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	MHL026-912	A. BUILDING: _____ B. WING _____	R 12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 000	INITIAL COMMENTS A complaint and follow up survey was completed on December 19, 2018. The complaints were substantiated (intake #'s NC00146381, NC00146496 and NC00146592). 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 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	V 110		

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V 110	Continued From page 1 for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

This Rule is not met as evidenced by:
Based on record reviews and interviews one of three current staff (#2) and one of one former paraprofessional staff (Former Staff (FS) #6) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:

Review on 12/19/18 of client #3's record revealed:
-23 year old male.
-Admission date of 01/04/13.
-Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Mild Mental Retardation and Autistic Disorder.

Review on 12/19/18 of staff #2's record revealed:
-Hire date of 05/26/15.
-Direct Care Staff.

Review on 12/19/18 of FS #6's record revealed:
-Hire date of 11/17/15.
-Associate Professional/Direct Care Staff.

Review on 12/19/18 of the North Carolina Incident Response Improvement System (IRIS) report for client #3 revealed:
- Date of Incident: 12/11/18.
- Time of incident: 9:00am.
- Incident Comments: "On December 11, 2018 [Client #3] was completing his morning chores and he was asked to clean his room. [Client #3]

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refused to clean the room Staff [FS #6] told him that she would clean it for him when he goes to his Day Program. [Client #3] asked if he could go and check the mail and Staff said yes and he went to the Mail box and act as if he was coming back to the house and then he took off running down the street. [FS #6] (Staff) gathered the other clients and [Client #4] (Client) went down the street to get [Client #3] to come back. [Client #4] (states) caught up with [Client #3] falls to the ground [Client #4] sat beside holding with his left arm on him to keep him running. [FS #6] (Staff) catches up with [Client #3] and [Client #4], [Client #3] he refuses to get in the van, so a pass byer stopped to assist with deescalating [Client #3] to get him in the van. Once [Client #3] got in the Van Staff went back to the home to ensure that the home was locked and secured. Staff was on her way to the Office to get the Director to talk to him about his elopement. In route to the office [Client #3] was kicking the back of the driver seat and Staff asked [Client #3] to refrain from kicking the back of the seat. [Client #4] also asked [Client #3] to stop kicking the seat and [Client #3] began to kick [Client #4]. [Client #4] grabbed [Client #3] and began to hold him down and while [Client #4] was trying to keep [Client #3] from kicking him and [Client #4] stated that he heard a "Pop" and [Client #3] stopped and said that his leg hurt. Director met with [FS #6] and requested that [Client #3] go to the doctor and [FS #6] said yes. Staff states that she asked [Client #3] if he wanted to go the Doctor and he said no he asked for an PRN (as needed) of Ibuprofen for his pain. Third Shift came in and completed his bed check and discovered [Client #3] was in pain and he (staff) called the Group Home Manager ([Group Home Manager]) and he advised Staff ([Staff #3]) to called 911 to take [Client #3] to the hospital. Staff ([Staff #3]) Called the Director at 2:58 am to

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inform them that [Client #3]s going to the Hospital and that the doctor needed to do surgery on his leg because it was broken. December 12, 2018: Director meet with Staff and clients to complete incident report. [Client #3] 's father and care coordinator has been informed about this incident. [Local] Police Department came out to complete and investigation about the incident."
- 12/19/18: "After completing an internal investigation and getting comments from the clients and staff it was alleged by [Client #3] that [FS #6] had hit [Client #3] with the Van. It cannot be determined whether he was hit by the Van or whether [Client #4] broke when he sat on the leg. It is determined that [FS #6] neglected to take [Client #3]to the hospital when instructed by the Director. The Agency has notified [Local] County DSS (Department of Social Services), [Local Management Entity], and the Healthcare Registry in reference to the incident."
- "Describe the cause of this incident, (the details of what led to this incident). [Client #3] being told what do by asking him to complete his morning chores."
- "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. The preventative measure for corrective action is to get additional staffing."

Review on 12/19/18 of the Police Incident/Investigation Report dated 12/11/18 at 23:07 (11:07PM):
-"Crime Description: Unknown incident occurred in victim injuring left femur.
Victim's Statement: [Client #3] stated that he was struck by a motor vehicle operated by an individual identified as an employee of the group home. [Client #3] stated he was walking on [local

