STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411068	A. BUILDING: _____ B. WING _____	05/14/2019

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V 000	INITIAL COMMENTS A complaint survey was completed on May 14, 2019. The complaint (Intake #NC00150612) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Mental Illnesses.	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 develop and implement strategies in the treatment/habilitation plan to address the client's needs affecting 1 of 1 Former Client (FC #1). The findings are: Review on 5/6/19 of FC #1's record revealed: -An admission date of 5/1/16 -Diagnoses of Mental Retardation, Mild, Impulse Control Disorder, Not Otherwise Specified, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder and Obsessive Compulsive Disorder. -A discharged date of 4/11/19 -An assessment dated 5/1/16 noting "Needs structure and 24 hour supervision, as his grandfather, the Legal Guardian, is no longer able to provide these services. Was having behavior problems in his home environment and has limited social skills due to his diagnosis of impulse control and mild mental retardation, needs medication monitoring, likes to keep his area clean and tidy, needs to be re-directed when he becomes argumentative, needs to decrease his excessive use of pornography and public masturbation and he needs to be supervised and have structure, needs expectations to be communicated clearly to him and has had incidents of public masturbation that makes other uncomfortable." -An updated treatment plan dated 5/1/18 noting "Will improve his independent living skills by folding and organizing his laundry, making his bed daily and changing his bed daily and linen once per week, will improve his coping skills by reducing incidents of aggression towards others and ask questions when confused about a	V 112		

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situation, will reduce excessive use of pornography and incidents of masturbation in shared spaces, at the home by increasing his social interaction with others in the home and using the internet with staff supervision, will increase his safety in the community settings by remaining with staff at all times and having zero incidents of aggressive or predatory behaviors towards others, will take his medications as prescribed and increase his understanding of his medications by identifying different medications and their purpose."
-No documentation of goals or strategies to address FC #1's peeping behaviors
-No documentation of goals or strategies to address FC #1's inappropriate behaviors towards females

Review on 5/10/19 of FC #1's Psychological Evaluation, dated 8/7/14, revealed:
-"Since 2008, his impulsivity has significantly increased and become more predatory, he continues to be at risk of being exploited because of his cognitive deficiencies and/or of exploiting other residents because of his sexual impulsivity ...rather than deal with normal adolescent urges in a more appropriate and acceptable ways, he would take inappropriate liberties with others such as touching a person's genitalia ...he doesn't always make the connection between his inappropriate behaviors and the resultant adverse consequences ...underneath the surface is a young man who struggles to keep his feelings and impulses under control with minimal success ...he lacks the internal control and emotional resources to consistently control his somewhat impulsive ways of reacting to situations and people ..."

Review on 5/7/19 of the facility's internal incident

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reports revealed:
-"On 3/20/18, [FC #1] was hanging up clothes on a rack at his place of employment. He noticed a woman at the rack, shopping. He then laid on the floor and proceeded to look under the women's dress. He was asked to leave. When it was discussed with [FC #1], he denied it.
-On 3/28/18 at 8:25am, staff went to pick up [FC #1] from work. Staff had gotten a phone call from his employer stating he needed to be picked up and he had been terminated for entering the women's rest room without knocking and a female was present. He then peeked over the stall to look at the woman."

Attempted interview on 5/6/19 with FC #1 was not successful as the Legal Guardian (LG) would not give consent for an interview due to pending legal charges and an attorney's involvement.

Interview on 5/8/19 with FC #1's Care Coordinator revealed:
-Worked with FC #1 since September 2014
-Was made aware of his sexualized behaviors by his LG
-Those behaviors included inappropriate touching, drawn to younger children, instances of public masturbation and excessive use of pornography.
-Needed to be supervised in the community especially around young female children
-In March 2019, FC #1 had other behaviors of concern which included peeping on women in fitting rooms, masturbating in the open area at the library and attempted to enter the women's bathroom.
-Prior to FC #1's admission into the facility the Director/Qualified Professional (D/QP) was made aware of his sexualized behaviors.
-Was not sure why FC #1's treatment plan was

