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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on August 17, 2018. The complaint (intake #NC00141611) was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court	V 291		

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V 291	Continued From page 1 or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility staff failed to coordinate services with the Qualified Professional (QP) and Legal Guardian (LG) for 1 of 3 clients (#1). The findings are: Review on 8/15/18 of client #1's record revealed: -An admission date of 8/19/15 -Diagnoses of Mood Disorder, Post-Traumatic Stress Disorder and Mild Intellectual Disability Disorder -Age 34 -An assessment dated 8/19/15 noting "was hospitalized at [a state hospital] two years ago, needs assistance with many independent living skills, total IQ is 56, prefers a steady routine, will lie, likes her privacy, will cuss at staff and be aggressive at times, has attention seeking behaviors, requires 24 hour supervision, is unable to avoid being taken advantage of, is easily influenced, will attempt to interrupt the conversations of others and may think others are talking about her." -A treatment plan dated 5/17/18 noting "needs assistance with stated goals to improve her living and social skills, will not interrupt the conversations of others, will respect the privacy of others by not listening in on their conversations unless invited, will learn to share her time accordingly in the group home with staff and housemates without having attention seeking behaviors, will clean her bedroom and bathroom weekly with two verbal prompts or less, will have less than three incidents of yelling, screaming	V 291		

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and/or crying when she does not get her way or is asked to do something she does not want to do, will be honest with everyone given four verbal prompts or less, will participate in various acts of meal preparation twice weekly, will refrain from using inappropriate behaviors while interacting with others in the home or community setting, will practice budgeting skills, will participate in an outing of her choice once per week and will participate in different types of exercise activities in order to increase awareness of her health."

Observations and interview on 8/15/18, at approximately 12:10pm, with client #1 revealed:
-Was wearing a sleeveless shirt
-Had a reddish purple bruise to her left wrist, approximately two inches long
-Several greenish-brown bruises inside her left upper arm which appeared to be in the shape of fingerprints
-Several darker greenish-brown bruises inside her right upper arm which appeared to be in the shape of fingerprints.
-A dark bruise on her back right shoulder, approximately two inches in diameter
-A large reddish purple bruise below the back part of her neck
-Stated she had a knot on her head which hurt when touched.
-When asked about the injuries to her body, client #1 stated staff #1 and staff #2 "took me down"
-The restraint occurred last week (8/7/18) at the facility
-"Afterwards, my neck and head hurt. I needed to see the doctor, but they didn't take me."

Interview on 8/15/18 with client #1's Legal Guardian revealed:
-No one had contacted her regarding the restraint or the injuries to client #1 on 8/7/18

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V 291	Continued From page 3 Interview on 8/15/18 with staff #1 revealed: -Worked at the facility on 8/7/18 along with staff #2 -There was an incident with client #1 on 8/7/18 where she grabbed staff #1's hair and both fell to the floor -Had observed a bruise on client #1's left wrist and documented it on the body check form -No medical treatment was sought for client #1's injuries on 8/7/18. Interview on 8/15/18 with staff #2 revealed: -Worked with staff #1 at the facility on 8/7/18 -Client #1 was upset because she had to share a hygiene pad with client #2 -Staff #2, when asked, confirmed client #1 complained the back of her head and her arm hurt after the restraint. -No medical care was sought for client #1's injuries 8/7/18 Interview on 8/15/18 with the RM revealed: -Had not seen any marks or bruises on client #1 until today (8/15/18) -Was contacted by staff #1 regarding a recent restraint on client #1 on 8/7/18 -Failed to contact the Qualified Professional (QP) so medical treatment could have been sought for client #1's injuries. Interviews on 8/15/18, 8/16/18 and 8/17/18 with the QP revealed: -Was not made aware client #1 was physically restrained by staff #1 and #2 on 8/7/18 -Was not aware client #1 had bruises on her arms, back and wrist until today (8/15/18). -Client #1 would be taken to urgent care immediately to have a medical doctor assess her injuries.	V 291		

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V 291	Continued From page 4 Interview on 8/17/18 with the Licensee revealed: -Was not informed there was a restraint on 8/7/18 that resulted in injuries to client #1 until 8/15/18 -Client #1's injuries were not assessed by a medical doctor until 8/15/18 This deficiency is cross referenced into 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (V537) for a Type B rule violation and must be corrected within 45 days.	V 291		
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	V 537		

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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 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

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V 537	Continued From page 6 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 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.	V 537		

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V 537	Continued From page 7 (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 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.	V 537		

