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	MHL0411146	A. BUILDING: _____ B. WING _____	07/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 7/3/19. The complaint was substantiated (Intake# NC00152538) and deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision	V 110		

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V 110	Continued From page 1 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on observations, records review, and interviews, 1 of 4 staff (the Owner/staff #5) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Cross reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111). Based on interview and record review, the facility staff failed to ensure an assessment was completed for each client, prior to the delivery of services, that included a minimum of client needs, strengths, social history, family history and other required information, for 2 of 3 current clients (#1 and #3) and 1 of 1 former client (FC #4). Cross reference: 10A NCAC 27G .0404 Operations During Licensed Period (V138). Based on record review and interview the facility failed to operate within its licensed capacity by accepting more clients than the number for which it is licensed. Cross reference: 10A NCAC 27G .5603 Operations (V291). Based on record reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the clients' treatment, affecting 1 of 1 former client (FC #4).	V 110		

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V 110	Continued From page 2 Cross reference: G.S. 122C - 62 Additional Rights in 24 Hour Facilities (V364). Based on interviews and record review the facility failed to ensure privacy during telephone calls affecting 3 of 3 current clients (Clients #1, #2, and #3) and 1 of 1 former client (FC #4) and restricted access to personal possessions affecting 1 of 1 former client (FC #4). Cross reference: 10A NCAC 27G .0604 Incident Reporting Requirements (V367). Based on record review and interview, the facility failed to report all Level II incidents to the LME (Local Management Entity) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. Cross reference: 122C-63 Assurance for Continuity of Care for Individual with MR (V368). Based on interviews and record review, the facility failed to notify the area authority serving the client of intent to discharge an intellectually disabled client at least 60 days prior to discharge affecting 1 of 1 former client (FC #4). Cross reference: 10A NCAC 27F .0104 Storage and Protection of Clothing and Possessions (V541). Based on interviews and record reviews, the facility failed to make every effort to protect each client's personal clothing from loss, affecting 1 of 1 former client (FC #4). Cross reference: 10A NCAC 27G .0303 Location and Exterior Requirements (V736). Based on observation and interviews, the facility was not maintained in a safe manner. Review on 7/3/19 of the owner/staff #5's record revealed:	V 110		

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V 110	Continued From page 3 - Hire Date: 4/12/17 - Position: Owner and Para Professional Finding #1 Interview on 7/3/19 with FC #4 revealed: - After she fell down the group home stairs outside on 5/13/19 and while on the ground the owner/staff #5 called her names. - The fall resulted in a broken right wrist and broken right ankle. - She was taken to the hospital by an ambulance. - "When I was still on the ground [the owner/staff #5] called me a prostitute, whore, nasty, and a sorry little girl. She just kept saying the word prostitute and was yelling at me." Interview on 7/2/19 with FC #4's legal guardian revealed: - During a phone call with FC #4 on 6/11/19 she documented that the owner/staff #5 called FC #4 "a prostitute and other unkind names" while FC #4 got into the ambulance on 5/13/19. - FC #4 also reported during the 6/11/19 phone call that the owner/staff#5 told FC #4 to take her cigarettes to the hospital so she would get in trouble for smoking in the hospital. Interview on 7/3/19 with the Owner/staff #5 revealed: - Reported that she never called the clients' names. - "No, I have never called them any names. I never call my girls names." Finding #2 Interview on 7/3/19 with FC #4 revealed: - The owner/staff #5 was with her when she was hospitalized on 5/13/19.	V 110		

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- "(At discharge) they (hospital medical staff) told me to stay off of my leg and not use my wrist and follow up with my doctor."
- The Hospital did not send her home with crutches.
- "They (hospital medical staff) said it was not a good idea for me to use crutches because I would fall and because of my wrist (being broken)."
- The owner/staff #5 provided her with crutches.
- "I was made to put up dishes, wash my own dishes, give my own self showers and go to appointments with other clients."