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V 112	Continued From page 4 not updated to include goals and strategies of his increasing sexualized behaviors towards females Interview on 5/7/19 with staff #1 revealed: -The D/QP was responsible for the client's treatment plans -FC #1 was known to have sexualized behaviors -"Once in the library he masturbated in public and can no longer be on their property." -Had witnessed FC #1 staring at females in the past and had to give him verbal prompts not to stare. Interview on 5/7/19 with the D/QP revealed: -Was responsible for developing FC #1's treatment plan -Was aware of FC #1's increased sexualized behaviors which included instances of staring at females inappropriately, peeping in stalls in the women's restroom and looking up their dresses. -Had not addressed FC #1's increased sexualized behaviors towards females in his treatment plan. -"It wasn't addressed, but looking back on it now, it should have been." This deficiency is cross 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 112		
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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V 367	Continued From page 5 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.	V 367		

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V 367	Continued From page 6 (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 review and interviews, the	V 367		

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V 367	Continued From page 7 facility failed to report a Level II incident to the Local Management Entity (LME) within 72 hours of becoming aware of the incident. The findings are: Review on 5/6/19 of the facility's incident reports revealed: -No documentation for the incident on 12/19/18 which involved FC #1 breaking into a neighbor's residence and attempting to commit rape Interview on 5/6/19 with the Director/Qualified Professional revealed: -Only learned of the incident from 12/19/18 with FC #1 and the neighbor recently -Was made aware by a detective investigating the case on 2/10/19 -"Because the incident did not occur on the facility's grounds, I did not think I had to do an incident report. I will submit an incident report immediately."	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 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 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	V 512		

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V 512	Continued From page 8 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 record reviews and interviews, 1 of 1 Director/Qualified Professional (D/QP) seriously neglected 1 of 1 Former Client (FC #1). The findings are: Cross Reference: 10A NCAC 27G .0205 ASSESSMENTS AND TREATMENT/HABILITATION OR SERVICE PLAN (Tag V112). Based on record reviews and interviews, the facility staff failed to develop and implement strategies in the treatment/habilitation plan to address the client's needs affecting 1 of 1 Former Client (FC #1). Review on 5/7/19 of the D/QP's record revealed: -A hire date of 3/1/03 -A job description of QP Finding #1 Review on 5/10/19 of FC #1's medication management visit, with his psychiatrist, dated 4/2/19, revealed: -"Patient reports heightened anxiety, racing thoughts when he sees pretty women and has been obsessed with masturbating even in public. He downloaded inappropriate pornography of females on his phone and table and cut the alarm to the group home during the night to leave	V 512		

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during the night (date not known)...he is easily distracted, has poor impulse control, obsessive thoughts and increased involvement in pleasurable activities...has been referred for individual therapy..."

Interview on 5/8/19 with FC #1's Care Coordinator revealed:
-"At his last psychiatric appointment (4/2/19), he told his psychiatrist he was able to disengage the alarms and chimes on the doors and windows of the facility."
-Learned FC #1 was arrested on 4/5/19

Interview on 5/10/19 with the detective involved in the case of FC #1 revealed:
-Responded to a report of a breaking and entering into a private residence across the street from the facility on 12/20/19
-Began interviewing people in the neighborhood
-On 2/10/19, he requested to interview the 3 male clients at the facility and discussed with the D/QP the reason for the interviews.
-During the interviews, one of the clients (#2) stated it was easy to disengage the alarms on the doors and the chimes on the windows.
-"The alarm was affixed to the frame of the window and when the connection breaks, the alarm sounds."
-Had asked FC #1 if he had disengaged the alarm?
-"[FC #1] would not state he had disengaged the alarm, but stated he was aware of how to do it and could if he wanted to."
-Had also interviewed the facility staff
-"[Staff #1] confirmed he was working the overnight shift on the 19th of December. He stated he was the awake staff. He told me there was a room upstairs that is fashioned into an office. He did not recall if he went upstairs that

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night. He could have been anywhere in the facility. It is not known where he was when [FC #1] left the facility."
-After providing the victim with a photo line-up, she was able to identify FC #1 as the person who broke into her residence and attempted to rape her
-FC #1 was arrested on 4/3/19 and charged with felony burglary and felony attempted second degree rape.

