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| V 000 | INITIAL COMMENTS<br><br>A complaint survey was completed on 5/17/19. The complaint was substantiated. (Intake # NC150676.) Deficiencies were cited.<br><br>This facility is licensed for the following service category:<br>10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living.<br><br>To clarify the following report, the Licensee of this facility contracted with a local Service Provider to provide specific services (see excerpt from contract in Tag V110). This Service Provider contracted with the local MCO (Managed Care Organization) for authorization and payment for services provided by the Licensee. | V 000 | | |
| V 110 | 27G .0204 Training/Supervision Paraprofessionals<br><br>10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS<br>(a) There shall be no privileging requirements for paraprofessionals.<br>(b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.<br>(c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.<br>(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.<br>(e) Competence shall be demonstrated by exhibiting core skills including:<br>(1) technical knowledge; | V 110 | | |

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| V 110 | Continued From page 1<br>(2) cultural awareness;<br>(3) analytical skills;<br>(4) decision-making;<br>(5) interpersonal skills;<br>(6) communication skills; and<br>(7) clinical skills.<br>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews the facility failed to ensure that 2 of 4 paraprofessionals (Staff #1 (live in caregiver) and #2) demonstrated knowledge, skills and abilities required by the population served. The findings are:<br><br>Record review on 4/19/19 for Staff #1 (live in caregiver) revealed:<br>-Date of hire was 7/11/18<br><br>Record review on 4/19/19 for Staff #2 revealed:<br>-Date of hire was 4/25/18.<br><br>Review on 4/18/19 of Contractual Agreement dated November 2014 and renewed annually between Caregiver (Licensee/QP #2) and (Service Provider) contracted with the local MCO (Managed Care Organization) revealed:<br>"Contracted agency [Service Provider] agrees to provide mental health and developmental disabilities services to each client placed by [Service Provider] and being served by Caregiver | V 110 | | |

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| V 110 | Continued From page 2<br>[Licensee/QP #2], including but not limited to (a) emergency services, (b) quality assurance, (c) the provision of a human rights committee, (d) the provision of a qualified professional for each client, (e) the coordination of services for each client as such services are approved by the MCO and Care Coordinator, (f) review of data collected to monitor progress, (g) the provision of a liaison and mediator to handle any disputes between the client's family, Caregiver, Care Coordinator and the MCO and (h) in general, the provision of services to assist the Caregiver in fulfilling the requirements of the habilitation plan for each client.<br>Supervision: To provide supervision to all Caregivers who are not qualified professionals. To assure training opportunities are provided to meet training needs. To maintain personnel records which include driving records, proof of insurance, criminal records and NC Health Care Registry checks for all adults in the home as well as the training of caregivers and back up caregivers."<br><br>Interview on 4/18/19 and 4/23/19 with Staff #1 (live in caregiver) revealed:<br>-Client #1 had always had these behaviors-they had just gotten more severe and more frequent.<br>-Staff did 15-30 minute checks on Client #1. He had more difficulty during down time in the evenings.<br>-Client #2 was non-verbal and required more 1:1 assistance with hygiene tasks such as showering or brushing his teeth.<br>-Staff #2 helped with Client #1 and Client #2.<br>-Staff #1 (live in caregiver) did not immediately notify the Contracted QP #1 nor did she seek medical attention for Client #1 who might have swallowed glass on 3/31/19.<br>-Staff #1 (live in caregiver) indicated she knew | V 110 | | |

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| V 110 | Continued From page 3<br>Client #1 had left the facility the morning of 4/1/19 but the police had him.<br><br>Interview on 4/24/19 with Officer #2 revealed:<br>-He and Officer #1 were called out first thing Monday 4/1/19 before 7AM. A neighbor had seen someone walking around the church and called the police. It was still dark outside.<br>-He found Client #1 huddled up in a stairwell leading downstairs at the church. He had no shirt and was sloppy wet and covered in blood. He was non-confrontational so he sat down next to Client #1 to talk. Client #1 told him the black eye had come from another resident the night before. The blood was from self-inflicted scratches. His partner stayed with Client #1 while he went to the facility to find staff. He talked with a short dark lady who said she had to take her daughter to school and there was no one else there. She stated the guardian did not want Client #1 to go to the hospital again. She stated she knew Client #1 had left but was not making any effort to come get him. Officer #2 asked if he could at least get some clean dry clothes for Client #1. She brought him some clothes for Client #1 and drove off with the little girl.<br>-He felt so badly, he sat in the back seat of the police car with Client #1 as they transported him to jail. Client #1 was there until Staff #3 picked him up at 4pm to return home.<br><br>Interview on 4/18/19 with Staff #2 revealed:<br>-Licensee/QP #2 paid him to be extra support in this facility. "He worked in both houses" (sister facility next door).<br>-He worked from 7am -11pm but "did not punch a clock."<br>-He helped watch Client #1 and assisted with hygiene for Client #2. | V 110 | | |