Interview on 7/2/19 with client #3 revealed:
- When FC #4 returned to the group home from the hospital on 5/13/19 with a broken right wrist and right ankle, she was "supposed to stay off her foot before surgery."
- FC #4 was being made by staff to walk on her foot to attend appointments of other clients.
- "Yes, she (FC #4) had to go to my appointments and with the other clients. Anyone who had appointment she had to go with them."

Interview on 7/3/19 with the Owner/staff #5 revealed:
- She stayed with FC #4 at the hospital on 5/13/19 after FC #4 fell down the group home stairs which caused FC #4 to break her right wrist and right ankle.
- "[FC #4's] discharge plans were to follow up with the orthopedic doctor. To stay off her leg and they said they were not going to give her crutches or a wheelchair because she needed to stay off both of them (right wrist and right ankle)."
- "We tried to get [FC #4] off of it (right leg) but she wanted to smoke so I loaned her my crutches"
- She never contacted the medical doctor to find

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V 110	Continued From page 5 out if FC #4 could use her leg/stand up or use crutches. Review on 7/3/19 of the Plan of Protection dated 7/3/19 and written by the Qualified Professional revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Describe your plans to make sure the above happens. "After reviewing the following cited violations, it is noted that Agape Home Living Care and it's staff when immediately put into action to correct effective 07/03/2019. 10A NCAC 27G.0205 Assessment and Treatment/Habilitation or Service Plan Effective July 3, 2019 all clients will have a completed and filed admission assessment that is admitted to the residential program for Agape Home Living Care LLC. During the initial intake process, the assessment will be completed to include the most accurate information to help clients with their individualized treatment while in the residential program. Intake staff (Qualified Professional) will make sure that all areas of the assessment are completed and signed by the legally responsible person/party. 10A NCAC 27G.0404 Operations During Licensed Period Effective July 3, 2019 Agape Home Living Care LLC will not accept any clients when at capacity for current License, which is no more than 3 clients. There will be a definite discharge date for the client leaving and admission date for the incoming client to make sure that there is no more than 3 clients in the home at one time.	V 110		

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V 110	Continued From page 6 10A NCAC 27G.5603 Operations Effective July 3, 2019 Agape Home Living Care will notify legal guardians of any hospitalization and coordination of care for any clients that reside in the residential program. Also coordination for any client discharging from the program will be immediately discussed, and specific dates will be given for discharge and inventory pickup. The legal guardian will contacted by staff on duty or other designee immediately once a hospitalization is needed. At that time, any coordination of care will be discussed such as a specified date to debrief, discharge, and pick up of client and/or belongings. 10A NCAC 27G.0604 Incident Reporting Requirements Effective July 3, 2019 all incidents required to be reported through the IRIS system for Level II and/or Level III incidents will be reported within 72 hours of the incident date. All staff will receive documentation training to learn how to complete an IRIS report within 30 days. The Qualified Professional will make sure that staff of aware of when to file an IRIS report, and what the timeframe to do so in. G.S. 122C -62 Additional Rights in 24 Hour Facilities Effective July 3, 2019 all staff will respect client rights to privacy and not monitor phone calls of client unless officially documented to be done so. Staff will allow the clients to go into their bedroom to have privacy on their calls. Staff will not listen at the door, and will not allow other clients to intervene in their personal phone calls as well. If in case, supervision is documented in the treatment plan and needed for a client to have privacy, staff will either ensure privacy in their personal room or have the other clients removed from the common areas in order for client to have	V 110		