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road] and identified the vehicle as a 'blue van' and the driver as a '[Former Staff (FS) #6].' [Client #3] stated that he was struck and was then placed back in the van by group home staff and returned to the residence.
Complainant's Statement: [Staff #3] stated he works for the group home and had just came on shift at 11:00pm. [Staff #3] noticed [Client #3's] left thigh was double the size of his right thigh. [Staff #3] stated he was informed that [Client #3] ran away from the group home at approximately 8:00am this morning and one of the other group home residents tackled him to stop him. [Staff #3] stated he was not informed of any incident by the staff prior to his shift.
Officer's Statement: On Tuesday, December 12, 2018, at approximately 11:07pm, [Detective] responded to [Facility address] to an unknown assault. Upon arrival, I activated my body camera and made contact with the victim, [Client #3], and the reporting party, [Staff #3]. During the investigation, the staff supervisor, [Group Home Manager(GHM)] arrived on scene. [GHM] stated he was not on scene when the incident occurred but that a staff member by the name of [FS #6] was. [GHM] could also not advise of the facts of how the incident and injury occurred and stated he would provide a detailed report and statements from all parties involved in the morning and provide them to [Police Department]. I observed a blue Chevrolet Mini Van in the driveway of the group home. I did not observe any damage to the vehicle that appeared to be consistent with striking a pedestrian. [FS #6] was attempted to be contacted but was unsuccessful. [Fire Department and Emergency Medical] arrived on scene to treat the injury. [Client #3] was transported to [Hospital] by [Ambulance]. I contacted and informed the Watch Commander [name], and notified him of

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V 110	Continued From page 5 the incident and was instructed to complete a Calls for Service report until further details are provided." Interview on 12/19/18 client #1 revealed: -FS #6 did not like client #3 at all because he always lied on her. -FS #6 asked client #3 to clean his room and he did not do it. -Client #3 ran away. -Client #4 ran after client #3 to bring him back to the facility. -Everyone else got in the van with FS #6 to get client #3. -FS #6 cornered client #3 in front of a fence with the van to keep him from running and to block him. -FS #6 did not hit him with the van. -Client #4 "tackled" client #3 and sat on him in the van and hurt client #3's leg. -Client #4 heard client #3's leg "pop." Interview on 12/19/18 client #4 revealed: -Client #3 had a broken leg because FS #6 told him to sit on client #3 to keep client #3 from running away. -The incident occurred the week before last. -Client #3 ran away from the house because he had to clean his room. -When client #3 ran out of the house FS #6 told him to go after client #3. -He had to "tackle" client #3 to get him to stop running. -FS #6 pulled to van in front of client #3 to block him from running. -FS#6 did not hit client #3 with the van but she blocked him by pulling up to a gate. -Client #3 was kicking the seat when he got in the van. -FS #6 told him to sit on client #3 to keep him	V 110		

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from kicking the seat.
-He pulled his leg back and when he did he heard a "pop."
-FS #6 said client #3 was lying and he was not hurt.
-FS #6 did not believe he was hurt so she did not take him to the hospital.
-He felt bad that he broke client #3's leg.
-Client #3's leg did not get broke from being hit by the van the leg was broke from FS #6 telling him to sit on client #3 to keep him from kicking the seat.

Interview on 12/19/18 FS #6 stated:
- She had worked at the agency for approximately 4 years.
- She recalled the recent incident with client #3.
- She arrived to work at approximately 8am. She asked client #3 to clean his room because of the mess.
- Client #3 wanted to check the mail from the day before and she watched him go outside. Client #3 took off running.
- She asked client #4 to watch client #3 while she got the other two clients in the van. When she got down the street client #4 had client #3 pinned down on the ground.
- She was the only staff with the 4 clients. Someone from the neighborhood assisted with getting client #3 in the van.
- Client #3 had asked for a pain reliever.
- She was taking the clients to the agency office and client #3 began kicking her seat and client #4. Client #4 sat on client #3.
- She did not recall anyone requesting client #3 to go to the doctor. The pain medication seemed to work. She did not see any bruising or swelling on client #3.
- She only asked client #4 to watch client #3. She learned later client #3 may have had a fracture.

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V 110	Continued From page 7 Interview on 12/19/18 staff #2 stated: - He had worked at the facility for approximately 4 years. - He normally worked on the 2nd shift- 4pm to 12 midnight. - He recalled the incident on 12/11/18 with client #3. - Client #3 had complained of leg pain during his shift however he thought the issue had been resolved on 1st shift (8am-4pm). - No one informed him client #3 had a significant injury. Client #3 had walked with a limp and he assumed they had followed up on the issue on the prior shift. Client #3 complained of pain but it did not seem to be intense. Client #3 went to his room and slept. - He did not see swelling on client #3's leg until 3rd shift (12 midnight to 8am) came in. - Before he left the facility the 3rd shift staff had called the ambulance due to client #3's complaint of pain. He saw swelling on client #3's leg when 3rd shift came in. Interview on 12/19/18 the Qualified Professional(QP)/Licensee revealed: -She terminated FS #6 because she did not take client #3 to the hospital or doctor when she was told to take him. -She completed the Health Care Personal Registry for FS #6 due to medical neglect. -She did not know FS #6 had not taken client #3 to the hospital. -She had just assumed she had until she got a phone call from the 3rd shift staff telling her client #3 was being taken to the hospital and that he had a broken leg. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (v289) for a Type A1 rule	V 110		