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| V 110 | Continued From page 4<br><br>Interview on 4/25/19 with the Contracted QP #1 revealed:<br>-She provided training to staff on how to follow those goals.<br>-If staffing needs changed or back up staff was needed, the Licensee/QP #2 had always taken care of that.<br><br>Multiple requests were made to interview the Licensee/QP #2 but he refused to be interviewed. The Director of the Service Provider also attempted to persuade the Licensee/QP #2 to allow an interview but he refused. There was no evidence of notification to back up staff for additional support needed for Client #1.<br><br>Interview on 4/25/19 with the Director of the Service Provider revealed:<br>-The Licensee/QP #2 was responsible for providing supervision to his direct care staff.<br>-The Licensee/QP #2 paid his staff out of pocket. The Service Provider did not maintain time sheets or any other documentation of time worked by direct care staff. The Service Provider paid the primary AFL caregiver (Staff #1 -live in caregiver) a daily rate but if there were additional staff providing service in that facility the Service Provider was not aware.<br><br>This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days. | V 110 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN | V 112 | | |

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| V 112 | Continued From page 5<br>(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.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews the facility failed to develop and implement strategies to address behaviors effecting 1 of 3 clients (Client #1). The findings are:<br><br>Record review on 4/18/19 for Client #1 revealed:<br>-Admission date 10/29/17 with diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Moderate Intellectual Disability and Persistent Disinhibition Social Engagement Disorder. | V 112 | | |

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| V 112 | Continued From page 6<br><br>Review on 4/18/19 of Electronic Medical Record of Incident Reports involving Client #1 and signed by Staff #1 (live in caregiver) revealed:<br>-1/2/19 -7:15pm- Staff noticed Client #1's room a mess and said he was feeling anxious. Accepted PRN (as needed) medication.<br>-1/13/19-4:30pm - Staff and Client #1 were at grocery store-Client not acting himself-would not calm down or sit in the car but instead walked into the busy street. Police were called and assisted in calming client and getting him into the car. Once home, he was administered PRN medication but continued to be irritable. He took a fork from the kitchen into his room but then gave it to staff. Staff continued to redirect and monitor. Staff entered his room and discovered he had broken his TV so it was removed from his room. Continued to observe him closely for the rest of the evening.<br>-1/14/19-9pm-Client #1 had fallen asleep around 7:30. "Staff check found [Client #1] on his floor ...noticed he attempted to eat his markers ...had marked all over his mouth ... He had broke a can opener and was trying to cut himself. He also had acquired a bottle of hand sanitizer ... he told staff he was drinking the sanitizer". He was very emotional and requested PRN. Staff cleaned him up and administered PRN and allowed him to sleep in the living area for the night.<br>-1/17/19-6:30pm-Client #1 ran out the front door and was pacing outside. Back up staff was called. Once they arrived, Staff repeatedly asked Client #1 to return home. He refused and took off running down the road with no shirt, shoes or socks. Staff notified other staff and continued following Client #1 into the cemetery on the church property. Client #1 was very emotional and refused to talk. Staff sat with him for about 45 minutes and finally got him in the car. PRN was administered but Client was still very upset | V 112 | | |

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| V 112 | Continued From page 7 | V 112 | | |

and paced for hours. Staff remained in the living area to monitor him.

-1/18/19-6pm-Staff was in living area watching TV with other clients and noticed Client #1 pacing through the house. "Staff followed him to his room. He became extremely emotional and went into his closet and would not open the door. Staff was able to open the door ...saw [Client #1] cutting himself with pieces of a light bulb. Client #1 refused to give staff the piece of glass and continued cutting but finally gave the glass to staff. Client #1 refused his regular meds but allowed staff to clean up his wounds. "Staff saw that the wounds were superficial and again asked Client #1 to take meds." He continued to refuse meds, returned to his room and attempted to exit through his window. Staff blocked the window and offered to sit with client while he tried to calm down. Client #1 agreed to sleep in the living area so that staff could monitor him better.

-1/20/19-5:30pm-Client #1 refused dinner and returned to his room. "Staff followed him to his room and proceeded to tell staff he wanted to kill multiple staff members. [Client #1] stated he wanted to leave and that he wanted to die." Staff sat with him for a while to calm him and he seemed to relax. He told staff he felt better so they went to check on the other clients. When staff came back, Client #1 was gone and his window was open. "Staff called backup. When they arrived proceeded outside to find [Client #1] on the front porch ...noticed his foot was bleeding." Client #1 refused to come inside and attempted to open the hood of staff's car. Staff called 911. Police arrived and talked to him. Client #1 told them he wanted to go to the hospital so they transported while staff followed to provide the hospital with necessary information.

-1/23/19-7:30pm-Staff administered meds and was watching TV in the living area. Client #1

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| V 112 | Continued From page 8 | V 112 | | |

asked to go to his room, "said he was tired. Staff went in to check on him. [Client #1] seemed depressed and asked for a PRN. Staff administered PRN. After taking PRN [Client #1] started to act different. [Client #1] tried to turn on the stove to burn himself ...then tried to turn on the toaster and burn himself." Staff removed all electrical devices and talked to Client #1. He said he was sad and agreed to go to his room. Staff remained with him but he did not speak much. Staff will keep a close eye on him for the evening.

-1/27/19-6pm-Staff was doing evening tidying and noticed Client #1 was nervously pacing. He refused to talk to staff and ran outside. Staff notified other staff and followed Client #1. He refused to speak or return inside and instead went into the road. "Staff got [Client #1] out of the road. [Client #1] sat next to the road but would not move. [Client #1] tried to grab staff multiple times." After about 45 minutes he agreed to return home and take his PRN. Staff monitored for the remainder of the evening.

