STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENT LIVING GROUP HOME AT OLD SALISI	2415 OLD SALISBURY ROAD WINSTON-SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on January 25, 2019. The complaint was unsubstantiated (intake #NC00147539). 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 reviews and interviews, the facility staff failed to implement strategies in the treatment/habilitation and the behavior support plan affecting 1 of 3 audited clients (#1). The findings are: Review on 1/24/19 of client #1's record revealed: -An admission date of 11/15/17 -Diagnoses of Impulse Control Disorder, Schizoaffective Disorder, Mixed; Mild Intellectual Development Disability, Personality Disorder with Anti-Social Traits, Hypothyroidism, Astigmatism, Chronic Constipation and Gastroesophageal Reflux Disease. -An assessment dated 11/15/17 noting "Guardian is seeking placement and would like him in an area to keep him busy, indicators of decompensation: being out of cigarettes, after family contact, not getting attention from others, where there is a break up with a significant other, when caught doing something inappropriate and is confronted and the holidays. When depressed he wants to hurt himself but has never made a serious attempt, suspected to have a history of being a victim of physical/sexual abuse as a child and is known to be a perpetrator of sexual misconduct with children and should not be allowed around them." -A treatment plan dated 4/26/18 noting "will improve his daily living skills and hygiene skills through the plan year, improve his social skills to reduce episodes of property damage, injury to self and others as well as reduction in inappropriate behaviors throughout the year, will improve healthy habits by exercising and maintaining healthy food habits throughout the	V 112		

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plan year, will improve his socialization skills by greeting others and improve attention to task, follow rules of the Day Program and complete his activities, will continue his behavior support plan which is monitored by his Psychologist to decrease inappropriate behaviors and hospitalizations"
-A behavior support plan, dated 6/1/18, noting "Goal #1: [Client #1] wants to improve his social skills. The rate of disruptive behavior will decrease to two or less episodes per month per target behavior and be maintained. [Client #1]'s disruptive behaviors include: Physical aggression: hitting, kicking, grabbing and/or pushing others or attempting to do so. Verbal aggression: threatening verbal statements or gestures to include cursing, yelling and screaming. Property destruction: hitting, kicking objects or throwing them in an effort to damage them. To prevent [client #1] from exhibiting aggressive behaviors, staff should use respectful non-commanding language. [Client #1] has been reported to respond negatively to aggressive, demanding language. Treatment procedures: Staff should ensure they are aware and adhere to the following prevention strategies. Know the signs: It is reported that the following are triggers in [client #1]'s disruptive behavior A) when he is out of cigarettes or can't get any. Staff should be aware that these events are likely to cause [client #1] to become aggressive. To prevent [client #1] from exhibiting aggressive behaviors (i.e. hitting, cursing), staff should use respectful non-commanding language and it has been reported [client #1] will respond negatively to aggressive, demanding language. If [client #1] is attempting to exhibit physical aggression, staff should remove others from his proximity and intervene with requesting him to calm down and allow and assist [client #1] to talk it out and then

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redirect him. If staff are unsuccessful in getting [client #1] to calm down and not able to manage the situation safety, follow company emergency policies to include calling 911. If [client #1] begins to yell, scream, cuss and/or threaten, staff should attempt to ask [client #1] in a quiet manner why he is upset and attempt to assist him in resolving the problem and self-calm (listening to music, journaling)."
-There was no documentation or strategies in client #1's treatment or behavior support plan regarding the use of restrictive interventions

Interview on 1/24/19 with client #1 revealed:
-He had issues with staff #1 approximately 2 weeks ago (1/12/19)
-Was told by staff #1 to go to his bedroom after being told he could not have another staff (#2) buy him a drink or give him money to buy a drink
-Got upset and slammed his bedroom door.
-"[Staff #1] came to my room 'running his mouth' and telling me I could not have my door shut. I was cussing and I spit on him. I threw a water bottle at him and threw my shoes at him...he kept saying don't slam the door. I said f**k you m*****f*****r. I spit at his feet and I called him the 'n' word and threw one of my shoes at him."
-Staff #1 pushed client #1 further down on his bed and grabbed client #1 by the collar
-"I punched him in the face. Then he picked me up and threw me on the floor ...he slammed me onto the floor like a sack of potatoes."
-Client #1 stated his back was on the floor and staff #1 "smacked" him (on the face) 5 or 10 times.
-"I tried to block it (the smack). I came around with a right hook and hit him in the mouth. I had bruises on both of my arms where he held me down on the ground. His feet were on both sides of me...I tried to knee him and told him to get out

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V 112	Continued From page 4	V 112		

of my room ..."
-He stated his triggers included being told no and being "nagged"
-Client #1 stated his calming techniques were going to his room to calm down, listening to his music, watching television or writing.
-Stated staff #1 did not help him to calm down by using his calming techniques.

