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
	MHL034-380	A. BUILDING: ______ B. WING ______	03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARPE AND WILLIAMS #8	937 GLENCOE STREET WINSTON SALEM, NC 27107

(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 March 22, 2019. The complaints (Intake #NC00149609) and (Intake #NC00149623) were substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illnesses.	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	V 110		

Division of Health Service Regulation

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

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V 110	Continued From page 1 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on observations, interviews and record reviews 1 of 2 staff (staff #1) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Review on 3/20/19 of staff #1's record revealed: -A hire date of 11/8/18 -A job description of Paraprofessional -Orientation training on 11/8/18 which reviewed the facility's policy on drug and alcohol use and visitors at the facility. Review on 3/18/19 of client #1's record revealed: -An admission date of 9/6/18 -Diagnoses of Schizophrenia, Alcohol Use, Chronic Kidney Disease and Substance Abuse -An assessment dated 9/6/18 noting "was admitted from [a state psychiatric facility], was admitted for agitation and disorganized thought process, is chronically disorganized, has a history of violence, past incarcerations and arrests, history of homelessness, lack of insight, history of medication non-adherence, needs a supervised setting, since 1996 there have been 25 prior hospitalizations, level of intelligence appears to be below average and the risk of violence is moderate." -An updated treatment plan dated 1/1/19 noting "will attend the Young Men's Christian Association (YMCA), will use his coping skills to better understand his mental illness as it is directly	V 110		

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V 110	Continued From page 2	V 110		

Continued From page 2

linked to his obsessions as he suffers from obsessive compulsive disorder around his finances."

Review on 3/19/19 of client #2's record revealed:
-An admission date of 9/3/15
-Diagnoses of Schizophrenia, Cannabis and ETOH (Ethyl Alcohol) Abuse
-An assessment dated 9/3/15 and noting "suffers from visual/auditory hallucinations and has a degree of mental illness that would make it difficult, yet impossible to manage his symptoms on his own without the proper education and regular therapy."
-A treatment plan dated 1/1/19 and noting "will reduce his symptoms of auditory and visual hallucinations through medication management, over the next year, will continue as an active participant in working with trans aid to help increase his independence to all medical and psychiatric appointments and facility staff will transport him to non-medical appointments."

Review on 3/19/19 of client #3's record revealed:
-An admission date of 3/27/18
-Diagnoses of Bipolar Disorder, Attention Deficit Hyperactivity Disorder and Nocturnal Enuresis
-An assessment dated 3/27/18 and noting "his grandmother is important to him, when having problems, he needs to be listened to and not cursed or yelled at, need to take his medications daily and as prescribed, needs reminders for appointment times and destinations, needs to set a schedule for the night to assist with his enuresis and encopresis, needs to discontinue drinking liquids at night to help with his incontinence issues, needs encouragement when he does have an accident during the night, acknowledge his diagnoses and to continue practicing good hygiene while cleaning up after said accidents."

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V 110	Continued From page 3 -A treatment plan dated 1/1/19 and noting "To manage symptoms of his mental illness with medication and therapy, needs monthly visits with his psychiatrist for medication management. Needs to attend all medical appointments and therapy sessions, is diagnosed with enuresis and encopresis, and will eventually eliminate all episodes of incontinence." Review on 3/19/19 of client #4's record revealed: -An admission date of 8/28/15 -Diagnoses of Suicidal Ideation, Non-Psychotic Mental Disorder, Tourette's syndrome, Reactive Disorder, Anxiety and Depression (Bipolar) -An assessment dated 8/28/15 and noting "wants to be able to care for himself without the assistance of others, would like to live on his own and manage his own affairs, he needs others to listen to his ideas, let him figure out things on his own, needs medication management and assistance with cooking meals." -A treatment plan dated 1/1/19 and noting "will increase adherence with medication following medical recommendations, take medications as prescribed, attend all medical appointments, following the doctor's orders and receiving education regarding medical recommendations, will learn to cope effectively and independently with symptoms associated with his mental health diagnosis by taking his medications daily, reducing the number of hospitalizations as well as the duration of hospital stays over the next twelve months." Review on 3/19/19 of client #5's record revealed: -An admission date of 6/25/18 -Diagnoses of Delusional Disorder, Personality Type, Traumatic Brain Injury, Diabetes Mellitus Type II and Hypertension -An assessment dated 6/25/18 and noting "needs	V 110		

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assistance with medical appointments, taking medications as prescribed, awareness of his responsibilities within the group home, working things out for himself before others offer answers or suggestions to a problem. Does not like to be talked to as if he was a child, wants more freedom in the group home."
-An updated treatment plan dated 9/1/18 and noting "following the rules of the group home, taking all medications as prescribed by physicians and attending all scheduled appointments and will be allowed to travel in the community without direct staff supervision."

