school students..group home would continue to try to find him a program. During interviews between 05/18/18 and 07/25/18, the Qualified Professional reported the following about client #2: -Not in school during the day...remained at a sister facility of the group home during school hours -The group home awaited approval for day treatment services...paperwork for the day program was submitted in early May. During interview on 07/09/18, client #2's Probation Officer reported: - She was aware client #2 had been suspended long term from school as a result of the April 2018 robbery at public school that involved him and two of his group home peers...conversation regarding school occurred during his hearing in May 2018 but was not listed as a condition of his detention release...there was an agreement client #2 should be in school or receive educational services as he referenced helping other clients with their homework on the computer...not sure if the group home was required to await ten days after the long term suspension was initiated before they could request additional services...not sure if the terms day program and the summer program (for all group home clients) were used interchangeably during conversation with the group home. During interview on 07/05/18, the Qualified Professional reported: -At the time of release from Detention (05/09/18), client #2's judge was aware it would take a while to confirm day treatment services...she did not have documentation of the	V 293		

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V 293	Continued From page 16 court order with requirements regarding his restrictions or conditions for his release -She initiated contact with a day treatment service provider...the coordinator was in the process of "reviewing" the request...the day services needed an updated Comprehensive Clinical Assessment (CCA), however client #2 was in detention at that time...judge requested the group home continued to look for day treatment upon client #2's release from detention. During interview on 07/06/18, the day treatment service provider identified by the Qualified Professional reported: -Contact was initiated via email by the facility's Qualified Professional on 05/07/18 regarding client #2 "need day treatment"...follow up feedback indicated the process could not be continued until his CCA was updated by a Clinician with an amendment for day treatment services and justification...no other contact received from the group home since 05/07/18 -Once the necessary information was received from the group home, the day treatment goals would be added to the Personal Care Plan (PCP)...The day treatment would submit the packet to the Local Management Entity/Managed Care Organization for approval, which he estimated a week to complete the process...he would expedite the time due to client's long term suspension from school....CCA can be updated by the Clinician without a physical visit from the client, if needed urgently. C. Review on 05/18/18 of the NC IRIS (North Carolina Incident Response Improvement System) revealed: -Incident reports submitted 05/18/18 for client #1, client #2 and DC #3...reports indicated on 05/14/18, all three clients ran away from the	V 293		

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V 293	Continued From page 17 group home escaping through the bedroom windows at the same time during the overnight shift...all went to a national superstore chain located within a one mile radius from the group home...client #1 and client #2 initially denied their involvement in the runaway but changed their recollection of the incident over the course of a few days. DC #3 was fatally ran over with a vehicle by a citizen because he stole the citizen's cellular phone. Review on 05/18/18 of the facility's internal investigation conducted between May 14-18, 2018 by the Director revealed: -An interview with staff #1 "[staff #1] reported no alarms on the windows, they had been missing as long as he had been at FQ (Fuquay). He started working at FQ the last 2 months. He thought we already knew that the alarms were not there. He usually checked the windows when he came on shift." Review on 06/11/18, of the facility's records provided by the Residential Support Specialist employed by the group home revealed: -Verification of payment between January-June 2018 for services to a national chain alarm system company. -No lapse in alarm system service noted on the receipts provided -Between 05/14/18-05/18/18 a new updated alarm system was installed at the group home Review on 06/18/18 of police evidence revealed a photo labeled "provided by [Residential Support Specialist] via text on 5/15/18...window in home had been tampered with"....photo consisted of a window with a sensor attached to it. Strips of what appeared to be thick tape were observed vertically along the entire left side of the sensor	V 293		

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V 293	Continued From page 18 and one strip across the middle of the sensor. During interview on 05/25/18, client #1 reported the following about the facility's alarm system: -Group Home had an alarm...he had been told by some other clients the alarm system did not work but he had never tried to see if it worked or not -The night of 05/13/18, DC #3 came to their window to ask them to run away with him...DC #3 said he tampered with the alarm and it "would not go off"...client #1 and client #2 went out their bedroom window to runaway to the national chain superstore.. client #1 returned back to the group home alone using the same window...no alarm "went off" as the window opened and closed night of 05/13/18 During interview on 06/06/18, client #2 reported the following about the facility's alarm system: -The group home had a working alarm system...he would hear it chime as doors opened and closed. During interview on 05/29/18, staff #6 reported: -He worked for the agency for two years...worked at this location at least twice a month on weekends...last worked at the facility in April 2018 -Alarm was working at that home, staff checked to see if its attached to the window...staff were to check the alarm every night..."It's not like we had to document that we checked it. We could put in the communication log if it was working or not. I am pretty sure it was working." During interview on 05/25/18, staff #7 reported: -He worked at the group home on the weekends and during the week as needed...last worked at the group home two weeks prior to this	V 293		