Interview on 1/25/19 with staff #1 revealed:
-Had worked at the facility on 1/12/19 along with staff #2
-After returning from an outing, staff #1 heard client #1 ask staff #2 to buy him a drink
-"He has gotten in trouble on 2 separate occasions by asking staff to buy him things. I told him to go to his room (to calm down). He did and slammed the door and was cussing."
-Client #1 repeatedly asked why he had to go to his room.
-Staff #1 went to client #1's bedroom and told him he was not allowed to have his door closed due to safety reasons
-Client #1 threw his water bottle and it broke into several pieces
-"I asked [client #1] to clean up the pieces of the bottle and the water. He told me he was not doing s**t. I told him he had lost a cigarette (for punishment). He told me he did not care and spit at me."
-Client #1 threw shoes at staff #1 hitting him several times as staff #1 remained in the door way.
-"I went to do a therapeutic wrap but he was on his bed 'squirming'. I tried to gain control of the situation, but he fell on the floor. He called me the 'n' word several more times. I walked out of his room as he punched the wall. I called our Team Lead who told me to call the police."
-"I thought what I did was to try to de-escalate

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V 112	Continued From page 5 him ..." -Denied slapping client #1 -Denied holding client #1 down on the floor. -Had been trained in client #1's treatment and behavior support plans -Did not use any of the interventions listed in the behavior support plan such as requesting client #1 to calm down, to talk it out, using re-direction, asking client #1 why he was upset or attempt to use self-calming skills such as listening to music or journaling Interview on 1/24/19 with staff #2 revealed: -Client #1 became upset on 1/12/19 when he asked her to buy a soda -"[Staff #1] came up and told him he was not to ask for money from the staff. [Client #1] became upset and started cussing. [Staff #1] told him to go to his room." -As client #1 headed to his room, he yelled and called staff #1 a n****r. -"Once [client #1] got to his room, he slammed the door and [staff #1] followed him. I stayed in the living room with the other two clients. I heard a loud thud and went to [client #1]'s room." -Staff #2 stated staff #1 had client #1 on his stomach, face down during the restraint. -Described the restraint as where client #1's head was turned to the side and his hands/arms where underneath his stomach. -The Team Lead was called as was 911. -The police arrived and took him to the hospital. -Observed a small red scratch and slight swelling to client #1's knuckles on his right hand. -Did not hear staff #1 use any strategies listed in client #1's treatment and behavior support plans "except to tell [client #1] to go to his room." Interviews on 1/24/19 and 1/25/19 with the Qualified Professional revealed:	V 112		

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V 112	Continued From page 6 -Was aware of the incident on 1/12/19 where client #1 was restrained by staff #1 -Was recently made aware of client #1's statements he was restrained on the floor and slapped in the face by staff #1 -Had started his internal investigation and removed staff #1 from the schedule -All facility staff had been trained in client #1's treatment plan and behavior support plan -This included his triggers and de-escalation techniques -Staff #1 was trained to use a restraint as a last resort. -Staff #1 should have followed his behavior support plan and allowed him to calm down. Interview on 1/25/19 with the Licensee revealed: -Knew some of client #1's triggers, included any aggressive tone used by facility staff towards client #1 -Was aware of information listed in client #1's treatment plan, but did not want to be quoted on the information given. -Was aware of what occurred on 1/12/19 when staff #1 restrained client #1. -Stated client #1 spit on the staff, threw a filled water bottle on the floor and punched staff in the face. -"It is not unreasonable to think when [client #1] pulled away, that could have led to him falling (on the floor). How do you know he didn't slip on the water that was in his room?" -Did not agree with the surveyor's findings For more information please refer to tag V537. This deficiency is cross referenced into 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint and Isolation Time-Out (V537) for a Type A1 rule violation and must be corrected	V 112		

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V 112	Continued From page 7 within 23 days.	V 112		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service	V 537		

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

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V 537	Continued From page 9 by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in 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.	V 537		

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V 537	Continued From page 10 (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 3 staff (staff #1) failed to demonstrate competence in the use of restrictive interventions. The findings are: CROSS REFERENCE: 10A NCAC 27G .0204 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record reviews and interviews, the facility staff failed to implement strategies in the treatment/habilitation	V 537		

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and the behavior support plan affecting 1 of 3 audited clients (#1).