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V 537	Continued From page 8 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility staff failed to demonstrate competence in restrictive interventions for 2 of 6 staff (#1 and #2). The findings are: Cross Reference: 10A NCAC 27G .5603 OPERATIONS (V291). Based on observations, record reviews and interviews, the facility staff failed to coordinate services with the Qualified Professional (QP) and Legal Guardian (LG) for 1 of 3 clients (#1). Review on 8/16/18 of staff #1's record revealed: -A hire date of 4/8/16 -A job description of Paraprofessional -A training certificate for North Carolina Interventions (NCI) parts A and B dated 5/5/18 to 5/31/19 -A two handed hair pull release technique was included in the NCI Training. Review on 8/16/18 of staff #2's record revealed: -A hire date of 3/16/18 -A job description of Paraprofessional -A training certificate for North Carolina Interventions (NCI) parts A and B dated 10/20/17 to 10/31/18 -A two handed hair pull release technique was included in the NCI Training. Review on 8/16/18 of the facility's shift event and behavior log, dated 8/7/18, for client #1 revealed: -" ...Verbal de-escalation. [Client #1] grabbed staff's hair. [Staff #1] had to physically remove [client #1] from staff's hair (remove the clients' hands) ...was refusing to follow household rules. Failure to listen to staff. [Client #1] became very aggressive when staff told her to do something	V 537		

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that she didn't want to do ...she began yelling and cursing at staff when staff tried to re-direct client telling her consequences have actions. She pulled staff's hair ..."

Review on 8/16/18 of the facility's Body Check Form for client #1 revealed:
-On 8/7/18, staff #1 documented at 6:00pm "[Client #1] has no new marks. The redness is going away, small bruise on wrist ..."
-On 8/7/18, staff #2 documented at 8:00pm "[Client #1] has a small bruise on her wrist from staff having to remove her hands from staff's hair ..."
-On 8/15/18, at 8:00am, facility staff documented "small marks on top of her right upper arm"
-On 8/15/18 at 3:00pm, facility staff documented "small marks on her arms/bruises on wrist and back ..."
-On 8/16/18 at 7:00am, facility staff documented "small mark healing on top of arm ...has a sore wrist ..."

Review on 8/16/18 of the facility's shift event and behavior log, dated 8/7/18, for client #1 revealed:
-" ...Verbal de-escalation. [Client #1] grabbed staff's hair. [Staff #1] had to physically remove [client #1] from staff's hair (remove the clients' hands) ...was refusing to follow household rules. Failure to listen to staff. [Client #1] became very aggressive when staff told her to do something that she didn't want to do ...she began yelling and cursing at staff when staff tried to re-direct client telling her consequences have actions. She pulled staff's hair ..."

Review on 8/16/18 of the daily staff summaries for client #1 revealed:
-On 8/7/18 on second shift "[client #1] had a good day up until she came home. She had a behavior

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that involved a physical altercation with staff"
-On 8/15/18 on second shift "[client #1] had a good day today ...was having a little pain around her wrist where the bruise is ..."

Interview on 8/15/18 with staff #1 revealed:
-Was trained in NCI Part A and B
-There was an incident (restraint) with client #1 on 8/7/18
-Worked at the facility on 8/7/18 along with staff #2
-Client #2 had her period and no feminine pads
-Asked client #1 to share her pads with client #2
-Client #1 declined and became "very aggressive"
-"I tried to redirect her and she grabbed both sides of my hair. We went to the floor and [client #1] stayed on her back."
-Stated she grabbed client #1's wrists and held them while she talked with client #1
-"She grabbed tighter, so I sat her down on the floor. [Staff #2] came in and he tried to intervene."
-She released client #1's wrists when her hair was freed
-Was taught the hair pull release during NCI classes provided by the facility.
-Had observed a bruise on client #1's left wrist and documented it on the body check form
-"You have to understand we (facility staff) have to protect ourselves. If marks appear on them (clients) it is because we use the same force as they do to control them. We do our best to keep them safe ..."

Interview on 8/15/18 with staff #2 revealed:
-Had NCI training part A and B
-Worked with staff #1 at the facility on 8/7/18
-Client #1 was upset because she had to share a hygiene pad with client #2 on 8/7/18
-Client #1 lunged at staff #1 in her bedroom and staff #1 "immediately took her down"