-2/3/19-7pm-Client #1 had been extremely anxious all day. While staff was administering evening meds to another client, Client #1 exited outside without staff. "Staff went to talk to [Client #1] ...refused to return inside ...started to walk down the road." Staff alerted backup and then followed Client #1. Client #1 ended up at the church. "Staff told [Client #1] he was trespassing and that he had to leave the property." Client #1 refused to speak or to move. The church called the police. Staff informed the police what was going on and they assisted in returning him home. Client #1 requested his PRN and it was administered. Staff monitored the rest of the night.

-2/23/19-7:30pm-Staff had administered evening meds and noticed Client #1 pacing. He refused to speak and returned to his room. "Staff went to

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check on him and discovered he had broke scissors and was cutting himself." He gave staff the scissors but again refused to talk. Client #1 came out of his room continuing to pace and attempted to go outside. "[Client #1] was going outside staff got in front of him. [Client #1] then tried to grab staff neck. He also grabbed staffs hair. Staff redirected him and called for backup staff." Staff administered PRN and cleaned/bandaged cut area. Client #1 returned to his room and removed his window but did not jump out. Staff replaced the window and monitored Client #1 from the living area.

-3/15/19-10pm-Staff found "[Client #1] not in his room. Staff checked all over the house and could not find him." Staff alerted back up staff and went outside to search for Client #1. Client #1 refused to talk or take PRN. "[Client #1] started onto the road. Staff tried to get [Client #1] to return home. Staff followed [Client #1] up the road ...ended up at the church. Police were called due to aggressive behavior. [Client #1] tried to hit and grab staff's hair." Police talked to Client #1 in their vehicle and escorted him home but he refused to get out saying he was going to kill himself. Police took him to the hospital.

-3/20/19- 5:45am-Staff was assisting another client with morning routine-heard Client #1 walk out the front door. He refused to come in and continued walking. Back up staff was alerted to finish helping other clients while staff followed Client #1. Client #1 was found at the church and refused to get into the car. He "started eating dirt and anything he could find." Staff tried to clear the area around him. Staff remained with him until he calmed and got in the car to return home.

-3/31/19-10pm-During room checks, staff found Client #1 in his closet cutting himself. "Client #1 refused to give staff the glass and started to eat the glass. [Client #1] dropped the piece of glass

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and staff was able to pick it up." Staff asked him to take PRN and clean up his wounds but he refused. Staff asked if he would at least sit in the living area to calm down but became very anxious. Staff asked multiple times about taking PRN. He refused. He began playing music loudly, pulling down curtains and blinds, banging on walls in the living area. Staff attempted to calm him and redirect with no success. He would not stop being disruptive and attempted to assault staff. One of his housemates came out to the living area to ask Client #1 to please stop. When he continued, the housemate attacked Client #1 hitting him in the face. Staff pulled the two apart and calmed the housemate and to his room. "[Client #1] refused to get washed up ..." Staff made sure all wounds were superficial and allowed Client #1 to sleep in the living to continue monitoring.

-4/1/19 -6:30am-Staff was assisting another consumer brush his teeth to prepare for school and "noticed [Client #1] was not in his room and his window had been removed. Staff alerted back up staff. While staff was waiting police arrived. Police notified staff that Client #1 was at a nearby church. Police took Client #1 to jail. "

-4/4/19- 4:10pm-While meeting with his therapist outside, Client #1 became angry and walked off toward the road. He initially refused redirection and his PRN but staff convinced him to take it. Staff continued to talk with Client #1 on the porch until his 1:1 worker arrived.

-4/11/19-9:30pm-Staff was completing laundry and checked on Client #1 to find him gone and his window removed. Staff alerted backup staff to monitor consumers and went outside to check for Client #1. He continued to walk towards the road not responding to verbal prompts to return. "[Client #1] wandered onto church property. Staff tried to redirect him multiple times. [Client #1]

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| V 112 | Continued From page 11<br>disrobed and started to eat grass. Staff again verbally prompted him to put on his clothes. He did put his pants on. Staff notice an unknown man approaching. [Client #1] started returning towards home. Staff returned home. [Client #1] returned home but would not go back inside. [Client #1] broke his tablet and was trying to cut himself with pieces of it. He began to eat anything he could find. Staff removed pieces of plastic so he could not self-harm." Staff continued redirection. Client #1 refused all prompts and became physically aggressive several times. Client#1 finally went inside but refused PRN. Staff checked for any physical cuts none were found. Client #1 again became physically aggressive towards staff. Staff monitored all night.<br><br>a)<br>-History of self-harm, property destruction and severe aggression.<br>-Goals in Person Centered Plan (PCP) dated 10/1/18 written by Contracted Qualified Professional (QP) #1 included:<br>--will follow a daily personal hygiene schedule;<br>--will complete at least 2 daily chores;<br>--will practice conversation skills daily;<br>--will practice social and friendship skills;<br>--will practice emotional regulation strategies;<br>--will participate in activities to improve health and reduce stress;<br>--will plan, shop for and prepare 1 simple meal per week;<br>--will maintain a personal budget.<br>No goals or strategies indicated in the treatment plan to address self-harm or property destruction based on Client #1's history and the treatment plan was not updated as the self-harming and destructive behaviors increased.<br><br>b) | V 112 | | |