Finding #1
Review on 3/18/19 of the facility's staff meeting on 5/18/18, revealed:
-"Visitors for clients and staff: Staff are not to have any guests (at the facility) after 8:00pm. Period. Point Blank. You should have 1 visitor per day and only for 1 hour. No exceptions. If your family members cannot handle seeing you for a week, then you may need to find another job ..."

Review on 3/18/19 of staff #1's visitor in/out log, from 3/1/19 to 3/11/19, revealed:
-Visitors came to the facility on the following dates: 3/2/19, 3/3/19, 3/4/19, 3/5/19, 3/6/19 and 3/11/19.
-No documentation of any overnight visitors.

Interview on 3/19/19 with staff #1 revealed:
-Had worked at the facility since November 2018
-Her shift was to work 7 days on and 7 days off
-During orientation, she was told about the facility's policy about visitors at the facility while on shift.
-Had visitors at the facility, but never overnight

Interview on 3/18/19 with client #1 revealed:

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-Staff #1 had visitors spend the night during her shift on numerous occasion
-The woman drove a black car

Interview on 3/18/19 with client #2 revealed:
-Sometimes a woman would come to the facility and spends the night with staff #1 (no dates unknown)
-Did not know the name of the woman
-The woman drove a black Acura.

Interview on 3/19/19 with client #3 revealed:
-Acknowledged by shaking his head yes, staff #1 had overnight visitors.

Interview on 3/19/19 with client #4 revealed:
-Staff #1 has had visitors at the facility several times (no dates known)
-"Her female friend comes over and will spend the night. Her friend drives a black car ..."

Interview on 3/19/19 with client #5 revealed:
-Staff #1 had overnight visitors every time she worked
-Was unable to provide any dates

Interview on 3/18/19 with client #1's Psycho Social Rehabilitation Program's Program Director (PSR PD) revealed:
-There was always seemed to be an issue with that particular staff (#1).
-Client #1 would always state he did not like staff #1 and she cussed at him a lot.
-"[Client #1] reported to me the staff (#1) had company at the facility which spent the night (no dates or how often were given) ..."

Interview on 3/20/19 with the Qualified Professional #1 revealed:
-During orientation, staff #1 signed she had read

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and acknowledged the facility's policy on visitors.
-Facility staff had the right to have visitors because they are there for a week and do not go home.
-Regarding the overnight visitors, "no one has ever reported [staff #1] had overnight visitors ...we are in the process of putting cameras in the driveway and in the common areas ..."

Interview on 3/21/19 with the Qualified Professional #2/Administrator revealed:
-Had no knowledge staff #1 had overnight visitors during her shift at the facility
-"We do not allow any overnight visitors for staff or clients ..."

Finding #2
Interview on 3/18/19 with client #1 revealed:
-"[Staff #1] is always nagging me. She gets in my face, real up close, and argues with me."
-Staff #1 cusses all the clients at the group home, "especially if she is mad."

Interview on 3/18/19 with client #2 revealed:
-Stated staff #1 would "get loud" sometimes.
-"When people don't listen to her or talk back, she uses bad words."

Interview on 3/18/19 with client #3 revealed:
-Staff #1 used "tough love" with the clients
-When asked what tough love was, client #3 did not respond to the question
-Staff #1 would get loud sometimes when talking to the other clients.

Interview on 3/19/19 with client #4 revealed:
-Staff #1 was "very difficult to work with."
-"When I lose my cool, [staff #1] will cuss at me. I try to ignore her but she'll just keep cussing me ...I just walk away ..."

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Interview on 3/19/19 with client #5 revealed:
-Had heard staff #1 talk loudly to the other clients, "but not to me because I behave."

Interview on 3/19/19 with staff #1 revealed:
-Had anger issues in the past, "but working with the clients have helped me (to deal with her anger) ..."
-Had worked at the facility since November 2018
-Denied yelling, screaming or cursing at the clients
-"You have to be calm at all times (when the facility's clients are upset) ..."

Interview on 3/20/19 with the Qualified Professional #1 revealed:
-Was not aware of any allegations of staff #1 yelling, cursing or screaming at the clients
-"She had the proper training (on interacting with clients). It is an entry level job. Sometimes it is not a good fit ..."

Interview on 3/21/19 with the Qualified Professional #2/Administrator revealed:
-Was not aware of any instances where staff #1 had yelled or cursed the clients.
-Staff #1 had been trained appropriately on how to interact with the clients.
-"We gave her a lot of hands on experience. I worked with her and so did the administrative team. All the clients stated they liked her as she encouraged them ..."

Further interview on 3/21/19 with the QP #2/A revealed:
-Staff #1 was terminated on 3/20/19 due to the results of the internal investigation.

Finding #3

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Review on 3/18/19 of the facility's staff meeting held 5/18/18 revealed:
-"Drug Policy: For staff, there is absolutely, positively no drinking of any kind on [the Agency]'s property. NO DRUGS. If anybody from the administration team thinks that a staff member is under the influence, you will be terminated on the spot, no questions asked. If we get reports from any clients or clients' family that you are under the influence, you will be let go ..."

