STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-106	A. BUILDING: _____ B. WING _____	R 10/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & J HOMES, INC.-RICHMOND AVENUE	511 RICHMOND AVENUE BURLINGTON, NC 27217

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on October 10, 2018. 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 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews facility staff failed to develop and implement strategies to address the needs and behaviors affecting one of two clients (#1). The findings are: Cross Reference Tag 115 10A NCAC 27G .0208 CLIENT SERVICES Based on record review and interviews staff failed to provide supervision to ensure safety of one of two clients (#1). Review on 10/10/18 of a Plan of Protection written by the Qualified Professional dated 10/10/18 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?: "L & J Homes will do the following: Hire a Licensed Professional to train staff on assessment and behavior that require (a). 1:1 coverage (b). deescalation of consumer episode (c). crisis response (d). documentation of incidents (e). submission of incident and report writing for submission to IRIS (Incident Response Improvement System), DSS (Department of Social Services), Health Care Registry (f). [Client #1] -we will rewrite treatment plan to address 1:1 coverage. L & J Homes will submit in writing each training by the following: *The name/title of each training. *The training procedure, context and protocols. *Written signature and date of each training. *Log training. *Continuing training ongoing process monthly, quarterly and annually with documentation of incidents and its nature. Describe your plans to make sure the above happens: Immediate mandatory training within the next 7-10 days of all above mentioned. Termination or suspension of any staff who fails	V 112		

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V 112	Continued From page 2 to attend training. When incidents occur use the following process: *Require staff to write incident and submit within 8 hours of incident. *Interview consumer and document incidents. *Interview any other person other than staff person in the community and write report at office of L & J Homes office.*If deemed necessary suspend or terminate staff for incident that involves abuse, neglect or lack of supervision of consumer. Administration Action: *Immediate conduct and internal review of all policies and procedure of L & J Homes to ensure policies address proper guidelines needed to report violations. *Update any policies that are needed updates to follow state regulations. *Self-study to update internal delegation of duties which include: (1). Chain command. (2). Submission of incidents and to ensure whose responsibility it is to retain documentation for submission of incidents. (3). Report incidents in a timely manner. Client #1 had two separate incidents in the last month due to lack of staff supervision. Client #1 had a history of being impulsive, aggressive and property damage. Client #1 also lacks appropriate boundaries. The agency receives funding to provide 1:1 supervision to client #1 at all times. Client #1 went to a neighbor's home unsupervised and exposed his penis to the neighbor and her 9 year old son. Staff #1 was supposed to be supervising client #1, however he allowed client #1 to remain outside alone. Client #1 was on an outing in the community and started a fire at the public library. Client #1 was in the bathroom alone for about 10 minutes and set a roll of toilet paper on fire. Staff #2 was in different area of the library with another client not supervising client #1. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An	V 112		

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V 112	Continued From page 3 administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed each day the facility is out of compliance beyond the 23rd day.	V 112		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children.	V 115		

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V 115	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interviews staff failed to provide supervision to ensure safety of one of two clients (#1). The findings are: Review on 10/4/18 of client # 1's record revealed: -Admission date of 6/15/18. -Diagnoses of Mild Intellectual Disability, Disruptive Mood Dysregulation Disorder, Impulse Control Disorder, Post Traumatic Stress Disorder, Hypothyroidism, Traumatic Brain Injury, Fetal Alcohol Syndrome and Asthma. -Assessment completed 6/1/18 by Qualified Professional revealed: Client #1 needs structure and 24 hour supervision. Client #1 needs 1:1 supervision. Client #1 has a history of impulsive and aggressive behaviors. -"Neuropsychological Evaluation" dated 2/19/16 revealed: Client #1 had a history of impulsive and aggressive behavior. Client #1 had a history of aggressive behaviors towards peers, adults and property. He had a history of physical and sexual abuse. 1. The following is evidence the facility staff failed to provide supervision at the group home. Review of personnel records on 10/5/18 revealed: -Staff #1 had hire date of 5/28/18. -Staff #1 was hired as a Direct Care Worker. -"Employee Warning Notice" dated 9/21/18 had the following: "Leaving [client #1] unattended which could cause physical harm to himself and to personal property." Review of facility records on 10/4/18 revealed: -An incident report dated 9/22/18 had the following: "[Client #1] was outside smoking a cigarette. [Staff #1] went outside to ask for the lighter back. [Client #1] was down by [sister	V 115		

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V 115	Continued From page 5	V 115		

facility] facility doing pushups and [Staff #1] returned inside. [Client #1] came in and went straight into his bedroom. About a minute later the lady down the street told [Staff #1] that [Client #1] exposed himself to her in front of her 9 year old son, then told her to "come get it." [Staff #1] asked [Client #1] about the incident. [Client #1] admitted to doing everything the lady said. [Staff #1] called [the Manager, the Licensee and the Qualified Professional] about the incident."