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| V 112 | Continued From page 12<br><br>-Positive Behavioral Intervention and Support Plan by contracted Psychologist last updated 1/25/19 revealed goals for the following:<br>--will learn to not hurt self by trying to choke self by putting belt or other cords around his neck or he will not put dangerous objects in his mouth such a metal staples;<br>--will learn that putting non-nutrients in his mouth (Pica behavior) is dangerous to his health;<br>--will learn that it is never acceptable to threaten, attempt to or actually strike others;<br>--will learn that it is not acceptable to purposely destroy his own or another's personal property when angry or frustrated;<br>--will learn that it is not acceptable to be disruptive to others by teasing or pestering others and not acting too clingy toward others;<br>--will learn to respect the personal space of others by not inappropriately touching, standing too close to persons and/or repeatedly teasing others;<br>--will learn to follow reasonable requests/directions from caregivers after being given 2 verbal prompts.<br><br>c)<br>January progress summary: " ...This therapist holds weekly psychotherapy sessions with him at his residence ...He needs to be frequently verbally reinforced ...His history is one of what he perceives as rejection. He wants to belong and be accepted but when he perceives that this is developing he acts out in a self-defeating manner and rejects before he is rejected. This might appear to be attention seeking but it seems more likely to be a coping strategy to protect himself against loss of comfort and control of his life situation ...It is my current recommendation that he should possibly be eye-site monitored every 15-30 minutes during waking hours." | V 112 | | |

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| V 112 | Continued From page 13<br>-No other progress summaries were available for review.<br>-Despite multiple occurrences of behaviors of AWOL, self-harm and property destruction, no additional strategies were put into place.<br><br>Interview on 4/25/19 with the Contracted QP #1 revealed:<br>-She wrote the provider portion of the treatment plan with the residential goals but had not updated it because Client #1 had not made any progress toward his goals.<br>-When she wrote the plan in September 2018, Client #1 was not having behavioral issues.<br>-She expected the Contracted Psychologist to have all the behavioral goals/strategies in the Positive Behavior Support Plan which was part of the PCP (Person Centered Plan).<br>-She probably should have updated the plan with behavioral concerns.<br>Interview on 4/25/19 with the Contracted QP #1 revealed:<br>-She provided training to staff on how to follow those goals.<br>-She was responsible for reviewing incident reports that were submitted electronically by direct care staff.<br>-She was aware of Client #1's increasing behaviors of AWOL (absence without leave), self-harm and property damage but did not update plan. The behavioral issues were addressed in the Behavior Support Plan.<br>-She expected the Contracted Psychologist to handle all the behavioral issues via the Behavior Support Plan.<br><br>This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days. | V 112 | | |

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

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

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| V 289 | Continued From page 16<br>ensure that 2 of 4 paraprofessionals (Staff #1 (live-in caregiver) and #2) demonstrated knowledge, skills and abilities required by the population served.<br><br>Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112) Based on record review and interviews the facility failed to develop and implement strategies to address the behaviors effecting 1 of 3 clients (Client #1).<br><br>Cross Reference: 10A NCAC 27G .5603 OPERATIONS (V291) Based on record review and interviews, the facility failed to maintain coordination with other qualified professionals responsible for client's treatment for 1 of 3 clients. (Client #1).<br><br>Record review on 4/18/19 for Client #1 revealed: -Admission date 10/29/17 with diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Moderate Intellectual Disability, Persistent Disinhibition Social Engagement Disorder history of AWOL (absence without leave) and Pica behavior.<br><br>Observation on 4/25/19 at 3pm revealed the location of the facility was approximately 1/10th of a mile north of local church where Client #1 was frequently found when he left the facility without permission. The road between the facility and the church was 2 lane with no sidewalk and a speed limit of 55 MPH (miles per hour).<br><br>Review on 4/18/19 of Electronic Medical Record of Incident Reports involving Client #1 and signed by Staff #1 (live in caregiver) revealed:<br>-1/13/19-4:30pm -Client #1 walked into a busy | V 289 | | |

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street while at grocery store. Police were called to help him calm down and get into the car.

-1/14/19-9pm-Client #1 attempted to eat his markers. He had broken a can opener and was trying to cut himself. He told staff he was drinking hand sanitizer.

-1/17/19-6:30pm-Client #1 ran down the road with no shirt, shoes or socks into the cemetery on the church property.

-1/18/19-6pm- Client #1 was cutting himself with pieces of a light bulb; finally gave the glass to staff. Client #1 refused his regular meds but allowed staff to clean up his superficial wounds. He then attempted to exit through his window. Staff blocked the window.

-1/20/19-5:30pm- Client #1 told staff he wanted to kill multiple staff members. [Client #1] stated he wanted to leave and that he wanted to die. Client #1 left through his window but found him on the front porch with his foot was bleeding. He refused to come inside and Staff called 911. Police arrived, talked to him and transported him to the hospital.

-1/23/19-7:30pm-Client #1 tried to turn on the stove to burn himself ...then tried to turn on the toaster and burn himself.

-1/27/19-6pm-Client #1 refused to talk to staff and ran outside into the road. Staff got him out of the road and sat with him next to the road. He tried to grab staff multiple times.

-2/3/19-7pm- Client #1 exited outside without staff and refused to return inside ...started to walk down the road ending up at the church. Police were called and assisted in returning him home.