Interview on 3/18/19 with client #1 revealed:
-Staff #1 smoked "stink weed (marijuana)" during her shift at the facility.
-Staff #1 also drank alcohol on her shift
-Was not able to give any dates but stated it was "all the time"

Interview on 3/18/19 with client #2 revealed:
-Had smelled marijuana when staff #1 worked at the facility
-When asked how client #2 knew about the smell of marijuana, he stated "I know what it smells like. I used to smoke it."
-Staff #1 smoked marijuana in the staff's bedroom and in the front yard.
-Had never seen staff #1 drink alcohol

Interview on 3/19/19 with client #4 revealed:
-Staff #1 was "very difficult to work with."
-Denied any clients or staff drinking alcohol at the facility
-Stated he had smelled marijuana in the facility before.
-"It is only when [staff #1] works. I can smell it coming up through the vents in the house. She will be go in her room smoking it. I have been around people that have smoked it, so I know what it smells like. It has a skunk smell. It stinks! It smells terrible."

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Interview on 3/18/19 with client #1's Psycho Social Rehabilitation Program's Program Director revealed:
-"[Client #1] reported to me the staff (#1) smoked marijuana and drank alcohol at the house when she is on shift) ..."
-Was unable to give dates of these instances, but reported this to the Qualified Professional (QP #1) on 3/11/19 after talking with client #1

Interview on 3/21/19 with client #1's Legal Guardian revealed:
-Client #1 made statements about staff #1 smoking marijuana while at the facility (on numerous dates).
-This information was revealed during a second interview with client #1 and the QP #1 was informed.

Interview on 3/2/19 with staff #1 revealed:
-During orientation, she was told about the facility's policy regarding drug and alcohol use
-Denied drinking alcohol at the facility
-"My business is my business ...I don't do things like drink alcohol ..."
-Denied smoking marijuana at the facility or ever
-"You will have to prove it (marijuana smoking) to me. If you don't have any proof, no one can say I smoke it ...it is my word against theirs (the clients) ..."

Interview on 3/20/19 with the Qualified Professional #1 revealed:
-Regarding the allegation of staff #1 smoking marijuana, "I don't know why [client #1] and [client #4] are saying [staff #1] smoked marijuana and drank alcohol on her shift ...I pulled the trash can out of the road. I did not see anything in it at all ...I did not see any evidence of anything like drugs or

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alcohol in [staff #1]'s room which is also the staff's office ...The house did not smell of anything. We did not see anything ..."
-Most of the clients have substance abuse issues and "I would never put them in a situation where they were exposed to marijuana ..."

Interview on 3/21/19 with the Qualified Professional #2/Administrator revealed:
-Had no knowledge of staff #1 abusing any substances while on duty at the facility.
-"We do not allow any drug or alcohol use at the facility and [staff #1] had been informed of that."

V 112 — 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan — V 112

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

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obtained.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility staff failed to develop and implement goals and strategies in the treatment plan to address the needs of 1 of 5 clients (#1). The findings are:

Review on 3/18/19 of client #1's record revealed:
-An admission date of 9/6/18
-Diagnoses of Schizophrenia, Alcohol Use, Chronic Kidney Disease and Substance Abuse
-An assessment dated 9/6/18 noting "was admitted from [a state psychiatric facility], was admitted for agitation and disorganized thought process, is chronically disorganized, has a history of violence, past incarcerations and arrests, history of homelessness, lack of insight, history of medication non-adherence, needs a supervised setting, since 1996 there have been 25 prior hospitalizations, level of intelligence appears to be below average and the risk of violence is moderate."
-An updated treatment plan dated 1/1/19 noting "will attend the Young Men's Christian Association (YMCA), will use his coping skills to better understand his mental illness as it is directly linked to his obsessions as he suffers from obsessive compulsive disorder around his finances."
-A court order, dated 4/27/18, for a felony conviction of breaking and entering and larceny with supervised probation for 24 months with a minimum of 9 months and a maximum of 20

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months in custody
-No goals or strategies to address client #1's current probation requirements
-No goals or strategies to address client #1's agitation
-No goals or strategies to address client #1's non-adherence to medication

Interview on 3/18/19 with client #1 revealed:
-Was currently on probation and had served several months in jail
-Met with his probation officer monthly and was transported to the appointments by the Qualified Professional #1 (QP #1)
-Refused to have his blood pressure checked daily
-Would occasionally refuse to take his prescribed medications.
-Was easily agitated by loud noises and had pushed facility staff in the past.

