STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-061	A. BUILDING: _____ B. WING _____	R 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALSAM ROAD HOME	35 AQUIFER BRAE LANE WAYNESVILLE, NC 28786

(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 and follow up survey was completed on May 3, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. A sister facility is identified in this report. The sister facility will be identified as sister facility A. A client will be identified using the letter of the facility and a numerical identifier.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their	V 108		

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V 108	Continued From page 1 equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that 1 of 4 current staff (Staff #3) was trained to meet the treatment needs of clients and failed to ensure that 1 of 4 current staff (Staff #3) and 1 of 2 former staff (FS #4) were trained in first aid and cardiopulmonary resuscitation (CPR). The findings are: Review on 4/4/19 of the personnel record for Staff #3 revealed: -Hired on 1/4/19. -Basic Life Support Training completed on 10/9/18. -There was no training in First Aid. -Client specific training was completed on 4/4/19 (after the survey had begun). Review on 4/4/19 of the personnel record for FS #4 revealed: -Hired on 7/11/18. -No training in First Aid and CPR. Interview on 4/4/19 with the Qualified Professional (QP) revealed: -Staff #3 was originally hired for a sister facility then moved to the new facility that was a better fit for her. -Client specific training was included in the new	V 108		

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V 108	Continued From page 2 hire packet. This training was missed for Staff #3. Interview on 4/4/19 with the Director of Operations revealed: -Staff #3 had Basic Life Support which covered the CPR requirement. She was also a Certified Nursing Assistant #1. They felt that her nurses aid training would meet the requirement for first aid. -Human Resources kept track of all trainings due. -The First Aid and CPR training for FS #4 was missed. She was unaware how that occurred. -First Aid and CPR were scheduled every other Wednesday. -Each QP was given a training packet for every new staff hired. This packet included the client specific training. -No staff began working in a facility without first aid and CPR training. FS #4 was an oversight. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 108		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.	V 114		

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V 114	Continued From page 3 (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to complete fire and disaster drills quarterly on each shift. The findings are: Review on 4/3/19 of fire and disaster drill documentation for May 2018 through March 2019 revealed: -No fire drill or disaster drill was conducted on third shift for the third quarter (July-September) in 2018. -No fire drills or disaster drills were conducted on any shift for the fourth quarter (October-December) in 2018. -No fire drill or disaster drill was conducted on first shift for the first quarter (January-March) of 2019. Interview on 4/4/19 with the Qualified Professional revealed: -The facility operated three shifts. The shifts were 8:00AM-2:00PM, 2:00PM-9:00PM, and an overnight shift. -They conducted one fire and one disaster drill per month. -Oversight of drills had been transferred to the lead staff member. -The drills were possibly missed during the last quarter of 2018. -Other drill documentation could not be located.	V 114		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection	V 132		

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V 132	Continued From page 4 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 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.	V 132		

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	MHL044-061	A. BUILDING: _____ B. WING _____	R 05/03/2019

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V 132	Continued From page 5	V 132		

This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to report an allegation of neglect to the Health Care Personnel Registry (HCPR). The findings are:

Review on 4/8/19 of the police report dated 11/22/19 revealed:
-"time: 20:10 (8:10PM) ...Driver: [FS #4] ...vehicle 1 was traveling south on the PVA-[street name]. Vehicle 1 made a right turn onto [road number], crossed left of center and ran off the road to the left. Vehicle 1 then drove down an embankment and overturned. Vehicle 1 came to rest on its left side ...Charges: DWI (driving while impaired)/Failure to maintain lane ..."

Review on 4/4/19 of the facility Critical Investigation and Review revealed:
-" ...On November 22, at 8:10PM [FS #4] was in an automobile accident. He had left [facility] with [client from sister facility], dropped [client from sister facility] off at [sister facility], and then on the way back to [facility] ran off the road in a single vehicle accident. [FS #4] was charged with driving while intoxicated by law enforcement that responded to the scene. [FS #4] attempted to conceal this from coworkers and supervisor ...Findings and Conclusions: [FS #4] violated company policies on November 22 by being intoxicated on the clock, abandoning the residents of [facility] with someone outside the agency, and by transporting a person supported while driving under the influence ..."