Attempts to interview client #1 about the incident with the neighbors were unsuccessful.

Interview with a neighbor on 10/4/18 revealed:
-There was a recent incident with client #1 last month.
-Prior to that incident she had seen client #1 sitting near the road on several occasions.
-He would normally sit near the road and throw rocks towards cars.
-He would normally sit near the road unsupervised by staff.
-He came into her yard a few weeks ago and exposed himself.
-Client #1 took out his penis while she was in her yard with her 9 year old son.
-Client #1 said "you want some of this?"
-Client #1 then went back over to the group home.
-Client #1 laid on the ground and started "humping" the ground.
-She went over to the group home and reported the incident to a female staff.
-The female staff informed her client #1 lived at one of the other homes.
-She went to client #1's home and reported the incident to staff #1.
-Staff #1 asked client #1 about the incident.
-Client #1 admitted he did expose himself to

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V 115	Continued From page 6 them. -Her and her son were upset about that incident. -The Licensee and Manager came over to her home later that day. -They both apologized for client #1's actions. Interview with staff #1 on 10/4/18 revealed: -He does work 1:1 with client #1 during 2nd shift. -Client #1 did have a recent incident with a neighbor. -Prior to the incident client #1 was in the backyard area smoking a cigarette. -Another staff was standing in the kitchen area monitoring client #1 through the window. -He was in another area of the home doing his paperwork. -He also had to take phone call. -A little later he realized client #1 did not return the lighter. -Client #1 was no longer in the backyard area. -Client #1 was on the side of the home doing push ups on the ground. -It was not unusual for client #1 to do push ups on the ground. -Client #1 was not being supervised while he was on the side of the home. -He went back into the home while client #1 remained outside. -About 2-3 minutes later client #1 came back into the home and went straight to his bedroom. -He thought that was a little "strange." -A few minutes later a neighbor came over and said client #1 had exposed himself. -The neighbor told him client #1 had shown his penis to her and her 9 year old son. -He contacted the Manager about the incident. -Client #1 does require 1:1 supervision at all times. -During that incident he only left client #1 unsupervised for a few minutes.	V 115		

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V 115	Continued From page 7 -He confirmed facility staff failed to provide supervision to ensure safety. Interview with a staff person on 10/2/18 revealed: -There was an incident a few weeks ago with client #1. -One of the neighbor's came over and reported client #1 had exposed himself. -The neighbor told her client #1 came into her yard unsupervised by staff. -The neighbor told her that client #1 took out his penis in front of her son. -The neighbor said client #1 told them to "suck his penis." -The neighbor was "very upset" and so was her son. -The neighbor and her son were both crying when they came over to her home. -She informed the neighbor that client #1 lives at the group home next door. -During her shift she had seen client #1 on several occasions walking around unsupervised. -She did not think client #1 had unsupervised time at home or in the community. Interview with the Manager on 10/5/18 revealed: -About two weeks ago he received a call from staff #1. -Staff #1 reported there was an incident with client #1. -Staff #1 told him that client #1 had gone to a neighbor's home and exposed himself. -Staff #1 told him that he had gone into the home for about 1-2 minutes. -Staff #1 said client #1 was unsupervised outside while he was in the home. -A neighbor went over to the group home and reported the incident to staff #1. -He and Licensee went over to the neighbor's home and apologized.	V 115		

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V 115	Continued From page 8 -Client #1 was supposed to be supervised at all times. -Staff #1 received a written warning due to lack of supervision. -He confirmed facility staff failed to provide supervision to ensure safety. Interview with the Qualified Professional on 10/4/18 and 10/9/18 revealed: -Client #1 should have 1:1 monitoring at all times by staff. -The agency had received money in order to provide 1:1 staff coverage for client #1. -Client #1 can be impulsive and physically aggressive. -Client #1 does not seem to have a fear of anything. -Client #1 had no boundaries and no fear of strangers. -Client #1 had a history of being sexually abused. -He was aware of the incident with client #1 exposing himself to a neighbor. -Staff contacted the Licensee and Manager about the incident. -He thought the Licensee and Manager took care of that incident with staff. -Client #1 did not have any unsupervised time at the home or community. -Staff was supposed to be supervising client #1 at all times. -He confirmed facility staff failed to provide supervision to ensure safety. Interview with the Licensee on 10/9/18 revealed: -He was aware of the recent incident with client #1. -Staff #1 was responsible for supervising client #1 while at the group home. -Staff #1 contacted management about the incident.	V 115		