Interview on 3/20/19 with the QP #1 revealed:
-Regarding treatment plans, the QP #1 is responsible for them and the treatment plans are based off the assessments.
-Was responsible for goals and strategies
-With client #1's treatment plan, was aware client #1 was on probation and had met with his probation officer
-"I always put about 2 goals for everyone. When we do treatment team meetings, we will add goals ...we recently met with a new probation officer and we will be updating his goals ...I see where we need to address his verbal aggression ...it's off the charts. The morning confusion (agitation) is going to be addressed ...the treatment plan is about the clients and their needs. I was also aware of his non-compliance with medications and having his blood pressure checked daily ...it has only been an issue recently

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V 112	Continued From page 13 ..." Interview on 3/21/19 with the Qualified Professional #2/Administrator revealed: -The QP #1 was responsible for the treatment plans which included goals and strategies based on a client's assessment -Was aware client #1 was on probation because he was readmitted to the facility after his incarceration -Was also aware of client #1's refusal to have his blood pressure checked daily, his refusal of prescribed medications at times and his level of agitation which results in verbal aggression. -"How he is presenting himself now is a new behavior for us ..."	V 112		
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 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	V 132		

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V 132	Continued From page 14 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 interviews, the facility failed to protect the client from harm while the investigation was in progress. The findings are: Interview on 3/18/19 with client #1 revealed: -Was hit by staff #1 on 3/11/19 with a broom handle -Staff #1 was allowed to continue working at the facility after the incident on 3/11/19 Interview on 3/19/19 with staff #1 revealed: -Was aware of client #1's allegations of being hit with a broom handle by herself -Remained on the schedule after 3/11/19 and her last day working at the facility was 3/14/19	V 132		

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V 132	Continued From page 15 Interview on 3/21/19 with the Qualified Professional #2/Administrator revealed: -The HCPR was not notified of the allegation of physical abuse to client #1 by staff #1 -"Since [client #1] recanted his story, we did not notify the HCPR. He originally stated he fell down the steps and that is how he got the injuries to his back ..." -Staff #1 remained on the schedule and continued to work at the facility after the allegations of abuse by staff #1 on 3/11/19 -Staff #1 was not removed from the scheduled until 3/14/19 -Was not aware of the allegation of staff #1 pouring water on client #4 and his food -Was not aware of the allegation that staff #1 grabbed client #4's wrist and tried to slap a cigarette out of his hand. This deficiency is crossed referenced into 10A NCAC 27D .0304 Protection from Abuse, Harm, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 132		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).	V 318		

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V 318	Continued From page 16 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the Health Care Personnel Registry (HCPR) of all allegations against health care personnel and report the results of the investigation. The findings are: Review on 3/20/19 of the facility's Level III incident report for 3/11/19 revealed: -No level III incident was submitted to the HCPR within the mandated time frame Interview on 3/21/19 with the Qualified Professional #2/Administrator revealed: -The HCPR was not notified of the allegation of physical abuse to client #1 by staff #1 Division of Health Service Regulation -"Since [client #1] recanted his story, we did not notify the HCPR. He originally stated he fell down the steps and that is how he got the injuries to his back ..." -Was not aware of the allegation of staff #1 pouring water on client #4 and his food -Was not aware of the allegation that staff #1 grabbed client #4's wrist and tried to slap a cigarette out of his hand.	V 318		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the	V 367		

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consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.

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(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the

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facility failed to report a Level III incident to the Local Management Entity (LME) within 24 hours of becoming aware of the incident. The findings are:

Review on 3/20/19 of the facility's internal incident report, dated 3/11/19 with the time noted as 7:20am and written by staff #1, revealed:
-"Description of the Incident: [Client #1] walked out of the home because he refused to let me check his blood pressure. He pushed me and he was also in my face but everything is fine. He went to [the Psycho-Social Rehabilitation Program (PSR)]."
-"Additional comments and/or steps taken to prevent reoccurrence: I asked him to come take his medication this morning (3/11/19). He got upset and started talking junk. He called me a name and was all in my face. He also left the facility with no permission. He came back and left and went to the PSR."
-No documentation of client #1 falling on the back steps of the deck
-No documentation of the injuries to client #1's back
-No documentation of client #4's allegation against staff #1 for grabbing his wrist and attempting to slap a cigarette out of his hand
-No documentation of water being thrown on client #4 and his food by staff #1

Review on 3/20/19 of the facility's Level III incident report for 3/11/19 revealed:
-No level III incident was submitted to Incident Reporting Improvement System (IRIS) within the required 24 hour time period

Interview on 3/20/19 with the Qualified Professional #1 (QP #1) revealed:
-The QP #1 and The Qualified Professional

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#2/Administrator (QP #2/A) were made aware, immediately, on 3/11/19, of the allegation of physical abuse by staff #1.
-"She did not put it in IRIS within 24 hours, but on Thursday (3/14/19) or Friday (3/15/19), she called for additional information on the incident ..."
-Does not know why the QP #2/A did not submit the incident report within 24 hours
-Was not aware of client #4's allegation of having his wrist grabbed by staff #1 or staff #1's attempt to slap a cigarette out of his hands.