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V 110	Continued From page 7 privacy. 122C-63 Assurance for Continuity of Care for Individual with MR Effective July 3, 2019 clients with a IDD (Intellectual Developmental Disability) diagnosis will remain in the program for the full 60 days of treatment before being discharged from the residential treatment facility. No client will be discharged before their service level specified timeframe from the residential program. Coordination of care will continue, and if amends are needed to structure and/or new services implemented, Qualified Professional will make sure that it is put into place. 10A NCAC 27F. 0104 Storage and Protection of Clothing and Possessions Effective July 3, 2019 all client possessions will remain untouched and protected from theft, and tampering until legally responsible party/person come to document the removal of all items. An initial inventory will be taken of all client belonging upon admissions to the residential program. This inventory will be signed off by legal guardian or designee. Throughout stay, belongings will be update due to new items added, items destroyed, or items thrown away and signed off by a staff and a witness staff. At the time of discharge, the legal guardian will sign off on the inventory list and receive a copy of the final inventory. 10A NCAC 27G. 0303 Location and Exterior Requirements Effective July 3, 2019 the table will be moved to different location on the back deck from in front of the stairway. Staff will move the table from any access point to the back deck, and Qualified Professional ensures that the table will not be in the walk way of clients trying to get off of the back deck. (V110) Paraprofessional Competence Effective July 3, 2019 no staff member will speak	V 110		

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V 110	Continued From page 8	V 110		

about or call any client a derogatory name.
Qualified Professional will conduct a staff meeting and discuss professionalism, and effective communication within the next two (2) weeks.
Qualified Professional will also discuss taking client property away as means of punishment.
Qualified professional will provide supervision for Director and all other staff employed with Agape Home Living Care LLC.
In addition to the above interventions, the Qualified Professional will also do continuous and unannounced visits to the residential program to ensure continuity of above corrections to the violations."

This facility is licensed to serve 3 clients and the current clients have diagnoses which include but are not limited to: Intellectual Developmental Disability-mild; Bipolar 1 Disorder; Schizophrenia, unspecified; Post Traumatic Stress Disorder; Borderline Personality Disorder; Dissociative Identity Disorder; Oppositional Defiant Disorder.
The facility had one former female client who was in the facility from 5/1/19-5/24/19. Her admission put the facility over their licensed capacity of three. FC #4 was diagnosed with Intellectual Disability, moderate; Bipolar Disorder 1; Generalized Anxiety Disorder and had a history of running away to prostitute for cigarettes.
Two of the three current clients had no admission assessments and FC #4 had no strategies to address harmful behaviors. Shortly after admission, FC#4's rights to make and receive confidential phone calls and to have access to her cigarettes were restricted without evaluation by a Qualified Professional or without documentation of the detailed reason for the restriction. On 5/12/19 FC #4 ran away and prostituted herself to get money for cigarettes because of the restriction. When she returned to

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V 110	Continued From page 9 the group home the owner/staff #5 took all cigarettes away as punishment and chained a metal table to the top of the deck stairs in an attempt to prevent her from running away again. On 5/13/19 FC #4 attempted to leave the group home again to get cigarettes and she climbed on top of the chained table and fell down the stairs which resulted in her breaking her right wrist and right arm. The owner/staff #5 presented herself as the client's legal guardian at the hospital and refused to tell the true legal guardian what happened until two days later at a treatment team meeting on 5/15/19. No incident reports or IRIS reports were completed about the fall, hospital visit nor injuries. FC #4 was discharged from the facility without proper notice and upon discharge, the legal guardian was initially prevented from obtaining FC #4's belongings. When the belongings were obtained, it was discovered there were missing items and none of the client's medications. The legal guardian was informed the medications were sent back to the group home pharmacy. FC #4's medications were not filled for two days as the new pharmacy held the prescriptions for refill until confirming information with the medical doctor. This resulted in FC #4, who just had surgery on her broken wrist and ankle, going without pain medication and her regular medications for two days. This deficiency constitutes a Type A1 rule violation for serious abuse, neglect and harm and must be corrected within 23 days. An administrative penalty of is $2,000 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 110		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan	V 111		

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V 111	Continued From page 10 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on interview and record review, the facility staff failed to ensure an assessment was completed for each client, prior to the delivery of services, that included a minimum of client	V 111		