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V 132	Continued From page 6 Interview on 4/9/19 with a representative of the Health Care Personnel Registry revealed: -No report had been filed by the facility for FS #4. Interview on 4/4/19 and 4/9/19 with the Director of Operations revealed: -She was certain that she had contacted HCPR to report the neglect by FS #4. -There was no documentation to show that report had been made.	V 132		
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 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	V 367		

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V 367	Continued From page 7 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. (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	V 367		

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V 367	Continued From page 8 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 interview the facility failed to ensure Level II incidents were reported to the Local Management Entity (LME) within 72 hours of becoming aware of the incident effecting 2 of 3 current clients (#2, #3) and 1 of 1 client (#4) in a sister facility. The findings are: Review on 4/8/19 of the police report dated 11/22/19 revealed: -"time: 20:10 (8:10PM) ...Driver: [FS #4] ...vehicle 1 was traveling south on the PVA-[street name]. Vehicle 1 made a right turn onto [road number], crossed left of center and ran off the road to the left. Vehicle 1 then drove down an embankment and overturned. Vehicle 1 came to rest on its left side ...Charges: DWI (driving while impaired)/Failure to maintain lane ..." Review on 4/4/19 of the facility Critical Investigation and Review revealed: -" ...On November 22, at 8:10PM [FS #4] was in	V 367		

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V 367	Continued From page 9 an automobile accident. He had left [facility] with [client from sister facility], dropped [client from sister facility] off at [sister facility], and then on the way back to [facility] ran off the road in a single vehicle accident. [FS #4] was charged with driving while intoxicated by law enforcement that responded to the scene. [FS #4] attempted to conceal this from coworkers and supervisor ...Findings and Conclusions: [FS #4] violated company policies on November 22 by being intoxicated on the clock, abandoning the residents of [facility] with someone outside the agency, and by transporting a person supported while driving under the influence ..." Review on 4/3/19 of incident reports submitted to the Incident Response Improvement System (IRIS) revealed that no reports had been submitted for any client at the facility or the client living at the sister facility. Interview on 4/10/19 with a representative for IRIS revealed: -No reports had been created or submitted for the incident that occurred on 11/22/18. -She indicated that an IRIS report should have been submitted for clients left with an unauthorized person at the facility and for the client who had been transported by FS #4. Interview on 4/4/19 and 4/9/19 with the Director of Operations revealed: -She thought that an IRIS report had been submitted, or at least created, for the client transported by FS #4. -She had not thought to submit IRIS reports for the clients who had been left with his wife.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 10	V 512		
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 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 review and interview, 1 of 1 former staff (FS #4) subjected 2 of 3 audited clients (#2, #3) to neglect and 1 of 4 current staff (#1) failed to protect 2 of 3 audited clients (#2, #3) from neglect. The findings are: Record review on 4/3/19 for Client #2 revealed: -Admitted in July 2002 with diagnoses of Moderate Mental Retardation, Schizoaffective Disorder, Diabetes, obesity, Bi Polar Disorder, hypertension, asthma, and irritable bowel	V 512		

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V 512	Continued From page 11 syndrome. Record review on 4/3/19 for Client #3 revealed: -Admitted on 1/1/13 with diagnoses of Autism, Moderate Mental Retardation, hypertension, acid reflux, hyperlipidemia, and Anxiety Disorder. Record review on 5/2/19 for Client A4 revealed: -Admitted to the sister facility on 10/5/12 with diagnoses of Schizoaffective Disorder, Intermittent Explosive Disorder, Mild Intellectual Disability, Chronic Obstructive Pulmonary Disorder with asthma, allergic rhinitis, esophageal reflux, hyperlipidemia, and hyperthyroidism. Review on 4/4/19 of the personnel record for Staff #1 revealed: -Hired as a paraprofessional staff member on 1/12/17. Review on 4/4/19 of the personnel record for FS #4 revealed: -Hired as a paraprofessional staff member on 7/11/18. -Employment terminated on 11/26/18. Review on 4/8/19 of the police report dated 11/22/18 revealed: -"time: 20:10 (8:10PM) ...Driver: [FS #4] ...vehicle 1 was traveling south on the PVA-[street name]. Vehicle 1 made a right turn onto [road number], crossed left of center and ran off the road to the left. Vehicle 1 then drove down an embankment and overturned. Vehicle 1 came to rest on its left side ...Charges: DWI (driving while impaired)/Failure to maintain lane ..." Review on 4/4/19 of the facility Critical Investigation and Review revealed: -" ...On November 22, at 8:10PM [FS #4] was in	V 512		