Interview on 3/21/19 with the QP #2/A revealed:
-Was responsible for submitting Level II and Level III incident reports into the Incident Response Improvement System (IRIS).
-"I learned a little bit about the incident with the staff on Tuesday, 3/12/19, after [client #1] was interviewed by [the QP #1], I learned even more about it on Friday (3/15/19) ...I had gotten a call from [the LME] that the incident was to be submitted as a level III and not a level II. In our account the consumer made the allegations while at the PSR Program. [Client #1] admitted to making up the incident to get [staff #1] fired ...We did not do a full IRIS report ..."
-Was not aware of staff #1 pouring water on client #4 and his food.
-Was not aware staff #1 grabbed client #4's wrist and attempted to slap a cigarette out of his hand.

V 512	27D .0304 Client Rights - Harm, Abuse, Neglect	V 512		

10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION
(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.
(b) Employees shall not subject a client to any

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sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.
(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.
(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.
(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, 1 of 2 staff (#1) subjected 2 of 5 clients (#1 and #4) to abuse and 2 of 2 Qualified Professionals ((QP #1) and Qualified Professional #2/Administrator (QP #2/A)) failed to protect 2 of 5 clients (#1 and #4) from abuse and harm. The findings are:

Cross reference: NCAC 27G .0604 Incident Reporting Requirements (V132). Based on interviews, the facility failed to protect the client from harm while the investigation was in progress.

Review on 3/18/19 of client #1's record revealed:
-An admission date of 9/6/18
-Diagnoses of Schizophrenia, Alcohol Use, Chronic Kidney Disease and Substance Abuse
-An assessment dated 9/6/18 noting "was

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admitted from [a state psychiatric facility], was admitted for agitation and disorganized thought process, is chronically disorganized, has a history of violence, past incarcerations and arrests, history of homelessness, lack of insight, history of medication non-adherence, needs a supervised setting, since 1996 there have been 25 prior hospitalizations, level of intelligence appears to be below average and the risk of violence is moderate."
-An updated treatment plan dated 1/1/19 noting "will attend the Young Men's Christian Association (YMCA), will use his coping skills to better understand his mental illness as it is directly linked to his obsessions as he suffers from obsessive compulsive disorder around his finances."

Review on 3/19/19 of client #4's record revealed:
-An admission date of 8/28/15
-Diagnoses of Suicidal Ideation, Non-Psychotic Mental Disorder, Tourette's syndrome, Reactive Disorder, Anxiety and Depression (Bipolar)
-An assessment dated 8/28/15 and noting "wants to be able to care for himself without the assistance of others, would like to live on his own and manage his own affairs, he needs others to listen to his ideas, let him figure out things on his own, needs medication management and assistance with cooking meals."
-A treatment plan dated 1/1/19 and noting "will increase adherence with medication following medical recommendations, take medications as prescribed, attend all medical appointments, following the doctor's orders and receiving education regarding medical recommendations, will learn to cope effectively and independently with symptoms associated with his mental health diagnosis by taking his medications daily, reducing the number of hospitalizations as well as

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the duration of hospital stays over the next twelve months."

Finding #1
Review on 3/18/19 of the photographs, taken by Psycho Social Rehabilitation Program's Program Director (PSR PD), dated 3/11/19, revealed:
-A linear mark on the right side of client #1's back, approximately 8 inches in length which was approximately ½ inch in a cylinder shape width, angled down to right above the waist line.
-There was broken skin at the top of the linear mark which was pinkish to red in color
-The area of the broken skin was large and swollen
-Other marks in the area were reddish and raised.
-Client #1 also had broken skin on his right elbow

Observation and interview on 3/18/19 with client #1 revealed:
-Maintained good eye contact throughout the interview
-Had constant movement of his legs as if anxious
-On the morning of 3/11/19, client #1 refused to have his blood pressure checked by staff #1
-He went outside to have a cigarette and staff #1 followed him onto the facility's back deck.
-Was told by staff #1 to put his cigarette out and come into the facility to have his blood pressure checked
-Refused and called staff #1 a "b***h"
-"She was nagging me. She got in my face, real up close, and argued with me."
-When client #1 refused to go back into the facility, "She [staff #1] picked up a broken broom handle and hit me on the back ..."
-Client #1 lifted his shirt and pointed to his back stating "see my scar. My guardian already took photos of it ..."

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-Client #1's injury was observed to be a linear mark approximately 6 to 8 inches long, with scabbed over areas in several places.
-The injury had bruising around the scabbed areas
-The linear mark was fading towards the edge of his waist band, but the top of the injury had lines on each side and it appeared to have a larger injury at the end of the linear scabbed area.
-"I got mad after she hit me and I walked up to the store. She told me to go ahead and walk to the store because she had people that would kick my a**."
-After he was hit by staff #1, he returned to the facility and caught the transportation bus to the Psycho-Social Rehabilitation (PSR).
-Once at the PSR, client #1 told the PSR PD he was having a bad day.