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V 110	Continued From page 8 violation and must be corrected withing 23 days.	V 110		
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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies to address one of three clients (client #3)	V 112		

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V 112	Continued From page 9 behaviors of elopement. The findings are: Review on 12/19/18 of client #3's record revealed: -23 year old male. -Admission date of 01/04/13. -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Mild Mental Retardation and Autistic Disorder. -Treatment Plan for Short Term Goals dated 11/01/18 revealed: "RS5 (Residential Support): [Client #3] monitored for personal safety in the home and community. 5A: Daily with redirections, very instructions, monitoring and assistant from staff, [Client #3] will refrain from elopement for long periods of time." -No strategies for staff to follow for continued elopement behaviors. Review on 12/19/18 of the North Carolina Incident Response Improvement System (IRIS) reports for client #3 revealed: Date of Incident: 12/11/18. - Time of incident: 9:00am. - Incident Comments: "On December 11, 2018 [Client #3] was completing his morning chores and he was asked to clean his room. [Client #3] refused to clean the room Staff [Former Staff (FS) #6] told him that she would clean it for him when he goes to his Day Program. [Client #3] asked if he could go and check the mail and Staff said yes and he went to the Mail box and act as if he was coming back to the house and then he took off running down the street. [FS #6] (Staff) gathered the other clients and [Client #4] (Client) went down the street to get [Client #3] to come back. [Client #4] (states) caught up with [Client #3] falls to the ground [Client #4] sat beside holding with his left arm on him to keep him running. [FS #6] (Staff) catches up with [Client #3]	V 112		

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and [Client #4], [Client #3] he refuses to get in the van, so a pass byer stopped to assist with deescalating [Client #3] to get him in the van. Once [Client #3] got in the Van Staff went back to the home to ensure that the home was locked and secured. Staff was on her way to the Office to get the Director to talk to him about his elopement. In route to the office [Client #3] was kicking the back of the driver seat and Staff asked [Client #3] to refrain from kicking the back of the seat. [Client #4] also asked [Client #3] to stop kicking the seat and [Client #3] began to kick [Client #4]. [Client #4] grabbed [Client #3] and began to hold him down and while [Client #4] was trying to keep [Client #3] from kicking him and [Client #4] stated that he heard a "Pop" and [Client #3] stopped and said that his leg hurt. Director met with [FS #6] and requested that [Client #3] go to the doctor and [FS #6] said yes. Staff states that she asked [Client #3] if he wanted to go the Doctor and he said no he asked for an PRN (as needed) of Ibuprofen for his pain. Third Shift came in and completed his bed check and discovered [Client #3] was in pain and he called the Group Home Manager ([Group Home Manager]) and he advised Staff ([Staff #3]) to called 911 to take [Client #3] to the hospital. Staff ([Staff #3]) Called the Director at 2:58 am to inform them that [Client #3]s going to the Hospital and that the doctor needed to do surgery on his leg because it was broken. December 12, 2018: Director meet with Staff and clients to complete incident report. [Client #3's] father and care coordinator has been informed about this incident. [Local] Police Department came out to complete and investigation about the incident."
- 12/19/18: "After completing an internal investigation and getting comments from the clients and staff it was alleged by [Client #3]that [FS #6] had hit [Client #3] with the Van. It cannot

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be determined whether he was hit by the Van or whether [Client #4] broke when he sat on the leg. It is determined that [FS #6] neglected to take [Client #3]to the hospital when instructed by the Director. The Agency has notified [Local] County DSS (Department of Social Services), [Local Management Entity], and the Healthcare Registry in reference to the incident."
- "Describe the cause of this incident, (the details of what led to this incident). [Client #3] being told what do by asking him to complete his morning chores."
- "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. The preventative measure for corrective action is to get additional staffing."