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V 293	Continued From page 19 interview -Facility had an alarm because he would hear it chime when doors were opened -Sensors were on the windows however, he was not required to check the sensors to see if they were working During interview on 6/07/18, staff #1 reported: -He worked at the group home the night of 05/13/18 beginning at 7 PM until the morning of 05/14/18 at 7 AM -He had worked at this group home previously and served as a floater staff between houses as needed -This group home did not have an alarm system...he did not hear an alarm when the doors opened and closed.."don't the homes suppose to have alarms?...the other homes have alarms"...he did not alarm or disarm any alarm at this group home location. During interview on 06/07/18, staff #2 reported: -She worked at this specific group home only twice (05/12/18 and 05/13/18)...verified she worked with staff #1 the night of 05/13/18 -The night of 05/13/18 into the morning of 05/14/18, she walked in and out of the group home smoking cigarettes to remain awake...no alarmed sounded...the group home did not have an alarm because she did not hear chirping or any sound when the doors opened..she was not aware of any codes to the alarm system. She did not see any alarm control panel at the facility. During interviews on 05/22/18 and 06/07/18, the Qualified Professional reported: -The alarm at group home had been upgraded after 05/14/18...prior to 05/14/18, the group home non- managerial staff would not have access to set or disarm the alarm system. The	V 293		

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V 293	Continued From page 20 management (Residential Support Specialist, Qualified Professional, Director or the House Manager) would set the alarm remotely -The Residential Support Specialist would set the alarm for this group home -The morning of 05/14/18: "When [staff #1 and staff #2] left the group home to take [client #1] to school and [client #2] to the sister facility in Raleigh, the doors to the group home were not locked" in case DC #3 returned to the group home from runaway status... a staff (#5) had to return to the group home to "close up the house"...prior to a call from the police department to meet at the group home for an update, she had contacted staff #5 who resided closest to the group home to lock up the group home. Staff #5 was already at the group home, when police department requested someone to meet at the house. During interview on 07/05/18, the Qualified Professional reported: -During her previous interviews on 05/22/18 and 06/07/18 regarding the alarm system, she provided information related to the system installed after May 14, 2018. -Alarm system prior to May 14, 2018, the staff would set the alarm using the panel on the wall at the group home...each staff knew the code...expectation was for system to be on when the last person on third shift entered the home...second shift could set the system when the clients went to bed. There was a way to set the system that would only alarm if the window was raised. -Alarm systems were different so she couldn't recall specifics on how to arm/disarm this system...she needed to follow up with the Residential Support Specialist	V 293		

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V 293	Continued From page 21 During interview on 06/22/18, the representative from the national chain alarm system company reported: -The account for this specific address had been active since 2005....no lapse in service noted between January-June 2018...alarm system included 10 sensors inclusive of windows and doors hard wired and not wireless...the 2005 system would not have included monitoring of when doors opened, capability of the alarm system being set remotely, ability to verify when the alarm was armed or disarmed as those services were not available in 2005...based on the 2005 alarm system, no way to establish if the alarm was armed on 05/13/18 or any time prior. -As part of the monitoring agreement, customers have always been required to call in monthly for a maintenance test...address of group home was last tested in 2016...a reminder phone call was made in 2017, but no one returned the call for the system to be tested...test needed to verify services and signals to the home...if alarm triggered, the alarm company may or may not receive notification, therefore not able to provide services of emergency assistance. -No changes or upgrade made to the alarm system since 2005 until May 14, 2018, after which a new wireless system with remote access was requested and subsequently, installed. *Note: this interview was conducted with the Residential Support Specialist present on the phone During interview on 06/07/18 & 06/22/18, the Residential Support Specialist reported: -DC #3 was able to disengage the alarm window systems by placing tape where the sensors connected. If the window was lifted, the sensor would not trigger an alarm because the tape would block the signal the connection had	V 293		