Interview on 3/18/19 with the PSR PD revealed:
-Client #1 arrived at the PSR program on 3/11/19 and stated he had already had a bad day.
-"When I asked why he was already having a bad day, [client #1] stated [staff #1] hit him with a broken broom handle ...I spoke with him further. He told me the argument was over cigarettes, medications and blood pressure issues. [Client #1] stated he and the staff cursed one another. She followed him outside (onto the back deck), picked up a broken broom handle and hit him on the back with it ..."
-Had observed client #1's injuries and took photographs (on 3/11/19).
-Contacted the facility's Qualified Professional #1 (QP #1), completed an incident report and called the Department of Social Services
-Applied first aid as the injury appeared to have bled and "the skin was gone" at the very top of the injury.
-Client #1 had specifically mentioned the staff's

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name and what had occurred
-The QP #1 of the group home came to the PSR program on 3/11/19.
-"[The QP #1] stated he had spoken with the staff already and the staff said [client #1] fell of the porch when he pushed [staff #1]. [The QP #1] also stated [client #1] was trying to get the staff fired because he does not like her."
-Client #1 had been very consistent with what occurred on 3/11/19
-"He told me she did not need to do that...He said he got mad and pushed the staff off the porch and walked off. He stated he wanted that staff member to be removed ..."

Interview on 3/19/19 with client #1's Legal Guardian (LG) revealed:
-Had been working with client #1 for 2 years
-Was made aware of an incident on 3/11/19 between client #1 and staff #1
-Client #1 made statements staff #1 hit him on the back with a metal broom handle
-Observed a red linear welt with scabbing and bruising on client #1's back on 3/12/19
-Took photographs of the injuries
-Had spoken with the QP #1 regarding client #1's injuries
-"[The QP #1] told me [client #1] fell on the deck. [Client #1] denied falling on the back deck and getting any injuries ...my concern was the staff involved was not removed from the schedule and was allowed to continue working. I told [the QP #1] something had happened. [Client #1] told me he was upset because he wanted to smoke a cigarette and did not want his blood pressure checked on 3/11/19..."
-Had made it clear, to the QP #1, client #1 was not safe with staff #1 being allowed to remain working at the facility.

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Further interview on 3/21/19 with client #1's LG revealed:
-Client #1 stated "I am so glad I won't be around [staff #1] anymore."
-Statements by client #1 about staff #1 striking him with a metal broom had been consistent during several follow up interviews with the LG.
-Client #1 had not recanted his story during the interviews

Observations on 3/21/19, from approximately 7:58am to 8:33am, of the facility's grounds revealed:
-The facility's back door led to a wooden deck with wooden railings.
The wooden deck was approximately 20 by 12 feet
-Approximately 2 feet from the back door were 2 steps that lead to two steps.
-The steps led into the yard

Further observations on 3/21/19 of the inside of the facility revealed:
-Inside the facility, located in the kitchen area, were a gray mop and a gray handled broom.
-Both appeared to have been used and were not new
-No broken broom or broom handle were observed on the facility's grounds.

Interview on 3/20/19 with client #4 revealed:
-On 3/11/19, client #4 was asleep and heard yelling outside on the facility's back deck.
-"I could tell by their voices, it was [client #1] and [staff #1]. I heard a loud thump, but did not see anything ...later (on 3/11/19), [client #1] showed me a place where he said he got hit by [staff #1] when she hit him with the broom handle ...[Client #1] had a pretty deep cut on the back of him ..."

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Review on 3/29/19 of the facility's documentation, dated 3/11/19 at 7:20am and written by staff #1, revealed:
-"Description of Incident: [Client #1] walked out of the home because he refused to let me check his blood pressure. He pushed me and he was also in my face but everything is fine. He went to the PSR."
-"Additional Comments and/or Steps Taken to Prevent Reoccurrence: I asked him to come take his medication this morning and he got upset. He started talking junk. Calling me names. He got in my face. He also left the facility with no permission and came back and he went and went to the PSR."
-No documentation regarding client #'s slip or fall on the facility's back deck.
-No documentation of staff #1 being on the telephone with QP #1 during the incident.

Interview on 3/19/19 with staff #1 revealed:
-Had anger issues in the past, "but working with the clients has helped me ..."
-Had worked at the facility since November 2018
-Client #1 refused to have his blood pressure checked in the morning on 3/11/19
-He also refused to take his medications
-"He walked outside (to the back deck) to smoke a cigarette. I stood at the door way and told him to come inside and he refused. He forcefully pushed me in the chest as I stood in the doorway. Because it had been raining, he slipped off the deck. I did not see him land or anything. I did not even know he had any injuries. I was on the phone with [the QP #1] when he pushed me ... [client #1] never came inside and instead walked up the street ..."
-Staff #1 did not ask client #1 if he was okay after he slipped on the deck and did not check to see if he was injured.