Date of Incident: 11/23/18
- Time of Incident: 8:30am.
- Incident Comments: "Approximately 8:30 AM [Client #3] asked Staff if he could call his Father. Staff allowed [Client #3] to call his father in reference to him going on a day visit for Thanksgiving. His father shared that he could not come to see him nor pick him up for a day visit. [Client #3] in turn consistently tried to go outside to get Christmas bulbs alone so he could get away. Staff told [Client #3] to wait so she could assist him outside because she knew he planned to get away. [Client #3] paced the floor, in and out of his room. Staff contacted the Group Manager to come and assist with [Client #3]. While Staff was calling the GHM [Client #3] ran out the door running down the street. Staff contacted the authorities and they found [Client #3] and brought him back to the home. After returning to the home Staff processed with [Client #3] and other consumers in which they were good. [Client #3]

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V 112	Continued From page 12 was calm and they all did a group hugs and [Client #3] apologized. They all returned to doing their duties and watching TV. Prior to [Client #3]return Staff was assisting another consumer with their Laundry and [Client #3] went into the kitchen where she was doing laundry and said I am going to leave again, he grab the bleach and threaten to bleach Staff she called the police back. When they returned with [Client #3], he became aggressive and picked up a stick and hit staff's car while the Police was present. The Police explained to both Staff and [Client #3] that they were tired of coming out for his behaviors. Staff contacted the Director and the Director contacted Mr. [Client #3's father] ([Client #3]' father) to see if he could reason with [Client #3]. Mr. [Client #3's father] was not able to get through to [Client #3], so the Director requested that [Client #3] be taken to the hospital get evaluated. [Client #3] was taken to [Local] Hospital where he remains at this time. The Police did not do a police report for the damages on Staff's Care (car)." - "Describe the cause of this incident, (the details of what led to this incident). [Client #3]'s father has been locked up for over 30 days with no contact with [Client #3]. [Client #3] called his father and asked if he could come to see him or pick him up and Mr. [Client #3's father] ([Client #3]'s father) explained to [Client #3]that he could not come to visit him today. Mr. [Client #3's father] shared with [Client #3]the reasoning for his incarceration and the reason that he could not visit for Thanksgiving. [Client #3] got upset about his father not coming for a visit. - "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. [Client #3]'s father (Mr. [Client #3's	V 112		

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V 112	Continued From page 13 father]) needs to communicate more effectively about [Client #3] Triggers. He also needs to understand that [Client #3] copy cats him when he get in trouble, because [Client #3] desires to be like his father. Getting [Client #3's father] to limit his problems and issues with [Client #3]would assist with some of [Client #3]'s behaviors." Date of Incident: 11/17/18 - Time of Incident: 4:30pm. - Incident Comments: "At approximately 4:30 pm Staff ([Staff #3]) called Facility Manager ([Previous Manager]) to report that [Client #3] went outside to take the trash out and decided to elope. Staff was standing at the door watching [Client #3] take the trash to the trashcan and he looked at staff and said I am about to run. Staff ([Staff #3]) redirected [Client #3] to come back house and wait on his father to call. As staff ([Staff #3]) stepped on the porch [Client #3] ran out the yard. Staff ([Staff #3]) followed him. [Client #3] then sat down in the middle of the ran and said he wanted the cars to hit him. Staff ([Staff #3]) tried to encourage [Client #3] to get up out of the road for their safety. But [Client #3]decided to lay down in the road. Staff ([Staff #3]) then called Facility Manager ([Previous Manager]). Facility Manager tried to talk to [Client #3], but it did not want to move. Facility Manager instructed staff [Staff #3] to call 911. When the officers arrived, they recognized [Client #3]. The officer talked to [Client #3]hoping that he would just get up, but he did not. The officer asked [Client #3] what he wanted to do, and [Client #3] replied that he wanted to go to the hospital. Staff ([Staff #3]) gather [Client #3] information and gave it to the officer. The officer transported [Client #3] to [Local Hospital] where he was evaluated. The Hopsital contacted the owner to let them know	V 112		

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V 112	Continued From page 14 that [Client #3] would be evaluated and released on Sunday." - "Describe the cause of this incident, (the details of what led to this incident). [Client #3] was worried about his Father which he had not spoken to in the past 30 days. [Client #3] father explained to him what had happen to him which made [Client #3] upset and wanted to get locked too. [Client #3] enjoys going to the hospital for attention." - "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. Both [Client #3] and his father needs to understand that [Client #3] copy cat things that people tells him." Date of Incident: 10/27/18 - Time of Incident: 10:30am. - Provider Comments: "Today around 10:30 AM just before [Client #3] was to leave for his community Networking at the [Local Agency]. [Client #3] attempted several times to contact his father but however he was unsuccessful. [Client #3] got worried and began to say that his father was missing, and he was homeless. Staff and QP (Qualified Professional) continued to process with [Client #3] about his father being safe and sound. [Client #3] continued to get anxious and say that someone call the group home looking for his father and [Client #3] indicated that he answered the phone. Staff is always answering the incoming phone calls. [Client #3] waited staff went to bathroom and went out the door. Staff, the owner and the other client went looking for [Client #3] for 2 hours. After 2.5 hours passed 911 was activated. The [Local town] Fire Department found [Client #3] on [Local area]. [Local Police] took [Client #3]to [Local] Hospital where he was	V 112		