-2/23/19-7:30pm-Staff discovered Client #1 had broken scissors and was cutting himself. He refused to talk. He attempted to go outside, staff got in front of him and he tried to grab staff neck and hair. Staff cleaned/bandaged cut area. Client #1 returned to his room and removed his window

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but did not jump out.
-3/15/19-10pm-Staff found Client #1 starting onto the road and ended up at the church. Police were called due to aggressive behavior. Client #1 tried to hit and grab staff's hair. Police talked to Client #1 in their vehicle and escorted him home but he refused to get out saying he was going to kill himself. Police took him to the hospital.
-3/20/19- 5:45am- Staff followed Client #1 to the church; he refused to get into the car. He started eating dirt and anything he could find.
-3/31/19-10pm- Staff found Client #1 in his closet cutting himself. Client #1 refused to give staff the glass and started to eat the glass. Client #1 dropped the piece of glass and staff was able to pick it up. Staff asked to clean up his wounds but he refused. He began playing music loudly, pulling down curtains and blinds, banging on walls in the living area. Staff attempted to calm him but he attempted to assault staff. One of his housemates came out to the living area to ask Client #1 to please stop. When he continued, the housemate attacked Client #1 hitting him in the face. Client #1 refused to get washed up. Staff made sure all wounds were superficial and allowed Client #1 to sleep in the living to continue monitoring.
-4/1/19 -6:30am- Staff noticed Client #1 was not in his room and his window had been removed. While staff was waiting police arrived. Police notified staff that Client #1 was at a nearby church. Police took him to jail.
-4/4/19- 4:10pm-While meeting with his therapist outside, Client #1 became angry and walked off toward the road. He initially refused redirection and his PRN but staff convinced him to take it.
-4/11/19-9:30pm-Staff found Client #1 gone and his window removed. He walked towards the road, onto church property, disrobed and started to eat grass. Client #1 returned home but would

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not go back inside. He broke his tablet and was trying to cut himself with pieces of it. He began to eat anything he could find. Staff removed pieces of plastic so he could not self-harm. He refused all prompts and became physically aggressive several times towards staff.

Interview on 4/23/19 with Officer #3 revealed:
When asked about incidents in which local law enforcement was called to the facility or to the local church occurred on the following dates:
-12/18/18-Client #1 destroyed church property (no charges filed).
-1/20/19-County Sheriff's office responded-no specific information.
-2/3/19- Staff talked Client #1 back into their vehicle and returned home.
-3/20/19- Suspicious vehicle-staff following Client #1 around church property.
-4/1/19-Officer #2 knew Staff #3 and informed him of the situation. Staff #3 reported staff did not know Client #1 was gone. Staff #3 told them to charge Client #1 with 2nd degree trespassing and take him to jail.
-He stated EMS (Emergency Medical Systems) had also been called numerous times but could not verify why within their system-no specific information.

Interview on 4/24/19 with Officer #1 revealed:
-He had been called out to the local church the morning of 4/1/19 just before 7am.
-Client #1 had displayed a lot of aggression in the past.
-There were no staff with Client #1 or anywhere on the church property- felt the group home just let him wander off.
-Client #1 had cuts on his chest from his nipple to his navel and on his arms. He also had a fairly fresh black eye as it was still black and blue. He

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had on a thin fleece jacket, pajama pants and no shoes. It was cold and wet that morning and Client #1 was soaked.
-Officer #2 made the contact with staff while he put Client #1 in his car with the heat on.
-He had worked with Staff #3 who was also a police officer so he contacted him. Staff #3 told Officer #1 they wanted to have trespassing charges filed against Client #1 saying "the kid knows right from wrong".
-He did not think jail was where Client #1 needed to be but he took him to the county jail as requested.
-Client #1 was already having to pay restitution for property destroyed at the church.
-He did not know for sure but felt that Client #1 would have been in the general population in jail.

Interview on 4/24/19 with Officer #2 revealed:
-He and Officer #1 were called out first thing Monday 4/1/19 before 7AM. A neighbor had seen someone walking around the church and called the police. It was still dark outside.
-He found Client #1 huddled up in a stairwell leading downstairs at the church. He had no shirt and was sloppy wet and covered in blood. He was non-confrontational so he sat down next to Client #1 to talk. Client #1 told him the black eye had come from another resident the night before. The blood was from self-inflicted scratches. His partner stayed with Client #1 while he went to the facility to find staff. He talked with a short dark lady who said she had to take her daughter to school and there was no one else there. She stated the guardian did not want Client #1 to go to the hospital again. She stated she knew Client #1 had left but was not making any effort to come get him. Officer #2 asked if he could at least get some clean dry clothes for Client #1. She brought him some clothes for Client #1 and drove

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off with the little girl.
-He felt so badly, he sat in the back seat of the police car with Client #1 as they transported him to jail. Client #1 was there until Staff #3 picked him up at 4pm to return home.

Interview on 4/23/19 with Neighbor #1 revealed:
-He lived near the church and although was also a deputy sheriff he was a member of the church's Security Team.
-The first occurrence the church had been when Client #1 destroyed property-pulled gutters down, broke pickets, threw them at a vehicle and threw concrete bench.
-Another time Client #1 came up to the church was a Sunday night during a time they were having evening services in the church. When he saw Client #1 outside on the church grounds he circled back inside to have another member of security team lock the doors and he went back outside to find the "shirtless young man" near the side door. He watched as a "skinny Black man" talked roughly - using profanity to Client #1. He then called 911. It was not too long before a gentleman who had been working with Client #1 came by to talk and calm him down.
-Another time was a Saturday evening when he saw Client #1 in the old section of the cemetery. He was concerned that Client #1 was pushing over headstones or destroying other property. A car parked in front of the new cemetery was trying to get him into the car and eventually followed him down the road.
-"We are trying to be compassionate-we have no desire to have something happen to him."
-He was not aware of anyone who had threatened him or staff. "They were mostly just afraid of his behavior not knowing what he might do."