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V 293	Continued From page 22 been disengaged. -Prior to this interview, he was not aware of the monthly requirement to test the system...now, he was listed on the account as the first point of contact During Interview on 07/05/18, the Director reported: -When she obtained the property, the alarm was already installed...she continued to maintain the monthly obligation for the alarm... -It was her expectation the alarm would be engaged during client sleep hours on the third shift, but had not thought of second shift...she had not personally set the alarm at the facility.... with the new system management (Residential Support Specialist, Qualified Professional, Director) all had remote accessibility to the alarm...recently, had been brought to her attention that some staff may not feel comfortable setting the alarm or knew how to set the alarm...a few weeks ago, contact initiated with a representative to establish training, but no confirmation date/time had been established...a follow up would be required to solidify a date/time for training. D. No systematic method of monitoring "bed checks" of clients during overnight hours Review on 05/22/18 of the facility's forms revealed: -"Nightly bed check" sheet for each client individually...document served as a monthly overview... pre-typed 30 minute intervals noted between 11 PM-7 AM...no instructions noted on the form regarding Instructions or how to complete the document or codes to document if clients were awake or away from the facility. -Nightly bed check forms dated May 2018 for	V 293		

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V 293	Continued From page 23 client #1, client #2 and DC #3 reflected initials or documentation of "D"under the date between 11 PM-7 AM *Note: "D" documentation correlated with dates clients were in detention (Client #2-May 1-8, DC #3 May 1-11th) Review on 05/18/18 of the facility's internal investigation conducted between May 14-18, 2018 by the Director revealed: -An interview with staff #1 indicated the night of 05/13/18, he conducted bed checks. "Around 3:45 (AM) he looked into this room and thought [DC #3] was there and he went back to the living (room). He (DC #3) was covered from top to bottom with his covers. He (Staff #1) didn't actually see him (DC #3). The shape of the bed looked as if someone was there...he went into the room..he took the covers off him (DC #3)...[DC #3] had put clothes in the bed to make it look like a body." During interview on 06/07/18, staff #1 reported he: -Conducted bed checks by looking inside the room...could see body parts and knew clients were in the room. -Bed checks were documented immediately after each 30 minute check. During interview on 06/07/18, staff #2 reported: -Bed checks were completed every 30 minutes...checks consisted of walking in the doorway of the room to check on the male clients..she did not go inside the room because she noticed the clients slept with their shirts off and had on boxer underwear...she did not feel comfortable going further inside the bedroom..she did not want the clients to make any allegations against her. -The bed check form was completed at the	V 293		

and update to ensure goals are addressing any

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V 293	Continued From page 24 end of the shift. During interview on 07/05/18, the Director reported: -Not sure why the bed check forms were not completed for client #2 and DC #3...bed check forms should be completed as done throughout the shift as opposed to the end of the shift...expectation was for staff to have a close visual of clients during nightly bed checks "eyes on" -Prior to 05/14/18, the agency had not conducted bed checks trainings...bed checks had been discussed at staff meetings that clients should be eyes on at night. -After 05/14/18, a flashlight was purchased and staff could use their cell phone for light to visually see the clients during sleep hours Review on 07/06/18 of the facility's Plan of Protection dated 07/05/18 and submitted by the Director revealed: -"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Review Psychiatric Evaluations, CCA or any previous PCP (Personal Care Plan) for clients, Monitor second shift, [alarm company] security check, coordination of care -Describe your plans to make sure the above happens."QP will review current treatment goals and update to ensure goals are addressing any gang affixation, substance abuse and AWOL (Absent Without Official Leave) for new clients. If treatment plan must be modified QP will contact parents o night to inform them of the changes and schedule a CFT to approval. Residential Support Staff (Specialist) will conduct home visit during 2nd and 3rd shift tonight to make sure staff are completing bed checks every 30 minutes and	V 293		

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V 293	Continued From page 25 documenting bed checks as they are completed. Staff will sign off on training roster that they have been trained. RSS (Residential Support Specialist) will call [alarm company] to complete security check to ensure system is functioning properly. RSS will call [alarm company] representative to schedule training on how to use the system." Client #1, client #2 and DC #3 had a history of runaway and involvement in criminal activities both prior to admission and while at the group home. In 2010, the governing body assumed responsibility to continue an alarm system used to monitor the group home. The alarm system had not been updated since 2005 installation and not tested monthly as required by the monitoring company since 2016. Treatment plans updated monthly by the facility's Qualified Professional did not reflect strategies to address behaviors such as runaway or gang affiliation. Staff reportedly were also not aware of these behaviors. The group home did not develop and implement definitive procedures for staff to monitor and document client activity during overnight hours. As a result of all three systematic failures (no strategies to address behaviors such as runaway, alarm was not tested nor suitable to meet needs of the group home, no consistent method of bed checks), all clients #1, #2 and DC #3 residing at the group home the night of 05/13/18 were able to runaway without staff's knowledge. No alarm was engaged either as clients ran away by going out the window or when staff opened and closed the door. Collectively these deficient practices resulted in serious neglect. The violation constitutes a Type A1 rule violation and must be corrected within 23 days. An administrative penalty in the amount of $5000.00 is imposed. If the violation is not corrected within 23 days, an	V 293		

