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
	MHL092-262	A. BUILDING: ______ B. WING ______	C 10/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYRUS HOME	**3101 GINGER LAKE COURT ZEBULON, NC 27597**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 10/22/18. Complaint Intake # 00144011 was substantiated and deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/Alternative Family Living	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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This Rule is not met as evidenced by:
Based on record review and interview the governing body failed to ensure one of two staff (#1) demonstrated knowledge, skills and abilities required by the population served. The findings are:

Review on 10/17/18 of client #1's record revealed:
-Admission date of 11/23/11.
-Diagnoses of Severe Mental Retardation (non verbal), Bi-polar Disorder, Intermittent Explosive Disorder, Impulse Control, and Mild Cerebral Palsy.

Review on 10/17/18 of Incident Report dated 9/26/18 regarding client #1:
-"[Client #1] was being aggressive toward [client #2]. He hit [client #2] when we first got in the truck. He jumped at [client #2] a few times on the way there. When I asked [client #1] to remove his seatbelt, he did not. I reached in to undo his seatbelt, he laid back and hit [client #2] then kicked me in the groin. I grab his legs and pulled him out of the truck onto the sidewalk.
-[Client #1] was aggressive toward me and [client #2] when he kicked me in the groin, my reflex was to grab him by the legs and pull him out of the truck onto the sidewalk. He had a scuff mark on his arm, but I saw no blood."

During interview on 10/17/18 the Licensee stated:
-Was made aware of incident with client #1 and staff #1 by client #1's day program.

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-The day program called to let her know that staff #1 had called and stated "[staff #1] snatched [client #1] out of truck."
-Client #1's had a history of aggressive behaviors and often hit his peers, his mother and staff at the day program.
-Client #1 had never attempted to hit either she or her husband (staff #1).
-Client #1 always went after client #2 or people he felt were weaker than himself.
-Client #1 had lived with them for eight years.
-Since this incident, client #1 was taken to his doctor for medication adjustment due to his recent increased aggressive behaviors toward client #2.
-Questioned staff #1 about the incident and he stated client #1 had kicked him in his groin and he reacted by "reflex."
-Staff #1 stated he grabbed client #1 by his legs after he was kicked in the groin and pulled him out of the truck where he landed on his buttocks on the pavement outside of the day program.
-"This was an isolated incident."
-The Qualified Professional (QP) spoke with staff #1 on his approach with handling client #1 in this situation.
-"I can't fire my husband" and this was an "isolated incident" that had never happened and will never happen again.

During interview on 10/17/18 staff #1 stated:
-On 9/26/18 client #1 and #2 were walking to the truck to head to day program when client #2 got in the truck first, which set client #1 off because he always wanted to be first in the truck.
-During the ride to the day program, client #1 was "taunting" client #2 like he was going to hit him.
-Once at the day program, he asked client #1

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to remove his seatbelt off.
-He opened client #1's door to assist him, when client #1 punched client #2.
-After client #1 punched client #2 in the chest, then he leaned back in the truck and "kicked me in the groin."
-"I grabbed his legs and jerked him out of the truck" and he landed on the sidewalk on his buttocks area.
-Client #1 did not cry out or make any noises once he landed.
-Client #1 did scratch his elbows from the landing.
-Client #1 got up on his own and walked into the day program.
-Noticed a staff from the day program outside at the time.
-"I acted on reflex," I should have walked away after he kicked me and helped client #2 out of the truck to ensure his safety.
-Was taught to step away when a client is aggressive.
-Client #1 had never hit or kicked him in the past and this caught him off guard.

During interview on 10/17/18 the County Adult Protective Services worker stated:
-Visited client #1 on 9/27/18 and did not observe any scratches or bruises on client #1's arms or back.

Attempted interview on 10/17/18 with client #1 and #2 was unsuccessful due to client #1 is non verbal and client #2 could not provide information regarding incident on 9/26/18.

During interviews on 10/19/18 three staff with client #1's day program stated:
-Noticed staff #1 pull up with the clients, he is

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the usual one who transports them.
-It appeared that staff #1 was having issues getting client #1 out of the car.
-Client #1 had difficulties some mornings getting out of the truck, staff #1 would ask for assistance from day program staff.
-It appeared as though client #1 was laid back in the truck as staff #1 attempted to get him out.
-Did not observe client #1 kick, but due to their view could not see clearly what was going on inside of the truck.
-Observed staff #1 pull client #1 out of the truck by his legs, where he landed on the pavement.
-Did not hear client #1 cry.
-Once client #1 came inside of the program, they helped clean off his arms as they were "scuffed" and apply first aid to his scratches.
-Never observed staff #1 this "rough" with client #1.
-Client #1 had aggressive behaviors at the day program and is difficult to "transition" to and from the day program.

Further interview on 10/22/18 The licensee stated:
-Not aware of any witnesses from the day program observing the incident on 9/26/18.
-The day program is "exaggerating" what happened.
-Staff #1 would never hurt any of their clients.

Review on 10/22/18 of "Plan of Protection" completed by the Licensee revealed:
-"Effective today, staff #1 will be trained on managing aggressive behaviors by NCI (North Carolina Interventions) Instructor. Staff will regularly review [client #1] behavior plan as implemented and ensure the safety of other

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V 110	Continued From page 5 residents. This will be monitored by the licensee." Client #1 had a history of aggressive behaviors toward peers/family members and day program staff on a regular basis, but never toward the licensee and staff #1. On 9/26/18 during transport to client #1's day program, he became aggressive and punching client #2. Once at the day program, staff #1 attempted to get client #1 from the truck when client #1 kicked staff #1 in the groin. Staff #1 stated as a "reflex" he "jerked" client #1 from the truck by his legs, resulting in client #1 landing on his buttocks on the pavement. Client #1 had small scratches on his elbows from the landing. The incident was observed by several staff members from client #1's day program. Client #1 is non verbal and could not provide information to the incident. This deficiency 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 110		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services	V 132		

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as defined by G.S. 131E-201 are being provided.
b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
c. Misappropriation of the property of a healthcare facility.
d. Diversion of drugs belonging to a health care facility or to a patient or client.
e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).
Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure an allegation of abuse against one staff member (staff #1) was initially reported to the North Carolina Health Care Personnel Registry (HCPR) followed by results of an investigation within five working days. The findings are:

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Review on 10/17/18 of facility records revealed no initial notification and/or five day report to HCPR regarding an incident with client #1 on 9/26/18.

During interview on 10/17/18 the Licensee stated:
-Was made aware of incident with client #1 and staff #1 by client #1's day program.
-The day program called to let her know that staff #1 had called and stated "[staff #1] snatched [client #1] out of truck."
-Client #1's had a history of aggressive behaviors and often hits his peers, his mother and staff at the day program.
-Questioned staff #1 about the incident and he stated client #1 had kicked him in his groin and he reacted by "reflex."
-Staff #1 stated he grabbed client #1 by his legs after he was kicked in the groin and pulled him out of the truck where he landed on his buttocks on the pavement outside of the day program.
-A level I incident report was completed by no report of allegations against staff #1 to HCPR.
-"There was no need to do HCPR, it was he reflexes, not intentional."
-"I reviewed the incident reporting requirements and felt this was just a level I incident."
-"This was an isolated incident."
-The Qualified Professional (QP) spoke with staff #1 on his approach with handling client #1 in this situation.
-"I can't fire my husband" and this was an "isolated incident" that had never happened and will never happen again