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V 111	Continued From page 11 needs, strengths, social history, family history and other required information, for 2 of 3 current clients (#1 and #3) and 1 of 1 former client (FC #4). The findings are: Finding #1 Review on 6/27/19 of client #1's record revealed: - Admission date: 9/15/17 - Diagnoses: Intellectual Developmental Disability-mild; Bipolar 1 Disorder; Schizophrenia, unspecified; Post Traumatic Stress Disorder - Admission Assessment: - 7 of 10 pages were blank. - The only information provided: identifying information, diagnosis, legal guardian's name (no phone number), current medical provider's name/phone number. - Omitted from the admission assessment: client needs, strengths, social history, family history and medical history. Review on 6/27/19 of client #3's record revealed: - Admission date: 11/19/18 - Diagnoses: Borderline Personality Disorder; Dissociative Identity Disorder; Post Traumatic Stress Disorder; Oppositional Defiant Disorder - No Admission Assessment could be found in record. Interview on 7/3/19 with the Owner/staff #5 revealed: - She was aware there were no admission assessments for client #1 and client #3. - "We went back today and filled them (admission assessments for client #1 and client #3) in." Finding #2	V 111		

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V 111	Continued From page 12 Review on 6/27/19 of former client #4's record revealed: - Admission date: 5/1/19 - Went to the local hospital for suicidal ideation and had ankle/wrist surgery: 5/24/19 - Discharged from local hospital and placed in new facility: 6/4/19 - Facility's discharge date on discharge form: 6/17/19 - Admission Assessment dated 5/1/19: "History of AWOL (absent without leave) to prostitute self and use crack, cocaine, chain smoker ..." - No strategies were developed to address the AWOL, drug use, prostitution or chain smoking. Interview on 7/3/19 with FC #4 revealed: - She is a heavy smoker and typically smokes 20 cigarettes per day. - On 5/12/19 the staff would not allow her to have more than 3 cigarettes so she ran away on 5/12/19 from the group home to prostitute to have money for cigarettes. - When she returned to the group home on 5/12/19 the owner/staff #5 took her cigarettes for punishment. - "I ran on Mother's Day which was the 12th (5/12/19) and I got back around 4 pm that day. I called my guardian when I was out and told her ...I was selling my body for money. I needed the money for cigarettes. Which I ended up getting, there was a guy I met and he took me to the store to get them (cigarettes)." - "She (owner/staff #5) took the rest of my cigarettes and took the cigarettes I bought (on 5/12/19) and told me I could not smoke the next day which was the 13th (5/13/19). She (owner/staff #5) was taking them (cigarettes) because I ran away." Interview on 7/2/19 with FC #4's legal guardian	V 111		

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V 111	Continued From page 13 (LG) revealed: - The staff was aware that FC #4 had a history of running away to prostitute for cigarettes. - There were no strategies in place to address FC #4's behaviors of running away to prostitute. - FC #4 ran away on 5/12/19 from the group home, prostituted and then used the twenty dollars to purchase cigarettes. - The owner/staff #5 told FC #4 after she ran away that her punishment was no cigarettes for the rest of the day. - The owner/staff #5 and another staff member became upset when she told them: "you can't take her cigarettes away because the lengths she will go to get her cigarettes." Interview on 7/3/19 with the Owner/staff #5 revealed: - FC #4 had a history of running way to prostitute to get cigarettes and wanted to smoke a lot. - On 5/12/19 FC #4 ran away and her LG was contacted by phone. - "[FC #4] stated she went down to the old folks home and stated she prostituted to get money for cigarettes." - Informed FC #4 when she returned to the group home on 5/12/19 that she could not smoke for the rest of the day. - "[The LG] spoke up on the phone and said ya'll can't do that she is addicted to cigarettes." - She used no other strategies to address the issue of FC #4's running away to prostitute for cigarettes. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule violation and must be corrected within 23 days.	V 111		