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V 293	Continued From page 26 additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 293		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or	V 500	V500 27 D. 0101 (a-e) Client's Rights-Policy of Rights Director updated the policy to include contact to the local County DSS of any allegations of abuse or neglect. On-going	

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LIFE SKILLS INDEPENDENT CARE #1	800 PERRY HOWARD ROAD FUQUAY VARINA, NC 27526

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V 500	Continued From page 27 allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interview, the governing body failed to assure all allegations of neglect and exploitation were reported to the County Department of Social Services (DSS) as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44. The finding is: Review on 07/05/18 of the facility's abuse neglect and exploitation policy revealed: -No procedure to notify DSS...no mention of notification of DSS as outlined by G.S. 108A	V 500		

and DC #3 were in the community, they were

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V 500	Continued From page 28 Article 6 or G.S. 7A Article 44 Review on 05/18/18 of the facility's internal investigation conducted between May 14-18, 2018 by the Director revealed: -On 05/13/18-05/14/18, all three clients (#1, #2 and Deceased Client #3) eloped from the group home without the knowledge of two on duty staff (#1 and #2). Initially client #1 returned to the group home, clients #2 and (Deceased Client) DC #3 remained on elopement status. As client #2 and DC #3 were in the community, they were involved in a robbery. DC #3 stole a cell phone. The victim of the robbery chased DC #3 and hit him with a vehicle which resulted in the death of DC #3 around 2 AM. Upon client #2's re-entry into the group home via the bedroom window, he shared the occurrences of the night with client #1. -Per an interview with client #1, staff #1 entered the bedroom as client #2 and client #1 discussed the events of 05/14/18. Staff #1 told them to go to bed. Staff #1 left the home that early morning. At time to get up around 6 AM, staff #1 told the clients to "go alone with his story" and began to look for DC #3 through the house and made a police report of DC #3 being missing. During interview on 07/05/18, the Director reported she: -Conducted the internal investigation for the group home. -Spoke with someone (can't recall who at another agency ie...Managed Care Organization) and thought the incident had been reported to the neighboring County DSS...no one from any DSS had contacted her of a report for the facility -Did not report the incident of 05/14/18 to the County DSS ....not aware she was to report the incident... focused on completing the investigation as well as reporting the incident to North Carolina	V 500		

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V 500	Continued From page 29 Health Care Personnel Registry	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on observation, record review and interview, two of seven audited staff (#1 and #2) subjected two of two clients (#1-#2) and one of one Deceased Clients (DC#3) to neglect. The findings are: Review on 05/22/18 of staff #1's personnel record revealed:	V 512	V512 27 D. 0304 Client's Rights-Harm, Abuse, Neglect A training was conducted with staff on how to complete nightly bed checks. On-going	

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V 512	Continued From page 30 -Hired: 09/02/14 Review on 05/22/18 of staff #2's personnel record revealed: -Hired: 05/04/18 Review on 05/22/18 of client #1's record revealed the following: -Admitted: 03/29/18 -Diagnoses: Conduct Disorder, Adolescent Onset type, Cannabis Use Disorder (Mild) and Intellectual Developmental Disability (Mild) -Age 14 -Admission Assessment dated 03/29/18 completed by the group home indicated charged with felony breaking & entering, possession of stolen property (01/27/16 & 02/04/16) ...2012 for injury to real property..involvement in the juvenile justice system for probation...more than 25 juvenile detention lock ups -08/21/17 psychological assessment by another agency listed additional concerns: Runaway, Substance Use and Crime delinquency Review on 05/22/18 of client #2's record revealed the following: -Admitted: 03/15/18 -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder and Substance Use (Severe) -Age 15 -Admission Assessment by Juvenile Court system last amended 12/22/17 client had to go to court for running away and ran away four times since June 2016. Review on 05/22/18 of Deceased Client (DC) #3's record revealed the following: -Admitted: 03/16/18 -Deceased: 05/14/18	V 512		