Review on 1/24/19 of staff #1's record revealed:
-A hire date of 8/18/18
-A job description of Paraprofessional
-A certificate of completion for client specific training, treatment and behavior support plans for client #1 on 8/23/18
-A certificate of completion for North Carolina Interventions Part A and B on 8/18/18.

Review on 1/24/19 of the body check form for client #1, dated 1/12/19, revealed:
-Shift Event and Behavior Log from 8am to 8pm, noting "had a behavior that required intervention: verbal de-escalation and emergency therapeutic hold for 2 minutes. Hold by [staff #1] due to physical aggression, spitting, cursing and yelling. [The Team Lead] was notified."

Review on 1/24/19 of the shift note for 1/12/19 and written by staff #1 revealed:
-"[Client #1] started off good and we went to the mall. Then [client #1] started being aggressive and was asking staff for money. I redirected him to his room. He then threw a cup of water on the floor and broke it. He tried to spit on me as well, throwing shoes at me and punched me in my lip ...claiming to commit suicide ...had to put [client #1] in a therapeutic hold ...cut on his right hand from punching the wall ..."

Review on 1/25/19 of the local police department's Incident/Investigation Report, dated 1/12/19, revealed:
-On 1/12/19 at 6:11pm, the police responded to a Simple Assault-non Aggravated Assault at the group home.
-The victim of the assault was listed as staff #1

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V 537	Continued From page 12 Review on 1/24/19 of client #1's Discharge Summary from a local hospital revealed: -On 1/12/19: "Reason for visit: Psychiatric Evaluation. Diagnosis: Injury due to altercation, initial encounter, abrasion of right hand, initial encounter, finger pain on left hand." -X-rays were taken of client #1's left finger and right hand: No fractures Interview on 1/24/19 with client #1 revealed: -Had asked staff #2 to buy him a soda. -Staff #1 interjected stating staff #2 would not be buying a soda. -Was told by staff #1 to go to his room, which he did and slammed his bedroom door. -Staff #1 went to client #1's bedroom door and told him he was not allow to have his door closed due to safety reasons. -Client #1 spit on staff #1, threw a water bottle at him, called him an "n****r" and then threw a shoe at him. -Was on his bed when staff #1 entered his room. -Was pushed back on his bed (by staff #1) and grabbed by his shirt collar -"[Staff #1] put me on the floor like a sack of potatoes and slapped me 5 or 10 times in the face." - Punched staff #1 in the face which resulted in a swollen upper lip to staff #1. -Was on his back on the floor, during the restraint, as staff #1 held him down by his upper arms and straddled client #1. -Stated he had bruises on both of his upper arms and a scratch on his knuckle. Interview on 1/24/19 with client #1's 1:1 worker at the Day Program revealed: -Client #1 did have a bruise on his arm after 1/12/19	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-288	A. BUILDING: _____ B. WING _____	01/25/2019

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-The bruise was black and blue
-"It was the size of a silver dollar, but it is no longer there. It was about 2 weeks ago ..."
-The 1:1 worker was told by client #1 there was an altercation at the group home (on 1/12/19) and the cops were called
-"He didn't say which staff at the house the altercation was with. He did not mention any names. He did show me the scratch on his knuckle. I saw the injuries but did not document them ..."

Attempted interview on 1/25/19 with the responding officer was unsuccessful as surveyor's telephone call was not returned.

Interview on 1/24/19 with client #2 revealed:
-The police came out when someone was acting out, "like the other night"
-"[Client #1] showed out while [staff #1] and a female were there. He spit on [staff #1] and busted [staff #1]'s lip. He also called staff the "n" word."
-Client #2 stated "he (staff #1) put him (client #1) down on the ground like he is supposed to."
-Did not see the restraint but was told about it.