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V 112	Continued From page 15	V 112		

evaluated. [Client #3] enjoyed the attention bragging about how he ran away. [Client #3] was released with medication for bronchitis. [Client #3] is to follow up with his primary care physician if his cough does not get better."
- "Describe the cause of this incident, (the details of what led to this incident). [Client #3] is worried about his father because he is not answering his phone calls."
- "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. The Agency tried contacting [Client #3's father] as well and there is no answer it goes straight to voice mail. The Agency left message on his phone today about the elopement incident."

Interview on 12/19/18 FS #6 stated:
- She had worked at the agency for approximately 4 years.
- She recalled the recent incident (12/11/18) with client #3.
- She arrived to work at approximately 8am. She asked client #3 to clean his room because of the mess.
- Client #3 wanted to check the mail from the day before and she watched him go outside. Client #3 took off running.
- She asked client #4 to watch client #3 while she got the other two clients in the van. When she got down the street client #4 had client #3 pinned down on the ground.
- She was the only staff with the 4 clients. Someone from the neighborhood assisted with getting client #3 in the van.
- Client #3 had asked for a pain reliever.
- She was taking the clients to the agency office and client #3 began kicking her seat and client

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V 112	Continued From page 16 #4. Client #4 sat on client #3. Interview on 12/19/18 the Qualified Professional (QP)/Licensee revealed: -The facility only had one staff per shift. -Client #3 had been running away every other weekend. -They were unable to put another staff on shift because of the rate they were getting reimbursed and they could not afford the cost of an extra staff. -She had discussed client #3's behaviors with his care coordinator and with the client. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (v289) for a Type A1 rule violation and must be corrected withing 23 days.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The	V 118		

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V 118	Continued From page 17 MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting three of four audited clients (#2, #3 and #4). The findings are: Finding #1: Review on 12/19/18 of client #3's record revealed: -23 year old male. -Admission date of 01/04/13. -Diagnoses of Oppositional Defiant Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD), Mild Mental Retardation and Autistic Disorder. a. Review on 12/19/18 of client #3's Physician orders revealed: -10/04/18 Invega Tablet Extended Release 24 hour 6 mg (milligram) Orally 1 tablet once a day. -11/01/18 Invega Tablet Extended Release 24 hour 6mg Orally 1 tablet once a day.	V 118		

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V 118	Continued From page 18 -Client #3 was admitted to the hospital on 11/23/18-11/29/18 and hospital discharge instructions were to stop taking Invega 6mg tablet extended release 24 hour. -Client #3 followed up with his Psychiatrist on 11/30/18 and was prescribed Invega 6mg 1 tablet once a day. Review on 12/19/18 of client #3's December 2018 MAR revealed: -Invega 6mg 1 tablet once a day- Hand written transcription "D/Ced (discontinued) on 11/29/18." -Client #3 had not received his Invega 6mg since being discharged from the hospital on 11/29/18. b. Review on 12/19/18 of client #3's Physician orders revealed: 11/01/18 -Atenolol 25mg (used to treat angina and hypertension) Take 1 tablet by mouth daily. -Lisinopril 10mg (used to treat high blood pressure) Take 1 tablet by mouth daily. -Metoprolol ER 25mg (used to treat angina and hypertension) Take 1 tablet by mouth everyday. 09/06/18 -Benztropine 2mg (used together with other medicines to treat the symptoms of Parkinson's disease) Take 1 tablet by mouth at bedtime. -Clonazepam 1mg (used to treat panic disorder) Take 1 tablet by mouth every morning and 2 tablets by mouth at bedtime. 11/30/18 -Clozapine 100mg (used to treat severe schizophrenia) 1 tablet in the morning and 3 tablets by mouth at bedtime. -Divalproex 500mg (used to treat manic episodes) Take 1 tablet by mouth daily. Review on 12/19/18 of client #3's October-December 2018 MAR's revealed the	V 118		