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V 512	Continued From page 31 -Diagnoses: Cannabis Use Disorder, Conduct Disorder, ADHD and Anxiety Disorder -Age 16 -Admission Assessment dated 03/16/18 completed by group home indicated on probation...history of skipping school, suspensions (in and out of school), THC (Tetrahydrocannabinol), Marijuana, Hash. Increasing use of drugs in last few months..history of robbing people. -On probation through the Juvenile Justice System Review on 05/18/18 of the facility's internal investigation conducted between May 14-18, 2018 by the Director revealed: -Staff #1 and Staff #2 worked at the facility beginning the night of 05/13/18 to the morning of 05/14/18. Clients #1, #2 and DC #3 resided at the group home and were present at the beginning of the shift. A. Example staff neglected to conduct bed checks and document accurately resulting in all three clients eloping from group home During interview on 06/07/18, staff #1 reported the following about the overnight shift that began at 7 PM on 05/13/18: -Client #1 and client #2 shared a room, DC #3 had a single bedroom located at the other end of the home -Upon arrival at the home, staff #2 wanted to split the staff duties at the home...she would be responsible for monitoring client #2 and DC #3...he would monitor client #1 and finish laundry....Staff #2 conducted bed checks for her clients (#2 and DC #3), he conducted 15-20 minute bed checks for his client (#1)...his client (#1) was present in the group home each time he	V 512		

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V 512	Continued From page 32 went into the bedroom...he saw body parts of the client so he knew client #1 was in the room...as client #2 was the roommate of client #1, he also saw client #2's arms and legs as well during his bed check time...no problems throughout the night...denied he slept through the night..indicated he had an upset stomach at some point during the shift -Around 5:45 AM, he went to wake up DC #3 with a knock on the bedroom door...the other clients were moving around and preparing for the day but DC #3 was not. Around 6:00 AM, he went inside DC #3's bedroom and discovered a "structure in the bed..assumed [DC #3] was still laying down", when he flipped the covers, he realized it "it was a dummy."...he ran out the front door but he knew it was locked, he observed the DC #3's bedroom window up. He saw a vehicle down the street but could not say the vehicle was associated with DC #3's runaway status..he got the company's van to check the local area for DC #3 which included shopping areas. While in the company van, he saw a police barricade near the local shopping area near the group home. He did not stop and returned to the group home. Management (Staff #3, Staff #4, Qualified Professional) and the police were called. Client #1 and client #2 denied they knew about DC #3's runaway -At the time of this interview, it was his understanding, only DC #3 ran away the night of 05/13/18. He had not worked at the facility or had contact with anyone from the group home since 05/14/18. -In regards to his bed checks, he felt the bed check form and notes would "match" his interview. During interview on 06/07/18, staff #2 reported the following about the overnight shift that began	V 512		

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V 512	Continued From page 33 at 7 PM on 05/13/18: -Verified she worked with staff #1...acknowledged they did not talk much that shift because she found it challenging to fully understand him..she had never worked with staff #1 prior to this date..had just started working for the agency an estimated two weeks prior. -That shift, no major concerns, except DC #3 liked to close his bedroom door and she would crack it open. She monitored all clients but didn't feel comfortable entering the male clients' bedrooms. Her monitoring occurred at the doorway. At 11 PM, DC #3 was still awake, went to the bathroom, asked for water and then went back to bed. Around 12 midnight, I heard a noise and asked staff #1 to check on clients. Staff #1 said the clients were up... she did a bed check around 12:30-12:35 AM, with no concerns...she described observing client bodies in their beds. Around 4:30 AM, she heard a noise again from the bedroom of client #1 and client #2. Staff #1 rechecked and said "they were fine." She did not ask any clarifying questions. As staff #1 began to awake the clients, he came and reported DC #3 was not in the house. Staff #1 walked the neighborhood. She was not familiar with the area so she would not have known where to look or how to get around the area. She called the police and made the initial missing person report for DC #3. Staff #1 assisted her with the questions asked by the police. -Staff #1 did go to sleep at some point during the shift. She would not have been able to sleep as she didn't feel comfortable. Review on 05/22/18 of the facility's May 2018 30-minute interval bed check forms for each client revealed the following for the night of 05/13/18 beginning at 11 PM ending 05/14/18 at 7 AM: -Client #1- initialed by staff #1 for the entire	V 512		