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V 537	Continued From page 11 -"[Client #1] had a fistful of [staff #1]'s hair. I saw [client #1] on the floor on her back and she had her legs wrapped around [staff #1]. I grabbed [client #1]'s wrists and put my hands over her fists." -Stated he did not learn this technique in his NCI class. -Later stated he may have grabbed client #1's wrists or elbows but was not sure. -"I was at [client #1]'s head and I held her left hand down on the floor. I also grabbed her right wrist because she had [staff #1]'s hair ...I am very good at de-escalating ..." -Client #1 complained the back of her head and her wrist hurt after the restraint. -"I asked her why she had her behavior and she said she did not like to share ..." Observations and interview on 8/15/18, at approximately 12:10pm, with client #1 revealed: -Was wearing a sleeveless shirt -Had a reddish purple bruise to her left wrist, approximately two inches long -Several greenish-brown bruises inside her left upper arm which appeared to be in the shape of fingerprints -Several darker greenish-brown bruises inside her right upper arm which appeared to be in the shape of fingerprints. -A dark bruise on her back right shoulder, approximately two inches in diameter -A large reddish purple bruise below the back part of her neck -Stated she had a knot on her head which hurt when touched. -When asked about the injuries to her body, client #1 stated staff #1 "took me down" -The restraint occurred in her bedroom -"[Staff #1] told me she was trained to take me down."	V 537		

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V 537	Continued From page 12 -The restraint occurred last week at the facility -"[Staff #1] told me to give a feminine pad to [client #2]. I did not want to. She told me I had better give her (client #2) my 'feminines'. I did not want her to have one because I only had 4 left ..." -Stated she was slammed on the floor by staff #1 and received bruises to her arms and wrist -"Afterwards, my neck and head hurt. I needed to see the doctor, but they didn't take me." -Attempted to get out of the restraint and her back was on the floor -"I grabbed her weave and I wouldn't let go. [Staff #1] had my wrists and squeezed them. [Staff #2] had my arms and pressed down hard. He had my hands over my head, on the floor. I was screaming for someone to help me." -Was afraid of staff #1 and staff #2 -"I think [staff #1] needs to go to jail for what she did." Interview on 8/15/18 with client #2 revealed: -Saw the bruises on client #1 -Had observed staff #1 put her hands on client #1 and "take her down" (was not sure of the date) -"[Staff #1] was holding [client #1]'s wrists and [client #1] had her weave. I don't want to see [staff #1] ever again. I don't like what she does and I am afraid of her ..." -Had not told anyone what occurred with staff #1 and client #1 -Did not feel safe when staff #1 or staff #2 worked at the facility -"I don't want [staff #1] back and I don't want [staff #2] back either" Interview on 8/15/18 with client #3 revealed: -Was present in the facility when staff #1 asked client #1 to give client #2 a feminine pad -"When [client #1] told [staff #1] 'no', [staff #1] put her in a hold. She got bruises on her by the way	V 537		

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	MHL034-223	A. BUILDING: _____ B. WING _____	08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME CARE SOLUTIONS	187 SCOTLAND RIDGE DRIVE WINSTON SALEM, NC 27107

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V 537	Continued From page 13	V 537		

she handled her (restraint) ..."
-Was afraid of staff #1 but not staff #2
-"I am afraid of [staff #1]. She could grab me and take me down. She can't be putting her hands on 'sumers' (consumers) ..."

Interview on 8/15/18 with client #1's Legal Guardian revealed:
-No one had contacted her regarding the restraint or the injuries to client #1 on 8/7/18

Interview on 8/15/18 with the Residential Manager (RM) revealed:
-Was contacted by staff #1 regarding a restraint on client #1 on 8/7/18
-"[Staff #1] called me (on 8/7/18) and said she had to put [client #1] in a therapeutic hold. They said she had a behavior."
-Was informed client #1 had grabbed staff #1's hair and would not let go.
-"I went to the facility (on 8/7/18) and [client #1] was in her bedroom, crying. I did not see any marks on her. I was told the restraint was over some sanitary pads and she did not want another consumer to borrow hers ...she became aggressive and grabbed [staff #1]'s hair ..."
-NCI Part A and B was used only when the clients were a danger to themselves or staff.
-Had no concerns with the facility staff and restraints

Interview on 8/16/18 with the Qualified Professional (QP) revealed:
-Was not made aware client #1 was physically restrained by staff #1 and #2 on 8/7/18
-Was not aware client #1 had bruises on her arms, back and wrist.
-"Staff are to fill out several forms and notify the LG. There was some miscommunication."
-Was made aware (on 8/15/18) of an altercation

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between staff #1 and client #1 (which occurred on 8/7/18)
-"It is my understanding [client #1] did not want to share her sanitary pads with [client #2]. [Client #1] admitted she grabbed [staff #1]'s weave. She did not change her story when I interviewed her yesterday (8/15/18). All of it seems plausible. If [client #1] had [staff #1]'s hair, I can see that another staff would need to intervene. [Staff #2] said he attempted to release the hair from [client #1]'s grip. She is strong ..."
-Identified triggers for client #1 as not getting attention, not getting her way, being told "no" or doing something she doesn't want to do.
-"A therapeutic hold should be used as a last resort ...I know [the NCI Instructor] taught us a hair pull release move. He even said you could pour shampoo on the hair ..."