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V 115	Continued From page 9 -He and the Manager went over the the neighbor's home and apologized for the incident. -Staff #1 received a written warning for lack of supervision. -He confirmed facility staff failed to provide supervision to ensure safety. 2. The following is evidence the facility staff failed to provide supervision while in the community. Review of facility records on 10/10/18 of a police report revealed: -On 9/8/18 police officers responded to an incident at the local library. Client #1 tore the toilet paper dispenser off the wall and set it on fire. Client #1 was arrested and charged with resisting arrest and injury to real property. Interview with client #1 on 10/4/18 revealed: -He just recently got into trouble while in the community. -He started a fire at the library in the bathroom. -He set the roll of toilet paper on fire. -He tore the toilet paper holder off the wall and put out the fire. -Staff #2 was working with him during that incident. -He thought he was in the bathroom alone for about 15-20 minutes. -He was arrested by police officers for starting the fire. Interview with staff #2 on 10/9/18 revealed: -He was the staff working with client #1 during the fire incident. -Client #2 was also with them at the library. -This incident occurred on a Saturday and he was working alone with both clients. -Client #1 did normally have a 1:1 staff working with him.	V 115		

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V 115	Continued From page 10 -Client #1 went into the bathroom alone. -He sat in another area of the library with client #2. -He thought client #1 was in the bathroom for about 10 minutes. -A library staff approached him and reported the incident. -When he went into the bathroom client #1 had the stall locked. -Client #1 initially would not come out of the bathroom stall. -Client #1 had already put out the fire in the bathroom. -Client #1 had set the toilet paper container on fire. -Client #1 did come out of the bathroom stall and handled him a lighter. -Client #1 had a lighter because he smokes cigarettes. -Once client #1 handed him the lighter he started kicking the walls. -A police officer was already at the library and called for back up. -Client #1 was arrested for the fire incident that occurred at the library. -He confirmed facility staff failed to provide supervision to ensure safety. Interview with the Qualified Professional on 10/4/18 revealed: -There was a recent incident with client #1 in the community. -Client #1 set a fire in the bathroom at the public library. -Staff #2 was with client #1 and another client at the library. -Client #1 went into the bathroom without staff. -Client #1 requires 1:1 staff at all times, however he went into the bathroom alone. -He thought client #1 set the trash can on fire.	V 115		

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V 115	Continued From page 11 -Client #1 was arrested as a result of the incident at the library. -He also had to go to court due to the fire incident. -He confirmed facility staff failed to provide supervision to ensure safety. Interview with the Licensee on 10/9/18 revealed: -He was aware of the incident with client #1. -He was told by staff #2 that client #1 set a fire at the library. -Client #1 was arrested for setting the fire at the library. -He did not know all the specifics of that incident. -He thought the Qualified Professional or the Manager handled the incident with the fire. -He confirmed facility staff failed to provide supervision to ensure safety. This deficiency is cross referenced into 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan(Tag V-112) for a Type A1 rule violation and must be corrected within 23 days.	V 115		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of	V 367		

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V 367	Continued From page 12 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III	V 367		

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V 367	Continued From page 13 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Review on 10/4/18 of client # 1's record revealed:	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-106	A. BUILDING: _____ B. WING _____	R 10/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 14 -Admission date of 6/15/18. -Diagnoses of Mild Intellectual Disability, Disruptive Mood Dysregulation Disorder, Impulse Control Disorder, Post Traumatic Stress Disorder, Hypothyroidism, Traumatic Brain Injury, Fetal Alcohol Syndrome and Asthma. Review of facility records on 10/10/18 of a police report revealed: -On 9/8/18 police officers responded to an incident at the local library. Client #1 tore the toilet paper dispenser off the wall and set it on fire. Client #1 was arrested and charged with resisting arrest and injury to real property. -There was no documentation on an incident report completed by the group home staff for the fire that occurred at the library. Interview with the Qualified Professional on 10/4/18 revealed: -There was a recent incident with client #1 in the community. -Client #1 set a fire in the bathroom at the public library. -Staff #2 was with client #1 and another client at the library. -Client #1 went into the bathroom without staff. -Client #1 requires 1:1 staff at all times, however he went into the bathroom alone. -He thought client #1 set the trash can on fire. -Client #1 was arrested as a result of the incident at the library. -He also had to go to court due to the fire incident. -He thought he did the incident report for the library fire. -He confirmed the facility failed to ensure Level II incident reports were submitted to the LME within 72 hours as required.	V 367		

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V 367	Continued From page 15 Interview with the Licensee on 10/9/18 revealed: -He was aware of the incident with client #1. -He was told by staff #2 that client #1 set a fire at the library. -Client #1 was arrested for setting the fire at the library. -He did not know all the specifics of that incident. -He thought the Qualified Professional or the Manager handled the incident with the fire. -The Qualified Professional normally did the incident reports. -He confirmed the facility failed to ensure Level II incident reports were submitted to the LME within 72 hours as required.	V 367		