Interview on 1/24/19 with client #3 revealed:
-Client #1 was "a handful."
-"A couple of weekends ago, [client #1] called [staff #1] the "n" word. He spit on [staff #1] and [staff #1] put him in a therapeutic hold."
-Stated she was in the shower when it happened and only heard client #1 spit on staff #1.
-"Then I heard a punch. [Client #1] used the 'n' word. [Staff #1] got upset and walked away. He had a cut to his lip. The top one. The police came out and took [client #1] to the hospital ..."

Interview on 1/25/19 with staff #1 revealed:

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V 537	Continued From page 14 -Had worked at the facility on 1/12/19 along with staff #2 -Client #1 became upset, slammed his bedroom door and became destructive. -"I went to do a therapeutic wrap but he was on his bed 'squirming'. I tried gain control of the situation, but he fell on the floor. He called me the 'n' word several more times. I walked out of his room as he punched the wall. I called our Team Lead who told me to call the police." -"I thought what I did was to try to de-escalate him ..." -Denied slapping client #1 -Denied holding client #1 down on the floor. Interview on 1/24/19 with staff #2 revealed: -On 1/12/19, she witnessed a restraint on client #1 by staff #1 -Staff #1 had client #1 on his stomach, face down during the restraint. -Described the restraint as where client #1's head was turned to the side and his hands/arms where underneath his stomach. Interviews on 1/24/19 and 1/25/19 with the Qualified Professional (QP) revealed: -Was aware of the incident on 1/12/19 where client #1 was restrained by staff #1 -Was recently made aware of client #1's statements he was restrained on the floor and slapped in the face by staff #1 -Had started his internal investigation and removed staff #1 from the schedule Review on 1/25/19 of the facility's Plan of Protection, dated 1/25/19 and written by the QP, revealed: -"What immediate actions will the facility take to ensure the safety of the consumers in your care? [Staff #1] was removed from the schedule on	V 537		

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1/23/19 and will continue to be removed from the schedule until the internal investigation is complete. Immediately today, 1/25/19, staff and QP will review consumer's crisis plan and behavior support plan to ensure best interventions are utilized as listed in the consumer's plan.
-Describe your plans to make sure the above happens? QP will train staff on the importance of early intervention strategies with the hopes that the consumer will respond well to the intervention strategies. I (the QP) will contact [Client #1's Psychologist] the person who writes the behavior plan to ensure the staff are competent and understand interventions to be support consumers. Staff will also review NCI (North Carolina Intervention) techniques to ensure that therapeutic holds are done properly and are used in emergency situations only as a last resort as taught in NCI training."

Client #1 had diagnoses which included Impulse Control Disorder and Schizoaffective Disorder. He had a history of physical aggression and property destruction which included hitting, kicking, grabbing and/or pushing others and throwing objects in an effort to damage them. The treatment plan included strategies to prevent client #1 from exhibiting aggressive behaviors such as, staff should use respectful non-commanding language, intervene by requesting him to calm down and assist him to talk it out. If client #1 begins to yell, scream, cuss and/or threaten, staff should ask him in a quiet manner why he is upset and attempt to assist him in resolving the problem and self-calm by listening to music or journaling.
On 1/12/19 client #1 got upset, slammed his bedroom door, and began cursing, spitting, and throwing items at staff #1 after being instructed

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V 537	Continued From page 16 that his door needed to remain open for safety purposes. Despite clearly identified intervention strategies to address the behaviors, staff #1 conducted an unapproved restrictive intervention on client #1's bed. Staff #1 was aware of the very specific guidelines for de-escalation and had training for appropriate physical interventions, however he neglected use of both. Client #1 asked Staff #2 to buy him a soda. Staff #1 told Client #1 that Staff #2 would not buy him a soda and told him to go to his room. Staff #1 entered the room, continuing to tell him he had to leave the door open. Client #1 began to curse and spit on staff #1. He threw a water bottle and his shoes at him. Instead of responding in keeping with the guidelines in his treatment plan, Staff #1 put the client in an unauthorized restraint on the client's bed which ended with them both being on the floor. Staff #2 heard a loud thud and went to client #1's bedroom and reported staff #1 had client #1 in an unapproved restraint on the floor, that resulted in bruises to both arms of the client. Client #1 was taken to the hospital. At no time during this incident did Staff #1 attempt to problem solve, or help client #1 use self-calming techniques. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 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 537		