Interview on 4/24/19 with Neighbor #2 revealed:

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| V 289 | Continued From page 22<br>-He used to live right behind the church but had moved 3/9/19.<br>-The 1st incident with Client #1 was at church after Christmas. A lot of property was destroyed that night-Client #1 threw one of the pickets at his vehicle and damaged it.<br>-He had concerns about how "gruff" the staff talked to Client #1.<br>-"We really only wanted to show him compassion ...Maybe he was coming to the church for a reason. Or maybe he was trying to get away from something. We just didn't know."<br>-Client #1 had come to the church during a time the grade school kids were there. They were concerned about a conflict but never threatened him.<br>-One time Client #1 had been there he had been cutting himself and his arms were bleeding. He also had a black eye.<br>-He was not aware of anyone at the church making threats-they were all very open. "They could tell this young man was mentally handicapped and wanted to show him compassion."<br><br>Interview on 4/18/19 and 4/23/19 with Staff #1 (live in caregiver) revealed:<br>-When Client #1 felt he was not getting enough attention he puts things in his mouth. Idle time was when he got into trouble. He had cut himself, tried to eat light bulbs, dirt and rocks. He had wrapped his headphone wires around his neck to choke himself.<br>-Following the incident in October when he swallowed glass he was taken to ED (Emergency Department)- they did an xray to find no internal damage.<br>-They had called mobile crisis for previous incidents but were told to call 911.<br>-The guardian (Licensee/QP #2) for Client #1 did | V 289 | | |

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not want him taken to the hospital-they didn't do anything and just sent him back home.
-The Licensee/QP #2 was 1 of 5 backup staff that would respond when she needed since he lived in the next door sister facility.
-The Licensee/QP #2 was also the guardian for Client #1. He was aware of all Client #1's behaviors.
-Client #1 had seen the Psychiatrist almost monthly and the Psychologist weekly. Staff completed data sheets for the behavior goals.
-She had never heard any of the male staff talk aggressively or cuss at Client #1. All staff needed to be firm with Client #1.
-Tried to watch Client #1 from a distance when he left the facility and headed toward the church. "Trespassing was trespassing and we were not to step foot on church property. We heard that the church people would 'take appropriate action' and didn't want something regrettable to happen."
-A kid on the bus told her 14-year-old son that his mom had a gun ready for that big guy that came up to the church.
-On 3/31/19 during night checks, she found Client #1 hiding in his closet cutting himself with a piece of glass. He refused to give her the glass, put it in his mouth, dropped it and she grabbed it. He continued to be disruptive, banging on the walls, pulling curtains down, and attempted to hit staff. Client #3 came out of his room and asked him to chill but when Client #1 went after staff again, Client #3 attacked Client #1, leaving him with a black eye. Staff tried to clean Client #1's cuts and did not see any deep cuts. She asked him to sleep in the living area so he could be monitored. When he got up the next morning she thought he was going to take a shower and going to his room to bed. He went out his window while she was helping Client #2 get ready. She contacted back up staff and they followed him to the church. She

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| V 289 | Continued From page 24<br>did not remember who the back up staff was that morning. The police had him at the church and he was arrested.<br>-They had taken the bedroom door and closet door off from Client #1's room so they could see him and he couldn't hide.<br>-The alarm system had not been operational for the 9 months she had been there.<br><br>Interview on 4/23/19 with Staff #3 revealed:<br>-Client #1 had lived with him in an AFL when he was an adolescent. They had a very good relationship.<br>-Client #1 had always these type behaviors since he was a little kid.<br>-He was a full time police officer as well as provider of Community Networking 1:1 services for Client #1 about 20 hours a week.<br>-Regarding the incident on 4/1/19, his friend and previous police co-worker called to inform him they had Client #1 at the church. He talked to local police department-made Client #1's release conditional to only himself when he got off work at 4pm. EMS was there-checked him out- said he was ok-transported to jail. "Jail was a very controlled situation-in a cell by himself."<br>-Client #1 needed to understand property damage was not a game.<br>-Client #1 had used self-harm to get attention-always only superficial cuts-never required a stitch. Even when he cut his tongue (in October) he did not need a stitch.<br>-Tried to focus more on positive behaviors-kept a calendar of positive behaviors.<br><br>Interview on 4/24/19 with Client #1 revealed:<br>-"I get angry sometimes-stuff that makes me sad-in the middle of the night."<br>-"I put rocks in my mouth and spit them out. I ate grass and dirt and glass and swallowed it." | V 289 | | |