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V 118	Continued From page 19 following blanks: -Atenolol 25mg-12/12/18-12/18/18. -Benztropine 2mg-10/13/18, 10/21/18, 11/30/18, 11/31/18, 12/13/18-12/17/18. -Clonazepam 1mg-11/30/18 pm, 11/31/18 pm, 12/12/18 am, 12/13/18-12/18/18. -Clozapine 100mg-11/30/18-11/31/18 pm, 12/01/18 am, 12/02/18 am, 12/12/18 am, 12/13/18-12/17/18 am and pm, 12/18/18 am. -Divalproex 500mg- 11/30/18-11/31/18, 12/12/18 am, 12/13/18-12/17/18 am and pm, 12/18/18 am. -Lisonopril 10mg- 11/31/18, 12/12/18-12/18/18. -Metoprolol 25mg- 12/12/18-12/18/18. During interview on 12/19/18 client #3 revealed: -He received his medication and was not aware of missing any medications. Finding #2: Review on 12/19/18 of client #2's record revealed: - 23 year old male. - Admission date of 12/03/10. - Diagnoses of Severe Intellectual Developmental Disability, ODD and Encephalopathy. Review on 12/19/18 of client #2's medication orders revealed: 10/04/18 - Benztropine 2mg - take one tablet twice daily. - Thorazine (antipsychotic) 200mg - take one tablet in morning, one in the evening and two at bedtime. - Multivitamin (treats vitamin deficiency) - take one tablet daily. - Depakote 500mg - take one tablet twice daily. - Inderal (treats high blood pressure) 10mg - take one tablet three times daily. 10/31/18	V 118		

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V 118	Continued From page 20 - Linzess (treats constipation) 290 micrograms - one tablet twice daily. Review on 12/19/18 of client #2's November 2018 and December 2018 MARs revealed the following blanks: December 2018 - Thorazine - 12/01/18 at 7am, 12/08/18 at 7am and 12/19/18 at 7am. - Benztropine - 12/01/18 and 12/19/18 at 7am. - Multivitamin - 12/01/18 and 12/19/18 at 7am. - Depakote - 12/01/18 and 12/19/18 at 7am. - Inderal 12/01/18, 12/17/18 thru 12/19/18 at 7am and 12/14/18 at 7pm. - Linzess - 12/01/18 and 12/19/18 at 7am. November 2018 - Benztropine - 11/30/18 at 7pm. - Thorazine - 11/28/18 thru 11/30/18 at 7pm. - Depakote - 11/30/18 at 7pm. - Inderal - 11/30/18 at 7pm. Finding #3: Review on 12/19/18 of client #4's record revealed: - 23 year old male. - Admission date of 06/10/13. - Diagnoses of ADHD, Mild Mental retardation, ODD, Bipolar Disorder and Seizure Disorder. Review on 12/19/18 of client #4's physician orders revealed: 08/29/18 - Denta Plus 5000 (prevents tooth decay) use to brush teeth twice daily. 11/29/18 - Intuniv (treats ADHD) 3mg - take once daily. - Vistaril (anti-anxiety) 100mg - take two tablets at bedtime.	V 118		

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V 118	Continued From page 21 - Oxcarbazepine (treats seizures) 600mg - take twice daily. Review on 12/19/18 of client #4's November 2018 and December 2018 MARs revealed the following blanks: November 2018 - Denta Plus, Intuniv, Vistaril and Oxcarbazepine at 7pm. December 2018 - Denta Plus, Intuniv, Vistaril and Oxcarbazepine at 7pm. Interview on 12/19/18 client #4 stated he received his medications as ordered. Interview on 12/19/18 the Group Home Manager stated: - He started working at the facility in his current capacity approximately 2 and one-half weeks ago. - He would ensure the staff completed MAR documentation as required. Interview on 12/19/18 the Qualified Professional (QP)/Licensee revealed: -She was unaware of the change in client #3's medication and was unware client #3 was not getting his medication. -Staff will be retrained in completing MAR's and following medication orders. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (v289) for a Type A1 rule	V 118		

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V 118	Continued From page 22 violation and must be corrected withing 23 days.	V 118		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is	V 289		

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V 289	Continued From page 23 substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record reviews, interviews and observations the facility failed to provide supervised living in a 24-hour facility which provides residential services to individuals who have a developmental disability or disabilities and who require supervision when in the residence affecting one of three audited clients (#3). The findings are: A. Cross Reference 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS. (V110). Based on	V 289		

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V 289	Continued From page 24 record reviews and interviews one of three current staff (#2) and one of one former paraprofessional staff (Former Staff (FS) #6) failed to demonstrate the knowledge, skills and abilities required by the population served. B. Cross Reference 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (Tag 112). Based on record reviews and interviews, the facility failed to develop and implement strategies to address one of three clients (client #3) behaviors of elopement. C. Cross Reference 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (Tag 118). Based on record reviews, observation and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting three of four audited clients (#2, #3 and #4). D. Cross Reference 10A NCAC 27G .5603 OPERATIONS (Tag 291). Based on record reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment, affecting one of three audited clients (#3). Review on 12/19/18 of the Plan of Protection dated 12/19/18 and completed by the Qualified Professional/Licensee revealed: "-What immediate action will the facility take to ensure the safety of the consumers in your care? -Describe your plans to make sure the above happens. The immediate action that Unity Home Care will take to ensure the safety of the consumer will to	V 289		