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V 512	Continued From page 34 shift. -Client #2- no initials by staff for the entire shift -DC #3-no initials by staff for the entire shift During interview on 05/25/18, client #1 reported the following about the night of 05/13/18 beginning at 11 PM ending 05/14/18 at 7 AM: -He heard a noise from his window. It was DC #3 asking him and client #2 to run away with him to the national department store chain...DC #3 stated he had fixed the alarm that it would not go off when they opened the window...DC #3 used some curse and threatening words to convince them to cooperate....client #1 and client #2 left the group home through their bedroom window...they walked to the store -While inside the store, DC #3 said "he was about to get a phone. I said I wasn't going to do that...He (DC #3) told [client #2] he was not going to have to do anything. He (DC #3) was going to ask to use the phone and run off. He (DC #3) told us that (stealing of phone) before we left the group home.." ..client #1 bought everyone candy from the store...he left client #2 and DC #3 and returned back to the group home. He re-entered the home through the window and went to sleep. He was awaken by client #2's re-entry into the house through their bedroom window...he was not sure of the lapse in time...client #2 said he saw DC #3 get hit by a car..client #2 was visibly upset and shaking and recapped the events of the night with client #1. Client #1 and client #2 began to argue and staff #1 entered the room...client #1 asked client #2 to share the occurrences of 05/13/18 *Note: (Refer to V500 regarding reporting allegations to local Department of Social Services...due to inconsistency of reports between staff #1 and client #1, the specifics of the conversation	V 512		

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V 512	Continued From page 35 between client #1, client #2 and staff #1 was not included in this citation.) During interview on 06/06/18, client #2 reported the following about the night of 05/13/18 beginning at 11 PM ending 05/14/18 at 7 AM: -Collaborated interview of client #1 that DC #3 initiated the runaway to the store, altered the window sensor that the alarm not sound..."I thought staff would hear us"...looked into the living room and checked on staff who were both asleep (client #1 had his hood on)...neither staff moved when he entered the living room area...DC #3 was hitting himself and called clients #1 and #2 derogatory names...also collaborated client #1 left them on runaway status to return back to the group home. He was not sure of a specific time frame. - He and DC #3 initially robbed a man at a local bank of his cell phone. Then, they went back to the national department store chain and approached several people before they made a connection with a 27 year old man that went after DC #3 to retrieve his phone. He left the scene and returned back to the group home. He told client #1 what happened and that he witnessed DC #3 get hit by a car. Client #1 thought he was joking until he heard the ambulance. He and client #1 paced the floor. Staff did not enter the room. He did not recall if staff came in the room but he deferred to whatever client #1 said as he was "upset and could not recall specifics." -Later in the morning, staff #1 came in and asked about DC #3 as he thought he was in their bedroom. He didn't say anything to staff about the runaway. Staff called the police. Review on 06/11/18 of a police narrative with entries from 05/14/18- 06/21/18 revealed: -On 05/14/18 at 12:01 AM, client #1, client #2	V 512		

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V 512	Continued From page 36 and DC #3 exited the store.... -On 05/14/18 at 1:37 AM, client #1 and client #2 observed returning to the store....1:40 AM, 27 year old man exit store and approached from behind by clients #1 and client #2...1:44 AM 27 year old man observed at his vehicle with client #1 and client #2 near the vehicle...1:47 AM, DC #3 fled on foot, 27 year old man observed enter his vehicle and in pursuit of DC #3 Review on 05/18/18 of a local newspaper article dated 05/17/18 revealed: -"A Fuquay-Varina man was charged with murder Monday (05/14/18) after he allegedly struck and killed a teen (DC #3) with his car while chasing the boy to recover a swiped cell phone, authorities said...Around 2 a.m., officers with the Fuquay-Varina Police Department responded to a call of a 'suspicious person' at a home at [address], where they found the body of the victim." B. Example staff neglected to provide accurate information to other's involved in investigating an incident. Review on 06/11/18 of a police narrative with entries from 05/14/18- 06/21/18 revealed: -On 05/14/18, at approximately 6:27 AM, staff #2 called the police to report DC #3 as missing.."checked on him approximately around 4, 4:30, 5 this morning, and he was in his room, so it had to be around 5:30, 6:00 that he slipped out..." -On 05/14/18, a police officer visited the group home and provided the following supplementary statement information: He interviewed staff #2 who indicated "[DC#3] had jumped out of his bedroom window and left the residence...[staff #1] went to wake up [DC	V 512		