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| V 289 | Continued From page 25<br>-On 3/31/19 he took the light bulb from the kitchen fixture. He stomped on it to break it, he picked up a piece of glass to scratch his arms, hid in his closet and blocked the doors so no one could get in. Staff #1 (live in caregiver) tried to get the glass away from him and he put it in his mouth. He bit the glass into pieces and swallowed some of it. He came out of his closet but was still angry. Client #3 got mad and punched him in the face. He slept on the floor in the living area that night.<br>-He did not receive any medical attention from EMS or the hospital after he swallowed the smaller pieces of glass.<br><br>Text messages between this surveyor and Licensee/QP #2 revealed:<br>-On 5/13/19 at 2:21pm- from Licensee/QP #2 " ...we don't need to meet. You have stated you guys position and I've stated New York Homes. So just send me the email on what you guys have decided and I will do our due diligence!"<br>-surveyor-"I want to share my findings and explain what it means! I need to interview you as well ...."<br>-from the Licensee/QP #2-"...New York Homes Residential Care will never accept a neglect citation from DHHS. There can be no correction on something you didn't do wrong."<br>-surveyor-" ...I do not have a report ready to give you ...Once I get [the plan of protection] I can exit. After exit I'll have 15 days to write and get the report to you."<br>-On 5/15/19 at 8:04am-from the Licensee/QP #2 " ...I have already told you there is no correction to be made, nothing was done incorrectly. Please send me what you have found us guilty of and we can move forward."<br>-On 5/17/19 at 3:06pm-surveyor-"I'm getting ready to exit. Just wanted to ask once more if I | V 289 | | |

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| V 289 | Continued From page 26<br>can interview you? I'm not allowed to interview you with an attorney present. An interview with you might be able to answer some of my remaining questions."<br><br>Review on 5/17/19 of Plan of Protection signed by the Licensee/QP #2, Staff #1 (live in caregiver) and an additional staff on 5/17/19 revealed:<br>"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?<br>1-Alarm company has been contacted today to install a comprehensive alarm system that will alert caregivers and guardian of any activity when windows and doors are open.<br>2-Psychiatric appointments were on 4/26/19 and on 5/14/19 and medications were reviewed and changed. Future appointments have been scheduled for 7/15/19 and 8/14/19.<br>3-[Contracted Service Provider] and QP's have assigned additional training for all staff to equip them with a better understanding of consumers behaviors and diagnosis, as well as how to respond to them. These training will include but not be limited to, IDD, Mood disorders, Attachment disorders, Behavior modification, Incident reporting and autism.<br>4-[Contracted Service Provider] staff met with Psychologist to review violations and to update behavior plan with strategies on how to prevent and address behaviors. [Psychologist] will train staff on these strategies on 5/16/19. A revision will be completed by 5/17/19.<br>5-[Contracted] QP will revise provider plan today to support psychologist behavior plan.<br>6-Consumer schedule will be accommodated with his available hours.<br>7-Staff has begun a positive reinforcement program a calendar of his positive behaviors and rewards accordingly. | V 289 | | |

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| V 289 | Continued From page 27<br>8-[Licensee] QP will ask VAYA to pay for a 3rd shift awake staff.<br>9-[Licensee] QP has sent a written email to VAYA care coordinator requesting Community Networking hours be increased from 20 hours week to 40 hours a week to enhance his quality of life and control his behaviors.<br>10-On 5/15/19 [Contracted Service Provider] assured [Licensee] staff has multiple [Contracted] QP contact numbers for on call needs.<br>11-[Contracted]QP and [primary] staff have weekly contact. This will occur every Monday at 10am.<br>Describe your plans to make sure the above happens.<br>1-[Contracted] QP supervisor and [Contracted] QP will meet weekly regarding this consumer.<br>2-[Contracted] QP and [Contracted Service Provider] President or [Contracted Service Provider] Executive Director will supervise the home/staff a minimum of monthly and will meet with consumer at least monthly to ensure health safety.<br>3-[Contracted] QP will have weekly contact with staff and guardian each Monday and written notes will be kept.<br>4-[Contracted] QPs will meet with [Psychologist] each Wednesday to discuss consumer concern.<br><br>Client #1 presented with significant mental health and intellectual disabilities needs with a history of self-harming behaviors, property destruction, pica behaviors and severe aggression. The Treatment plan did not initially nor was updated to include strategies to address dangerous behaviors that increased in frequency and intensity. The Licensee did not implement new or additional strategies with the client to address these behaviors. Multiple instances of self-harm included: cutting himself with pieces of a light | V 289 | | |

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| V 289 | Continued From page 28 | V 289 | | |

bulb, trying to burn himself on the stove and the toaster, walking into the 55 MPH road, wrapped headphone wires around his neck to choke himself, breaking a can opener and scissors to cut himself and eating non-food items. This pica behavior included eating glass on two instances. Other behaviors included: barricading himself in his closet, threatening to kill multiple staff members, AWOL without staff supervision, aggression toward staff multiple times. These behaviors resulted in local law enforcement responding at least 5 times in past 4 months. Of the 2 known occasions when Client #1 ate glass, he was taken to the emergency department only once. According to the IRIS report, the guardian (Licensee/QP#2) was aware Client #1 had put glass in his mouth on 3/31/19 although no medical attention was obtained.
On multiple instances of leaving the facility without supervision, Client #1 destroyed property at a local church and continued to trespass on the church property without supervision. According to police officers, no staff were aware or within sight the morning of 4/1/19 when the police found Client #1, bloody, shirtless and unsupervised at the church. When the police officer went to the facility to inform staff of Client #1's whereabouts, Staff #1 (live in caregiver) offered dry clothes then proceeded to take her daughter to school.
Despite having knowledge of all above behaviors and reviewing all incident reports, the Contracted QP failed to update the treatment plan or implement new strategies. The alarm system had not been operational for the past 9 months during Staff #1's tenure. Behavior Support Plan by contracted psychologist recommended eye-sight monitoring every 15-30 minutes during waking hours. There was no documentation of additional staff or when they might have been in the facility for additional support. Client #1 was