Interview on 8/16/18 with the North Carolina Intervention (NCI) Instructor for the facility revealed:
-A client should never be on their back during a restraint
-Did not teach the facility staff to restrain clients while they were on the floor
-Had never taught a two hand hair release to the facility staff
-"I do not teach that in my classes."
-Stated if a staff's hair was being pulled by a client, then staff were to put their hands outside of the client's arms, press firmly and use a sweeping motion to have their hair released.
-"What you have described to me is not a proper restraint. Staff should never grab a client's wrist and apply pressure and definitely there should be no bruising ..."
-When asked about using shampoo to loosen a client's grip on staff's hair, the NCI Instructor stated he had heard of that method, but did not

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V 537	Continued From page 15 teach that technique. Interview on 8/17/18 with the Licensee revealed: -Was not informed there was a restraint on 8/7/18 that resulted in injuries to client #1 until 8/15/18 -Client #1's injuries were assessed on 8/15/18 by a medical doctor -Staff #1 and #2 would attend the NCI training on 8/18/18 -The facility would ensure sanitary pads were in stock at the facility Review on 8/17/18 of client #1's discharge papers, from a local urgent care visit on 8/15/18 at 4:15pm, revealed: -"Reason for Visit: Acute pain of left wrist, neck pain, acute and contusion to left wrist." -"Diagnosis: Contusion of left wrist; take over the counter [a national aspirin company] per manufacturer's recommendations for pain; alternate cold/warm compress to affected area for 10 minutes 3 times a day." Review on 8/17/18 of the facility's Plan of Protection, dated 8/17/18 and written by the QP, revealed: -"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? [The facility] immediately took the accused staff off the schedule and notified staff that they must attend NCI training on Saturday 8/18/18. They must also follow up with the QP and do another training on communication and policy and procedures pertaining to therapeutic holds and the expectation of staff completing and contacting appropriate supervisors about the incident. Staff were also aware that they could not be on the premises while the investigation is ongoing. [Client #1] was also take to [an urgent care	V 537		

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center] on the same day (8/15/18) to be immediately checked out to make sure there were no serious damage done to her body parts. [The facility] also started their own investigation to see what exactly happened. Staff were also asked by the QP to give statements about the incident and what transpired with the therapeutic hold. Other clients in the home were questioned about the incident.
-Describe you plans to make sure the above happens. All staff in this investigation will be going to NCI training on 8/18/18. We will also re-train staff on the importance of communicating about anything pertaining to the clients especially therapeutic holds. Staff will be trained by the QP on the importance of completing proper documentation and using the correct therapeutic holds. Staff will then follow up with the QP and take a written test about the policies and procedures for ensuring that the clients are safe. Staff will closely be supervised by the QP. [The facility] will seriously follow up with all staff, in general, on the care of the clients. The QP will also educate staff on why we do not use certain techniques in the group home. For example, isolation or time out and why therapeutic holds are the last resort when de-escalating a behavior."

Client #1 was diagnosed with Mood Disorder, Post-Traumatic Stress Disorder, and Mild Intellectual Disability Disorder and is aggressive at times when she does not get her way or is asked to do something she does not want to do. On 8/7/18, staff #1 asked client #1 to give some of her sanitary napkins to client #2. Client #1 refused to do so and grabbed staff #1's hair. Staff #1 stated she and client #1 went to the floor where client #1 remained on her back. She grabbed client #1's wrists and did not release

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V 537	Continued From page 17 them until her hair was freed. Staff #2 admitted he held client #1's left hand down on the floor and grabbed client #1's right wrist. On 8/15/18, client #1 still had observable injuries. Those injuries were a reddish purple bruise to her left wrist, several greenish-brown bruises inside her left upper arm, several darker greenish-brown bruises inside her right upper arm, a dark bruise on her back right shoulder and a large reddish purple bruise below the back part of her neck. Both staff stated they had training in NCI Part A and B. The NCI Instructor stated the restraint described was an improper restraint. The Residential Manager was notified of the restraint on 8/7/18 by staff #1. The RM failed to notify the QP and therefore, the Legal Guardian was not notified and no medical treatment was sought for client #1's injuries until 8/15/18. This is detrimental to the health, safety and welfare of the client and constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 537		