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V 512	Continued From page 37 #3]..she heard a loud thump from [DC #3]'s bedroom, but figured it just him getting up and getting ready. She said when [staff #1] came back by a few minutes later to make sure [DC #3] was up, they realized that [DC #3] made the bed look like someone was in it..". - On 05/14/18, police officer that visited the group home provided the following supplementary statement information from staff #1: he attempted to awake DC #3 at approximately 6:00 AM, went back a few minutes later, discovered the bed had been made to appear person was inside, he drove to national chain department store in search of DC #3. During interview on 06/05/18, staff #3 reported: -She served as the interim House Manager for this location while the assigned House Manager was on medical leave -On 05/14/18, she received call from staff #1....he was only person on the phone, the first time... he reported DC #3 was not in the house he ran. She hung up and staff #4 was added to the phone call because she had a difficult time understanding staff #1...When the call resumed (with all three staff), staff #1 reported when he went to wake up the other kids, DC #3 was going out the window...he went to front door to catch DC #3 but DC #3 was getting in the car leaving..when asked the color, make/model and license plate of the vehicle, he said no he didn't see the plates and didn't know the color of the car. ..unsuccessfully attempted to 3-way the QP...were able to connect with the Director, which concluded conversation with staff #4. During interview on 06/05/18, staff #4 reported: -On 05/14/18, staff #1 called her around 6:33 AM. He reported DC #3 had ran away...he saw DC #3 when he went out the window...he went to	V 512		

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V 512	Continued From page 38 front door, and he saw DC #3 get into the car....he couldn't tell what kind of car it was. Staff #3 on the call too. Staff #1 was told to call the police ...he didn't say anything about how long DC#3 was gone. During interview on 06/07/18, staff #1 reported: -He did not observe DC #3 go out the window...he did observe a vehicle leaving the area..he could not associate that vehicle with DC #3 being on runaway status Review on 05/18/18 of the facility's internal investigation conducted between 05/14/18-05/18/18 completed by the Director revealed: -Verification of the same information provided in the interviews on 06/05/18 by staff #3 and staff #4 regarding staff #1's initial report of seeing DC #3 go out the window, get into a vehicle but was not able to describe any specifics regarding the vehicle -When asked for clarification, staff #1 denied he had indicated he saw client go out the window or saw him get into a vehicle. During interview on 05/18/18, the Director reported: -She conducted the internal investigation...her results were inconclusive due to inconsistency of statements from clients and staff regarding occurrences between 05/13/18 and 05/14/18. Review on 07/06/18 of the facility's Plan of Protection dated 07/05/18 and submitted by the Director revealed: -"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Bed Checks, blanks in documentation, consistency with events	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-795	A. BUILDING: _____ B. WING _____	R 07/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE SKILLS INDEPENDENT CARE #1	800 PERRY HOWARD ROAD FUQUAY VARINA, NC 27526

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V 512	Continued From page 39 of the shift, consistency with events of the shift and time frames -Describe your plans to make sure the above happens. ROSS (Residential Support Specialist) and or QP (Qualified Professional) will conduct training with 2nd and 3rd staff tonight to have them to complete a training roster indicating their participation in training regarding bed checks, completion of documentation, events of the shift and time frames. RSS and or QP will review bed checks and other client forms to ensure the bed checks are done every 30 minutes and to ensure other forms are completed for the shift. Copies of the completed documentation will be turned into Director the following day for signature and review. RSS and or QP will discuss with staff at the end of 2nd and 3rd shift the events of the evening and review documentation to ensure the events are documented accurately on forms and documentation is completely timely. Copies of the completed documentation will be turned into Director the following day for signature and review." The night of 05/13/18- morning of 05/14/18, three clients (#1, #2, and DC #3) ranging in ages 14-16, ran away from the group home unbeknownst to on duty staff (#1 and #2). Staff reportedly conducted 30 minute bed checks and all three clients were present between 11 PM-6 AM. However, police report revealed an investigation began around 2 AM of a fatal incident in which the victim later identified as DC #3 was hit by a citizen with a vehicle. Staff #1 and #2 provided various inconsistent statements once it was initially discovered DC #3 was not in the group home. The lack of monitoring by staff (#1, #2) and inconsistency of information provided to investigative authorities resulted in serious neglect. The violation constitutes a Type A1 rule	V 512		

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V 512	Continued From page 40 violation and must be corrected within 23 days. An administrative penalty in the amount of $5000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually).	V 536	V536 27E .0107 Client Rights-Training on Alt to Rest Int. Human Resource Manager will ensure Training certificates are received and filed in the employee records. On-going	

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V 536	Continued From page 41 (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may	V 536		

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V 536	Continued From page 42 review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program almed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years.	V 536		