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| V 289 | Continued From page 29<br>arrested being charged with trespassing and detained in jail for a day. These failures constitute a Type A1 rule violation for neglect and must be corrected within 23 days. An administrative penalty of $5000.00 is imposed. If the violation is not corrected within 23 days, an additional penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day. | V 289 | | |
| V 291 | 27G .5603 Supervised Living - Operations<br><br>10A NCAC 27G .5603 OPERATIONS<br>(a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.<br>(b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.<br>(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.<br>(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community | V 291 | | |

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| V 291 | Continued From page 30 | V 291 | | |

inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to maintain coordination with other qualified professionals responsible for client's treatment for 1 of 3 clients. (Client #1). The findings are:

Review on 4/18/19 of incident reports revealed -3/31/19-10pm-During room checks, staff found Client #1 in his closet cutting himself. "Client #1 refused to give staff the glass and started to eat the glass. [Client #1] dropped the piece of glass and staff was able to pick it up." Staff asked him to take PRN and clean up his wounds but he refused. Staff asked if he would at least sit in the living area to calm down but became very anxious. Staff asked multiple times about taking PRN. He refused. He began playing music loudly, pulling down curtains and blinds, banging on walls in the living area. Staff attempted to calm him and redirect with no success. He would not stop being disruptive and attempted to assault staff. One of his housemates came out to the living area to ask Client #1 to please stop. When he continued, the housemate attacked Client #1 hitting him in the face. Staff pulled the two apart and calmed the housemate and to his room. "[Client #1] refused to get washed up ..." Staff made sure all wounds were superficial and allowed Client #1 to sleep in the living to continue monitoring.
-No emergency medical assessment was completed after Client #1 put glass into his mouth and possibly swallowed some as well as cutting

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| V 291 | Continued From page 31<br>his body with pieces of glass.<br><br>Review on 4/18/19 of IRIS (Incident Response Improvement System) dated 4/2/19 regarding the incident on 3/31/19 revealed that guardian (Licensee/QP #2) was notified on 3/31/19 of the incident. Client #1 did not receive a medical assessment to determine the severity of possible injury.<br><br>Interview on 4/24/19 with Client #1 revealed:<br>-"I get angry sometimes-stuff that makes me sad-in the middle of the night."<br>-"I put rocks in my mouth and spit them out. I ate grass and dirt and glass and swallowed it."<br>-On 3/31/19 he took the light bulb from the kitchen fixture. He stomped on it to break it, he picked up a piece of glass to scratch his arms, hid in his closet and blocked the doors so no one could get in. Staff #1 (live in caregiver) tried to get the glass away from him and he put it in his mouth. He bit the glass into pieces and swallowed some of it. He came out of his closet but was still angry. Client #3 got mad and punched him in the face. He slept on the floor in the living area that night.<br>-He did not receive any medical attention from EMS or the hospital after he swallowed the smaller pieces of glass.<br><br>Interview on 5/17/19 with Contracted QP #1 revealed:<br>-She was not aware if the Licensee/QP #2 reviewed incident reports-she assumed that he did. He did have access to them on line.<br>-She did not notify the Client #1's guardian of incidents because she assumed he was aware being the Licensee/QP #2 of the facility and that he lived next door as well as provided back up for staff at times. | V 291 | | |

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| V 291 | Continued From page 32<br>-The Licensee/QP #2 kept most of their information (staffing issues, staff pay, minor conflicts with staff or clients, etc.) within their "own house". If more detailed information was needed for incident reports, Staff #1 (live in caregiver) would tell her "the guardian was handling it."<br><br>Multiple requests were made to interview the Licensee/QP #2 but he refused. No evidence of coordination with medical professionals to provide care for Client #1 after he ate glass and swallowed it.<br><br>This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 violation and must be corrected within 23 days. | V 291 | | |
| V 784 | 27G .0304(d)(12) Therapeutic and Habilitative Areas<br><br>10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT<br>(d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements:<br>(12) The area in which therapeutic and habilitative activities are routinely conducted shall be separate from sleeping area(s).<br><br>This Rule is not met as evidenced by:<br>Based on observation and interviews the facility failed to keep sleeping areas separate from areas in which therapeutic and habilitative activities are | V 784 | | |

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| V 784 | Continued From page 33<br>conducted. The findings are:<br><br>Observation on 4/24/19 at approximately 3:00pm revealed:<br>-3 client bedrooms, 2 bathrooms, 2 living areas with a couch and 2 chairs in each, 1 living area with large TV, kitchen and dining area. Live-in staff's (Staff #1 and her children) area was on the opposite side of the home from the client bedrooms.<br><br>Interview on 4/24/19 with Staff #1 (live in caregiver) revealed:<br>-She had been residential caregiver since July 2018. She and her 4 children live at the facility.<br>-She kept her girls separated from Client #1 when he was "in a mood".<br>-Staff #2 worked between the 2 facilities (sister facility next door and this facility) and usually slept on the couch outside Client #1's bedroom. He also helped support Client #2 who needed assistance with all activities of daily living.<br><br>Interview on 4/11/19 with Client #1 revealed:<br>-Staff #2 slept on the couch outside his bedroom.<br><br>Multiple attempts to interview Licensee/QP #2 were unsuccessful because he refused. No documentation such as time sheets or staff hours were made available therefore is was unknown who, when or how many staff were actually working in the facility at any given time. | V 784 | | |