Review on 5/6/19 of the criminal court docket for a local county revealed:
-FC #1 had been charged with felony burglary and felony attempted forcible second degree rape (the incident occurred on 12/19/18).
-The cases are scheduled to go to trial on 5/28/19

Attempted interview on 5/6/19 with FC #1 was not successful as the Legal Guardian (LG) would not give consent for an interview due to pending legal charges and an attorney's involvement

Interview on 5/7/19 with staff #1 revealed:
-FC #1 required 24 hour supervision and "awake staff at night".
-Stated he learned of the first incident (which occurred on 12/19/18 and involved a neighbor) with FC #1 when the detectives came by to interview the clients and facility staff
-Was unable to recall the exact date of the detectives' visit but thought it was in January or February 2019
-The detectives asked about the supervision of the clients at the facility.
-The detectives stated a burglary occurred overnight from December 19, 2018 to December 20, 2018
-Was working third shift at the facility from December 19 to December 20, 2018 and was the

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V 512	Continued From page 11 awake staff. -Was required to do bed checks of the clients on his shift -"I check on them 2 or 3 times a night" -Does not document the bed checks -The clients' bedroom doors remained closed during his shift -The facility had always had chimes and alarms on the doors and windows -Does not check the alarms or chimes on his shift -"The alarms on the windows stayed on at all times and the alarms on the doors can be turned off and on." -Was told by the detectives, FC #1 knew how to turn the door alarms on and off -Was not made aware of a sexual assault occurring with the neighbor until FC #1's arrest in April 2019. Interview on 5/7/19 with the D/QP revealed: -Was aware of FC #1's sexualized behaviors which included excessive use of pornography, public masturbation and staring at females inappropriately -FC #1 required 24 hour supervision and "awake staff at night". -FC #1 was drawn to young females and a young lady had moved in across the street from the facility in December 2018. -"I noticed when she moved in, she did not have any window treatments up and his room looked directly into her living room." -On or about 1/15/19 or 1/16/19, "the detective called me and wanted to talk to me about an incident that occurred in the neighborhood. He did not mention what it was. I was not in town, so we set an appointment. He interviewed me and wanted to talk with clients and I said he would have to speak with their Legal Guardians." -In February 2019, the detective alerted her there	V 512		

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was a robbery in the neighborhood
-"The detective was vague with the information he shared (about the incident in the neighborhood)"
-After the clients were interviewed, the D/QP stated she was informed by the detective they (FC #1 and client #2) knew how to disengage the alarms on the doors and windows.
-"I have seen [FC #1]'s window opened before and I addressed that with him. I was always concerned with why his window was open. It was more than one time, several times and one time the screen was out. I talked with the staff about it. I just asked staff to be aware and ensure the windows are closed."
-Was not sure how FC #1 got out of the facility with window chimes and door alarms
-"It is all puzzling (on how FC #1 got out and then back into the facility). He probably left when staff went to the bathroom. If the staff had checked the alarms and sensors more frequently, this may not have happened. After staff used the bathroom, they should have checked on the clients and then recheck the alarms"
-The D/QP stated she was out of the country from April 3, 2019 and returned on April 10, 2019
-"I was not made aware of [FC #1]'s arrest until 4/10/19 when I returned from my trip. [FC #1] was charged with felony Burglary and rape."

Finding #2
Review on 5/6/19 of the facility's level II incident report, dated 2/11/19 and written by the D/QP revealed:
-On 2/10/19 at 5:30am "a female staff member (the D/QP) was in the office upstairs completing documentation. The office is the only space upstairs and is not a common area for people living in the home. The staff member dozed off while working and awoke to a male figure standing in front of her with his hands in her

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V 512	Continued From page 13 panties, fondling her. The male in the room noticed the staff member's eyes were open. The staff followed the person out of the room and thought the figure looked like [FC #1]. She called his name and he turned to respond. When asked what he was doing upstairs, he said that he came upstairs to ask her a question. She asked why he was in the staff office area. He stated 'I don't know. I just cannot control myself.'" -Described the cause of this incident "The cause of this incident is unknown. Although, inappropriate sexualized behavior is common for this individual." -Incident Prevention: "[the D/QP] has changed the shifts for the group home to ensure that staff are able to stay awake and provide monitoring 24 hours per day. The upstairs office will remain locked after normal business hours." Attempted interview on 5/6/19 with FC #1 was not successful as the Legal Guardian (LG) would not give consent for an interview due to pending legal charges and an attorney's involvement Interview on 5/7/19 with staff #1 revealed: -The D/QP had shared with the facility staff of an incident with FC #1 on February 10, 2019. -"She told us she dozed off and when she woke up, [FC #1] was standing over her and reached for her private area." -Did not ask about any other information about the incident with FC #1 -There was no implementation or documentation of checks of ensuring the alarms were in working order or of ensuring the clients were asleep during night hours after the 2/10/19 incident. -There was no implementation or documentation of bedroom checks after the incident with the D/QP and FC #1 on 2/10/19	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411068	A. BUILDING: _____ B. WING _____	05/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 512	Continued From page 14 Interview on 5/7/19 with the D/QP revealed: -FC #1 required 24 hour supervision and "awake staff at night". -Worked third shift at the facility on 2/10/19 and was the awake staff -"I must have dozed off upstairs in my office because when I woke up [FC #1] was standing directly over me and had his hands in my pants, touching my vaginal area." -Immediately asked FC #1 what he was doing -"[FC #1] stated he could not help himself" -Had discussed what occurred with FC #1 with the facility staff on 2/11/19 -"I said to be careful and be mindful. If he comes close to guard their personal space." -Had not informed the police department of the sexual assault on her by FC #1 as she is not interested in pressing charges. -"I did not call the police. It was more for me than for him. I knew eventually he would be caught on the cameras. He has enough on him. He is now labeled as a sex offender which is what he needed." Review on 5/15/19 of the facility's plan of protection, written by the D/QP and dated 5/14/19, revealed: -"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Immediately following the incident (February 11, 2019), the D/QP sent a memo notifying staff of new shift patterns to ensure that 24 hour staff would be alert during overnight shifts and to have male staff covering the evening shifts. The decision was made to lock the staff office after normal business hours and change the location where the staff sit during shifts, to a central location in the center of the lower level. A conference call was held with the Human Rights Committee on	V 512		