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V 512	Continued From page 12	V 512		

an automobile accident. He had left Balsam Road Home with [client from sister facility], dropped [client from sister facility] off at [sister facility], and then on the way back to Balsam Road Home ran off the road in a single vehicle accident. [FS #4] was charged with driving while intoxicated by law enforcement that responded to the scene. [FS #4] attempted to conceal this from coworkers and supervisor ...Findings and Conclusions: [FS #4] violated company policies on November 22 by being intoxicated on the clock, abandoning the residents of Balsam Road Home with someone outside the agency, and by transporting a person supported while driving under the influence ..."

Interview on 4/3/19 with Staff #1 revealed:
-FS #4 worked on all shifts but mainly second shift and worked alone most of the time.
-He worked a lot of shifts.
-She indicated that "everything was fun and a party with him".
-She stated that she smelled alcohol on him every time she was around him. She could smell it on his breath.
-She indicated that he constantly used mints and carried a cup with him all the time. She further added that all the staff would talk about how he smelled like alcohol.
-She could not remember if she reported her concerns to the Qualified Professional (QP).
-On 11/22/18 (Thanksgiving) she worked the day shift until 2:00PM. FS #4 relieved her at 2:00PM. He brought another client from a sister facility with him when he came on shift.
-At approximately 8:30PM FS #4's wife sent a text that she was at the facility with the clients and FS #4 had taken another client back to the sister facility and subsequently had a car accident.
-The wife of FS #4 was not an employee and not

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALSAM ROAD HOME	35 AQUIFER BRAE LANE WAYNESVILLE, NC 28786

(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 512	Continued From page 13	V 512		

qualified to take care of the clients.
-FS #4 was given a DWI the night of 11/22/18.
-"I know I should have said something but I didn't have evidence." She thought he drank a lot on the nights before he worked. She indicated that she did not think he was drinking while on shift. She stated that if she had known for sure what was in the cup she would have reported her concerns.
-No clients had reported to her that he was drinking alcohol. However, two clients did tell her that on one occasion he fell down in the kitchen and they had to help him up.

Interview on 4/3/19 with the Lead staff revealed:
-She received a call from the wife of FS #4 that indicated FS #4 had "broken down in his car" after taking a client back to the sister facility and that she was at the facility with other clients. She sent a text to the QP to inform her of this.
-She did not know why his wife was at the facility, it was her understanding that family were not to be there when you worked a shift.
-FS #4's wife was at the facility approximately 3 hours with the clients.
-She later learned that FS #4 had been in a car wreck and was injured. Even later she learned that he had been charged with a DWI.
-He returned to work for 1 day and it was her understanding that he fell down that day and the clients had to help him up. The QP was on site and asked her to come in and relieve him that day. He never returned to work.
-One time she saw him with a plastic cocktail glass that had clear liquid in it. She could not smell alcohol.
-She stated that once she smelled a strange odor on him but did not know if it was alcohol or not.

Interview on 4/4/19 with the QP revealed:

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	MHL044-061	A. BUILDING: _____ B. WING _____	R 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALSAM ROAD HOME	35 AQUIFER BRAE LANE WAYNESVILLE, NC 28786

(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 512	Continued From page 14 -On Thanksgiving FS #4 brought another client to the facility for the day. -The lead staff member had texted her to report that FS #4's wife had called to indicate that she was at the facility with clients and that FS #4 had taken another client back to a sister facility and after doing so his car had broken down. -She indicated that staff were always supposed to transport clients in the facility vehicle but on this date FS #4 had taken his own car. -On 11/23/18 FS #4 was scheduled to work but had called in sick. -FS #4 returned on 11/25/18 for his regular shift. She had called FS #4 to inform him that she would be on site that day to meet with him for his supervision. When they talked over the phone she did not notice any issues with him. -When she arrived to the facility on 11/25/18 he was bent over in a chair, was shaking and his speech was slurred. He told her that he had been in a car accident and had hit his head. He had worked all day and had taken the 3 clients to a local fast food restaurant. -She told him he would need to go home and when he could not reach his wife, her husband took him home. -She remained with the clients until another staff member could arrive. -It later came to her attention that he had been charged with a DWI on 11/22/18. -She had no further communication with FS #4 and he never returned to work. -FS #4 had been a good employee. His interactions with clients were very good. She had never smelled any alcohol on him. -No staff had reported any concerns to her about his behavior or any smell of alcohol on him. Staff #1 never shared her concerns. -She believed that what occurred on 11/22/18 was an isolated incident.	V 512		