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V 536	Continued From page 43 (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure one of four audited staff (#2) was trained in Alternatives to Restrictive Interventions. The findings are: Review on 05/22/18 of Staff #2's personnel records revealed: -Hired 05/04/18 -No evidence of training in Alternatives to Restrictive Intervention During interview on 07/05/18, the Qualified Professional reported:	V 536		

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V 536	Continued From page 44 -The trainer for Alternatives to Restrictive Intervention would hand deliver the certificate for the trainings on 07/06/18...Certificates had not been obtained...Instructor awaited payment therefore, certificates had not been secured by the agency	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the	V 537	V537 27E .0108 Client Rights-Training in Sec Rest & ITO Human Resource Manager will ensure Training certificates are received and filed in the employee records. On-going	

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V 537	Continued From page 45 course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name.	V 537		

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V 537	Continued From page 46 (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in	V 537		

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V 537	Continued From page 47 CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed assure to one of four audited staff (#2) was trained in Restrictive Interventions. The findings are:	V 537		

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V 537	Continued From page 48 Review on 05/22/18 of Staff #2's personnel records revealed: -Hired 05/04/18 -No evidence of training in Restrictive Intervention During interview on 07/05/18, the Qualified Professional reported: -The trainer for Restrictive Intervention would hand deliver the certificate for the trainings on 07/06/18...Certificates had not been obtained...Instructor awaited payment therefore, certificates had not been secured by the agency	V 537		
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 governing body failed to assure the facility and its grounds were maintained in a safe, attractive and orderly manner. The findings are: Observation on 06/12/18 at 1:30 PM of the facility revealed: -Ceiling in the living room, hallway, client bedroom noted stained and discolored in patches -Living room: exposed wire near television due to no plate to cover, air filter vent rusty, hole in the wall -DC #3's bedroom: dresser with paint peeling	V 736	V736 27 G .0303 (c) Facility Grounds and Maintenance LCI has entered into a contract with an Independent Contractor to complete needed repairs at the home which should be completed within the next 30-45 days.	

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V 736	Continued From page 49 and areas broken, electrical outlet not covered with plate, bedroom door hole -Empty bedroom: carpet ripped, over head light fixture cracked -Dining area: two chairs for capacity of four clients...a third chair with no back for support only a seat cushion and legs..discolored stains in ceiling near the light fixture... -Kitchen area: cabinet food door discolored, one door to cabinet longer than the other and different color and type..cabinet doors near sink off track...flooring had slits of torn areas throughout - Flooring linoleum in kitchen area uplifted - In hallway bathroom used by clients in separate bedrooms, bulb missing in light fixture, debris from ceiling noted within the tub/shower area, tub with evidence of rust, broken toilet paper holder, vent rusty, wooden block holding shower curtain rod cracked - In bathroom located inside bedroom shared by two clients: paper towel holder rusted near base, overhead light fixture no covering, missing bulbs in light fixture near sink, debris noted from ceiling as well as flooring linoleum needed to be secured, wall area near commode repair started but incomplete which left wall soft to touch...linoleum flooring not secure and had vertical tear near the commode - In bedroom area shared by two clients, mattress on one bed not did not completely cover the length of bed, legs on same bed noted to lean not straight in nature, no curtain or blinds on window closest to backyard, - In hallway leading from shared bedroom area, no covering of light fixtures During interviews on 06/12/18 and 07/05/18, the Qualified Professional stated: -She went out to the home and conducted an	V 736		

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V 736	Continued From page 50 inspection monthly...inventory of broken items compiled and forwarded to the Residential Support Specialist -Prior to 06/12/18, she was not aware of the discoloring or stains in the ceiling throughout the home, carpet in the bedroom needed replaced, exposed wire in living room, mattress didn't fit the frame in bedroom shared by client #1 and client #2 -Since 06/12/18, maintenance had been out to resolve some of the Living environment matters identified During interview on 07/05/18, the Director stated: -She visited the group home every 2-3 months -The Qualified Professional had informed her of some concerns identified during the 06/12/18 tour of the group home.. -Regarding the holes in wall-"we constantly fixing hole in the walls" -Regarding stains around perimeter of ceiling throughout the home-last fall, the roof was replaced and discoloration was noted over the mantel...she had "no seen" the discoloration and stains around the perimeter of the ceiling..."not sure if a follow up call (to maintenance) had been made yet..the Residential Support Specialist primarily handled the maintenance issues" -Regarding furnishings- was in the process of looking at a sturdier quality of furniture -She was aware of some of the living environment concerns but relied on the staff at the home to inform her of issues with the physical environment of the group home This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		