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V 289	Continued From page 25 be to call Staff Meeting to address the followings: Medication Administration Trainings Training on the Protocol for a Crisis Incident Reporting/How to follow up on an incident The plan is to have a Staff Training to make sure that the reported incident does not happen again." Clients presented with diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Autistic Disorder, Mild Mental Retardation Client #3 presented with diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Autistic Disorder, Bipolar Disorder, Intellectual Developmental Disability and Mild Mental Retardation. Client #3 had several incidents of elopement from the facility with no strategies for staff to address this behavior. On December 11, 2018 client #3 eloped from the facility and FS #6 told another client in the home to assist in returning client #3 back to the facility. In the process of client #4 running after client #3 after his elopement client #4 tackled client #3 on the ground and then again in the van causing a broken femur which ultimately required surgery. Following this incident, staff failed to take client #3 to the hospital for treatment of the fracture and only gave him ibuprofen for the pain. Medical treatment was not sought for almost 24 hours following the incident. There were multiple medication errors for 3 of 4 clients residing in the facility including failing to administer psychotropic medications to client #3 as ordered. These systemic failures resulted in serious harm and neglect and constitutes a Type A1 rule violation and must be corrected within 23 days. An administrative penalty in the amount of	V 289		

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V 289	Continued From page 26 $2000.00 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 289		
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 or legal system is involved or when health or safety issues become a primary concern.	V 291		

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V 291	Continued From page 27 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment, affecting one of three audited clients (#3). The findings are: Review on 12/19/18 of client #3's record revealed: -23 year old male. -Admission date of 01/04/13. -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Mild Mental Retardation and Autistic Disorder. Refer to V110 for specific details Review on 12/19/18 of the local hospital report dated 12/18/18 revealed: "-Reason for hospitalization from 12/12/18-Chief complaint: Struck by a car. Broken Femur. Post Left Femur IM nailing. -Cheif Complaint: Motor Vehicle vs Pedestrian Left Femur Fracture. -Hospital Course: This is a 23-year old mentally retarded male who ran away from the group home he was residing in an during his caputure injured his left femur. The patient was found to be hehydrated with acute renal failure, however urinary tract infection, and was also found to have a left femur fracture. Taken to the operating room at [doctor] and underwent intramedullary nail into the left femur. Operatively the patient did well, his renal funtion improved with IV fluids..." Review on 12/19/18 of the written statement dated 12/11/18 by (FS #6) revealed: "-When staff arrived yesterday [Client #3] room	V 291		

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V 291	Continued From page 28 was not cleaned up and staff asked [client #3] to clean up his bedroom. [Client #3] didn't clean up his bedroom. [Client #3] came out of his bedroom and asked staff could he check the mail and I staff yes. [Client #3] then took off running away. Staff went inside and ask the one client (client #4) to go behind [Client #3] while I go get the van with the other 2 clients in it to go and follow [Client #3]. When staff arrived [Client #4] was holding [Client #3] on the ground. A man was passing by stopped and the man saw [Client #4] holding [Client #3] down and the man assisted staff with helping [Client #3] up off the ground and [Client #3] then got in the car and he started kicking the back of the driver seat. [Client #4] then started trying to hold [Client #3] legs down to stop him from kicking the seat. While [Client #4] were holding [Client #3] leg down [Client #4] hit his leg. [Client #3] came in the house and asked staff to give him something for pain. Staff gave [Client #3] 2 Ibuprofen for the pain." Review on 12/19/18 of a typed report (no date) completed by the Qualified Professional (QP)/Licensee revealed: "...Each client was interviewed based off the incident: [Client #2] stated that he does not know what happened because he was in the car. [Client #4] states that [FS #6] told him to go get [Client #3] to keep him from getting away. [Client #4] ran behind [Client #3] and tackled him down. [Client #4] waited for [FS #6] to pull up and assist him. [Client #4] was trying to pull [Client #3] toward the van and a stranger stopped and assisted with helping [FS #6] and [Client #4] get [Client #3] in the van. [Client #4] stated that [Client #3] was kicking the back of the driver seat and asked him to refrain from kicking the seat	V 291		

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V 291	Continued From page 29	V 291		

which will cause an accident. [Client #3] continued to attack [Client #4] with kicking. [Client #4] sat on [Client #3] leg and he heard an 'POP.' [Client #3] said you my legs is hurt and then they came to the office.
[Client #1] stated that it was not none of his business and he was going to stay out of it, but he told the Assistant Director that [FS #6] used the van to corner [client #3] from running away. The client (client #3) told everyone different stories."