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V 512	Continued From page 15 Interview on 4/9/18 with the Director of Operations revealed: -There had been no prior concerns expressed about FS #4. She never smelled alcohol on him. -When the QP went to the facility on 11/25/18 FS #4 was slumped over and "not making sense." She indicated that at that moment there was no indication of anything other than he had been in a car accident and was injured. On 11/26/18 they completed a critical incident review and received information about the DWI charge. This was verified and his employment was immediately terminated. -Staff were aware how to report concerns. Staff were trained to report any abuse or neglect. -There were a lot of avenues available for staff to make reports if they did not feel comfortable going to their supervisor. -Reporting requirements were covered in multiple trainings. "We drive it home to them." Review on 5/2/19 of the Plan of Protection signed on 5/1/19 by the Director of Operations revealed: "Immediate action to correct rule violation in order to protect clients from further risk of additional harm, effective 05/01/2019: -All staff will be retrained in Abuse, Neglect, and Exploitation training, to specifically highlight the definition of and response to Abuse, Neglect, and Exploitation. -Staff Competency focusing on Communication requirements of Direct Support Professionals will be focused on in Annual Supervision Plans and Monthly Supervisions. -QP Supervisor will increase 1:1 supervision time from monthly to weekly, with the staff at Balsam Home. QP Supervisors will provide opportunities in 1:1 supervision meetings for Direct Support	V 512		

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V 512	Continued From page 16 Professionals to address concerns of Abuse, Neglect, and Exploitation by reviewing the definitions, initiate conversation, and invite feedback. -Quality Assurance/Quality Improvement Committee will review policy and procedure addressing Abuse, Neglect, and Exploitation to ensure that all aspects are being followed and continue to support the well-being of persons receiving services. -Direct Support Professionals and Management Teams will be retrained in the National Alliance for Direct Support Professionals Code of Ethics to emphasize therapeutic decision-making and problem solving when encounters occur that may put persons supported at risk or in danger of abuse, neglect, or exploitation. -Leadership Team Supervisors will perform site visits to ensure additional monitoring occurs in between supervision times throughout the month." "Plans to make sure the above happens: -All Liberty Corner (Licensee) Direct Support Professionals and Management Team Members are assigned online new training materials addressing Abuse, Neglect, and Exploitation through Relias Learning. This training is being followed up with shared learning dialogue in supervision time with QP. -QP will evaluate Annual Supervision Plans and will update to include Competency in Communication, Decision-Making, and Technical Knowledge for staff working in the Balsam Group Home. -Executive Leadership Team will attend Staff Supervision Meetings throughout the next month to provide additional training in technical knowledge of detecting Abuse, Neglect, Exploitation, role play and facilitate	V 512		

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V 512	Continued From page 17	V 512		

decision-making and communication of incidents and observations.
-LCE (Liberty Corner Enterprises) Quality Assurance Quality Improvement Committee will review policy and procedure for addressing Abuse, Neglect, and Exploitation and implement changes as needed to ensure wellbeing of people receiving services.
-Leadership team will review training requirement above and identify areas that need to be addressed with follow up inquiry or supervisory action."

FS #4 worked at the facility for 4 months. Staff #1 had ongoing concerns about FS #4 due to smelling alcohol on his breath every time she was around him, his constant use of mints and always carrying around something to drink. She failed to report her concerns about FS #4 to anyone in management. On Thanksgiving, right after dropping off a client to the sister facility, FS #4 drove off the road and down an embankment and was ultimately charged with a DWI. FS #4 had been intoxicated while on shift, left 2 clients with his wife who was not a staff member, then put another client at great risk when driving him home under the influence. Due to the failure of Staff #1 to report her concerns, the QP had no opportunity to investigate and address the concerns, monitor him when he was working, or have him tested for alcohol use. For 4 months the concerns went unreported and unaddressed. FS#4 was ultimately terminated from employment but the facility failed to address the neglect that had occurred with other staff. This deficiency constitutes a type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1000.00 is imposed. If the violation is not corrected within 23 days, an administrative penalty of $500.00 per day will be

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V 512	Continued From page 18 imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		