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-"We don't even have a metal broom at the facility ..."
-On some days client #1 would refuse his medications.
-"He will not do what he is supposed to do. I have told him to calm down when he gets upset. He had never acted like he did on that day (3/11/19). I put everything in our documentation system of what occurred. I don't know what occurred after he walked off the premises. I don't know if he hurt himself while he was headed off the premises ..."
-The last day staff #1 worked was the morning of 3/14/19 when she was relieved
-Was not taken off the schedule until 3/14/19
-Client #1 was manipulative and lied.
-Would get in staff #1's face when he did not have any cigarettes
-"It gets on my nerves, but I deal with it ..."
-Was trained "not to hit them (the clients)"
-Denied hitting client #1 with a broom handle or any object
-"[Client #1] has pushed me in the past. This was not the first time (on 3/11/19). He got up in my face twice ...I should have pushed him back the first time, but I didn't ...sometimes you just have to bite your tongue when working with the clients. I just call my boss and do document it."
-"You have to be calm at all times ...sometimes when [client #1] gets upset, he goes on and on and on. [Client #1] 'knick knacked, paddy whacked' over stuff ...I am not trying to hear that. He is a grown man and knows right from wrong. He knows what he has to do. I could have reacted to him pushing me, but I didn't ..."

Interview on 3/20/19 with the QP #1 revealed:
-Was on the phone on 3/11/19 with staff #1 when she was pushed down by client #1
-There was no mention by staff #1 to the QP #1 that client #1 had slipped while on the deck.

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V 512	Continued From page 29 -Saw injuries to client #1's back on 3/11/19 at the PSR. -"I feel most comfortable saying he fell. He wants her (staff #1) out of there (the facility) ..." -The QP #1 stated he not only has to protect the clients but the staff as well. -"[Client #1] had mental issues and we have to take that into account. I believe [client #1] was trying to get away without having his blood pressure checked. I do not believe she hit him with a broom handle. I have looked into it and I cannot find any evidence of [staff #1] hitting [client #1] ..." -Stated, regarding client #1's injury, "he said nothing to me when he was injured. Nothing was ever reported he fell or hurt himself. When he got to the day program, his account of what happened was [staff #1] hit him with a broom handle ...his legal guardian called me and said there was an allegation of abuse by a staff member ...we went straight to the PSR. When we got there he was all smiles. His illness makes him difficult ...[staff #1] was trying to do her job. He was irate and she was not. I know that because I was on the phone with her. I did not hear any screaming between [staff #1] and [client #1] ...she called me a second time (on 3/11/19) to say he had walked off the property. She did not even know he was even injured at that time. She told me she was pushed by [client #1] ..." -Was told by client #1 he did not push staff #1 at all -"[Client #1] had a scratch on his back but he was not in danger ..." -Staff #1 was not removed from the schedule (on 3/11/19) and remained on her shift through 3/14/19. -"That (not removing staff #1 from the schedule as soon as the allegation was made) is on me." -Went directly to the PSR on 3/11/19 and	V 512		

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interviewed the other consumers
-Then the QP #1 interviewed client #1 a second time.
-"I got a different story than what you have been told by [client #1]. He changed his story (that he did fall) when he tried to get away from [staff #1]. In hindsight ...we should have taken her off the schedule. We are in the process of completing her termination papers. She had the proper training. It is an entry level job. Sometimes it is not a good fit ..."
-Staff #1 was terminated due to the results of the internal investigation as well as clients' interviews

Interview on 3/21/19 with the QP #2/A revealed:
-Was made aware of the incident between client #1 and staff #1 on 3/11/19.
-Was aware of the allegations of abuse and client #1 alleged he was struck by staff #1 with a broom handle.
-"When he was interviewed at the PSR, he admitted he made up the story and was trying to get [staff #1] fired ...he even recanted his story ..."
-Since client #1 had recanted, staff #1 was not removed from the schedule and continued to work her shift through 3/14/19.

Finding #2
Interview on 3/19/19 with client #4 revealed:
-Staff #1 was "very difficult to work with."
-Described an incident that occurred two to three weeks ago with staff #1 (exact date not known).
-Was eating alone at the table when staff #1 attempted to engage client #4 in conversation.
-"She was trying to talk to me. I did not feel like communicating with her. When I would not talk to her, she picked up my cup (gray 12 ounce size) and poured the water on me and my food ..."
-Another incident with staff #1 occurred sometime in December 2018 where staff #1 grabbed client

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#4's wrist and attempted to strike a cigarette out of his hand "because I would not stop smoking and come back into the house like she told me to ..."