Interview on 12/19/18 client #3 revealed:
-He had gotten home from the hospital yesterday (12/18/18).
-He ran away from the facility because FS #6 was being mean to him.
-FS #6 hit him with the van and broke his leg.
-He did not go to the hospital until late at night.
-FS #6 did not take him to the hospital.
-He went back to the facility after the incident.

Interview on 12/19/18 client #4 revealed:
-He broke client #3's leg by bending his leg and sitting on him after client #3 ran away from the facility.
-FS #6 did not take client #3 to the hospital.
-Staff #3 came on his shift (3rd 12:00am-8:00am) and noticed client #3's leg was out of place.
-The whole day and night client #3 was hurting.
-Client #3 finally went to the hospital around 12:30am because staff #3 saw how much pain client #3 was in and he called the ambulance.
-Client #3 was screaming because he was in so much pain.

Interview on 12/19/18 FS #6 stated:
- She had worked at the agency for approximately 4 years.

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V 291	Continued From page 30 - She recalled the incident with client #3 on 12/10/18. - She arrived to work at approximately 8am. She asked client #3 to clean his room because of the mess. - Client #3 wanted to check the mail from the day before and she watched him go outside. Client #3 took off running. - She asked client #4 to watch client #3 while she got the other two clients in the van. -When she got down the street client #4 had client #3 pinned down on the ground. -Someone from the neighborhood assisted with getting client #3 in the van. - She was the only staff with the 4 clients. - She was taking the clients to the agency office and client #3 began kicking her seat and client #4. Client #4 sat on client #3. -Client #3 asked for something to assist with his pain in his leg. - She did not recall anyone requesting client #3 to go to the doctor. The pain medication seemed to work. She did not see any bruising or swelling on client #3. - She only asked client #4 to watch client #3. She learned later client #3 may have had a fracture. Interview on 12/19/18 staff #2 stated: - He had worked at the facility for approximately 4 years. - He normally worked on the 2nd shift- 4pm to 12 midnight. - He recalled the incident on 12/10/18 with client #3. - Client #3 had complained of leg pain during his shift however he thought the issue had been resolved on 1st shift (8am-4pm). - No one informed him client #3 had a significant injury. Client #3 had walked with a limp and he assumed they had followed up on the issue on	V 291		

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V 291	Continued From page 31 the prior shift. Client #3 complained of pain but it did not seem to be intense. Client #3 went to his room and slept. - He did not see swelling on client #3's leg until 3rd shift (12 midnight to 8am) came in. - Before he left the facility the 3rd shift staff had called the ambulance due to client #3's complaint of pain. He saw swelling on client #3's leg when 3rd shift came in. Interview on 12/19/18 staff #3 revealed: -He came on his shift which was 3rd shift (12:00am-8:00am). -Staff #2 was the staff working when he came on his shift. -When he saw client #3's leg he immediately knew it was broken. -Client #3's leg was swollen and he was in a lot of pain. -Client #3 was hurting and no medical attention for 2 shifts. -Client #3 had to have surgery on his leg and had to have a rod placed in his leg due to the broken bone. Interview on 12/19/18 the Qualified Professional(QP)/Licensee revealed: -She terminated FS #6 because she did not take client #3 to the hospital or doctor when she told her to take client #3. -She completed the Health Care Personel Registry for FS #6 due to medical neglect. -She did not know FS #6 had not taken client #3 to the hospital. -She had just assumed she had until she got a phone call from the 3rd shift staff telling her client #3 was being taken to the hospital and that he had a broken leg. This deficiency is cross referenced into 10A	V 291		

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V 291	Continued From page 32 NCAC 27G .5601 Scope (v289) for a Type A1 rule violation and must be corrected withing 23 days.	V 291		
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 record review, observation and interview, the facility was not maintained in a safe and orderly manner. The findings are: Review on 12/19/18 of client #1's record revealed: - 21 year old male. - Admission date of 03/07/16. - Diagnoses of Moderate Intellectual Disability and Depressive Disorder. - Physician's order dated 10/07/18 - Rolling Walker. Observation on 12/19/18 at approximately 9:00am: - The two entrances utilized by the clients to gain entry into the facility involved steps. - No handicapped accessible ramps for entrance to the facility. - Client #1 and client #3 were in the living room and utilized rolling walkers for mobility. - A smoke detector in the facility emitted a chirping sound approximately ever 35 seconds indicating a battery was needed.	V 736		

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V 736	Continued From page 33 Interview on 12/19/18 the Group Home Manager stated he would follow up on the identified issues at the facility.	V 736		