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V 512	Continued From page 15 February 11, 2019 to inform of the incident and discuss security options. The decision was made to install security cameras at the location. Staff at the site were reminded to ensure the chimes on the windows and doors are active by 7pm in the evenings. An IRIS (Incident Response Improvement System) report was completed. Immediately following the incident (February 11, 2019), the D/QP contacted the guardian and a joint decision was made to schedule a medication review with the psychiatrist. Medication was updated at the appointment on February 28, 2019. A follow up visit was done on April 2, 2019 for medication monitoring. Immediately following the incident, the decision was made to change the bedroom assignments and people who live in the home were able to select new rooms. The D/QP discussed overnight monitoring with members of the Human Rights Committee via conference call and decided to start documenting sleep checks, which involves looking into the bedrooms to determine that the person is present, awake or sleeping. On February 18, 2019, the D/QP had six security cameras installed in the [facility's location] in common areas and outside entryways for the safety of those who live and work in the home. Abuse, Neglect and Exploitation training will be scheduled to be completed by the end of May 31, 2019. The D/QP will identify training for sexualized behaviors and how to look for signs and symptoms. The D/QP will schedule reviews of the treatment plans and assess whether all needs are addressed in the plan and update plans as needed. -Describe your plans to make sure the above happens. This entire plan will be reviewed and maintained by [an outside agency's QP] who serves as [the Licensee]'s Human Rights Committee Chairperson. [The outside Agency's	V 512		

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V 512	Continued From page 16 Qualified Professional] will visit the site and monitor on a weekly basis. In addition to the review, the D/QP will review the room check log weekly to ensure that it's being completed by staff and provide clinical monitoring of staff. The D/QP will ensure that cameras and door chimes remain in working condition. A sign-in sheet will be provided to ensure that all staff received the trainings documented in the plan. Certificates of completion will be added to employee records." Former Client #1 (FC #1) had diagnoses of Mental Retardation, Mild, Impulse Control Disorder, Not Otherwise Specified, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder and Obsessive Compulsive Disorder. FC #1 had a history of excessive use of pornography, public masturbation and required 24/7 supervision. On 12/19/18, FC #1 either disengaged the alarm on the door or disengaged the chimes on the windows and left the facility. FC #1 broke into a neighbor's home and attempted to rape her. This resulted in FC #1 being charged with felony burglary and attempted second degree forcible rape. On 2/9/19, The D/QP worked third shift and "dozed off" in the upstairs office instead of remaining awake. FC #1 was able to go into the office, stand over the D/QP and put his hands down her pants and fondle her. On 3/20/19 and 3/28/19, FC #1 had inappropriate sexualized behaviors in the community towards females which included lying on a store's floor and looking under a woman's dress, entering the females' bathroom while a woman was present, peering over the bathroom stalls at women and openly masturbating in a public library. The D/QP failed to ensure the bedroom alarms and window chimes worked appropriately, after noting FC #1 had his windows open, failed to remain awake during third shift	V 512		

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V 512	Continued From page 17 which resulted in her being sexually assaulted and failed to develop and implement strategies in FC #1's treatment plan to address his peeping and inappropriate behaviors towards females. 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 512		