Interview on 3/19/19 with staff #1 revealed:
-Had anger issues in the past, "but working with the clients has helped me ..."
-Had worked at the facility since November 2018
-The clients at the facility are "mental patients."
-"I would not go outside of my job duties to hit anyone (the clients)."
-The last day staff #1 worked was the morning of 3/14/19 when she was relieved
-Was not taken off the schedule on 3/11/19 to 3/14/19
-Denied throwing water on client #4 and his food
-Denied grabbing client #4 by the wrist
-Denied hitting a cigarette out of client #4's hand

Interview on 3/20/19 with the QP #1 revealed:
-Client #4 had never mentioned any issues with staff #1
-Not aware of staff #1 pouring water on client #4 and his food
-"He is making that up ..."
-Not aware of the allegation of staff #1 grabbing client #4's wrist or knocking a cigarette out of his hand.

Interview on 3/21/19 with the QP #2/A revealed:
-Was never made aware of client #4's allegations of having water poured on him and his food by staff #1
-Was not aware staff #1 had grabbed client #4's wrist or attempted to knock away his cigarette as he was not following staff's directives.

Review on 3/22/19 of the facility's plan of protection, dated 3/22/19 and written by Home

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Attendant Supervisor revealed:
-"What immediate actions will you take to ensure the safety of the clients? 1. The Incident Report concerning the assault was placed in the IRIS system by [the QP #2/A] on 3/15/2019. We will immediately schedule and insure retraining was completed on HCPR reporting requirements. 2. We will immediately schedule Abuse-Neglect-Exploitation-Harm training. 3. [The QP#2/A] and [the QP #1] will be retrained immediately in the IRIS system. 4. The staff member been removed permanently from employment with Sharpe and Williams Group Homes and is ineligible for rehire. 5. We will continue to meet with staff and clients weekly. Announced and unannounced visits to ensure the clients' safety and well-being and protection will be documented after each visit.
-Describe your plans to ensure the above happens. 1. I will be responsible for ensuring the incident report have been recorded in IRIS. Documentation will be provided for the training on HCPR reporting requirements. 2. I will be responsible for ensuring the report of the incidents have been recorded in the Healthcare Registry. Documentation will be provided for Abuse-Neglect-Exploitation-Harm training. 3. I will be responsible for ensuring the training in the IRIS system will be completed by [the QP #2/A] and the [QP #1], Documentation will be provided. 4. I will be responsible for ensuring the termination letter has be provided to the staff member and it will be immediately ready for review. 5. An outside Agency's QP will oversee these improvements occur within the plan of protection and document all findings.

Client #1 had diagnoses of Schizophrenia, Alcohol Use, Chronic Kidney Disease and Substance Abuse. He was admitted from a state

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psychiatric facility due to agitation, had a history of violence with the risk assessed as moderate, had a level of intelligence which was below average and a history of medication non-adherence.
Client #4 had diagnoses of Suicidal Ideation, Non-Psychotic Mental Disorder, Tourette's syndrome, Reactive Disorder, Anxiety and Depression (Bipolar). He wanted to be able to care for himself without the assistance of others, to live on his own, manage his own affairs, needed others to listen to his ideas, let him figure out things on his own, learn to cope effectively and independently with symptoms associated with his mental health diagnosis.
Staff #1 struck client #1 on his back with a broken metal broom handle when he refused to have his blood pressure checked, take his prescribed medication and come inside the facility as directed on 3/11/19. Review of photographs, taken on 3/11/19, of client #1's injuries, revealed a 6 to 8 inch linear mark which was raised and red in color. The top of the injury had numerous places where the skin was removed and had bled. When the injuries were observed 7 days after the incident (3/18/19) there was still a very straight linear mark approximately 6 to 8 inches long, at an angle. The linear mark was fading at the area which was located just above his waist band. There were several scabbed over areas at the top of the injury. Those injuries showed deeper marks of where the impact from the broom occurred. There were also dark bruises above and below the scabbed over areas. Staff #1 admitted she had anger issues in the past and got frustrated when client #1 did not follow her directives. The QP #1 was made aware of client #1's statements when notified by the PSR PD, client #1's Legal Guardian and by client #1 and observed the injuries on 3/11/19. The QP #1

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V 512	Continued From page 34 allowed staff #1 to remain on the schedule and work in the facility until 3/14/19. Client #4 was grabbed by the wrist by staff #1. Staff #1 also struck client #4's hand while he was smoking in an attempt to get him into the facility per her directives. During another incident, staff #1 poured water on client #4 and his food as client #4 would not respond to her questions. Both the QP #1 and the QP#2/A denied any knowledge of the incidents between client #4 and staff #1. The QP #1 and the QP #2/A did not believe either clients' statements of their allegations of abuse against staff #1. This constitutes a Type A1 rule violation for serious abuse and failure to protect from harm and must be corrected within 23 days. An administrative penalty of $5,000.00 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 512		