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 138	Continued From page 14	V 138		
V 138	27G .0404 (A-E) Operations During Licensed Period 10A NCAC 27G .0404 OPERATIONS DURING LICENSED PERIOD (a) An initial license shall be valid for a period not to exceed 15 months from the date on which the license is issued. Each license shall be renewed annually thereafter and shall expire at the end of the calendar year. (b) For all facilities providing periodic and day/night services, the license shall be posted in a prominent location accessible to public view within the licensed premises. (c) For 24-hour facilities, the license shall be available for review upon request. (d) For residential facilities, the DHSR complaint hotline number shall be posted in a public place in each facility. (e) A facility shall accept no more clients than the number for which it is licensed. This Rule is not met as evidenced by: Based on record review and interview the facility failed to operate within its licensed capacity by accepting more clients than the number for which it is licensed. The findings are: Review on 6/26/19 of the facility's Mental Health License revealed: - A license capacity of 3 clients. Interview on 7/3/19 with the Owner/staff #5 revealed: - From 5/1/19-5/24/19 she allowed 4 clients to be	V 138		

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V 138	Continued From page 15 served in the facility. - She was aware her license capacity during May 2019 was for three clients but felt she could serve four clients because "I am in the process of getting licensed for four." Review on 6/27/19 of client #1's record revealed: - Admission date: 9/15/17 - Discharge date: currently served Review on 6/27/19 of client #2's record revealed: - Admission date: 3/26/18 - Discharge date: currently served Review on 6/27/19 of client #3's record revealed: - Admission date: 11/19/18 - Discharge date: currently served Review on 6/27/19 of former client #4's record revealed: - Admission date: 5/1/19 - Went to the local hospital for suicidal ideation and had ankle/wrist surgery: 5/24/19 - Discharged from local hospital and placed in new facility: 6/4/19 - Facility's discharge date on discharge form: 6/17/19 This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule violation and must be corrected within 23 days.	V 138		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed	V 291		

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V 291	Continued From page 16 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. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (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. (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 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 reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the clients' treatment, affecting 1 of 1 former client (FC #4). The findings are: Review on 6/27/19 of former client #4's record revealed: - Admission date: 5/1/19 - Went to the local hospital for suicidal ideation	V 291		

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V 291	Continued From page 17 and had ankle/wrist surgery: 5/24/19 - Discharged from local hospital and placed in new facility: 6/4/19 - Facility's discharge date on discharge form: 6/17/19 Finding #1 Interview on 7/2/19 with FC #4's legal guardian (LG) revealed: - She had a meeting with FC #4's treatment team on 5/15/19 where she first learned about FC #4 falling down the group home stairs and breaking her right wrist and right ankle on 5/13/19. - She contacted the owner/staff #5 by phone on 5/15/19 just prior to the meeting and was told during the call "wait until you see your client (FC #4)." - She told the owner/staff #5 if there was something wrong she wanted to be informed on the call. - The owner/staff #5 informed her she would not tell the LG what occurred until the meeting. - When she arrived at the group home, the owner/staff #5 told her to "go on and see your client" who was outside. - She went outside and observed FC #4 to have a splint on her right arm and right leg. - When she asked the owner/staff #5 why she had not been called about the injuries to FC #4, the owner told her she did not call her because the legal guardian got upset about staff taking cigarettes from FC #4 on 5/12/19 (the day before FC #4 broke her right wrist and right ankle). Interview on 7/3/19 with FC #4 revealed: - On 5/13/19, she informed the hospital staff she had a LG but the hospital did not contact her legal guardian. - "The hospital did not call my legal guardian	V 291		

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V 291	Continued From page 18 because [the owner/staff #5] told hospital staff that she was my legal caregiver and she was taking me back to the home but if she decided not to take me back home that she could call the law and take me to jail." - "Hospital staff did not call my guardian because they thought [the owner/staff #5] was in charge." - Her LG learned about her accident and broken bones during a treatment team meeting on 5/15/19. Interview on 7/3/19 with the Owner/staff #5 revealed: - She did not contact FC #4's LG about FC #4 5/13/19 incident of falling down the group home stairs, going to the hospital and broken bones until 5/15/19. - "She (LG) was notified of the accident ...when there was an emergency meeting with [mental health facility] (5/15/19)." Finding #2 Interview on 7/2/19 with FC #4's LG revealed: - On 5/26/19 she requested to pick up FC #4's belongings and was told by staff that the owner/staff #5 would not allow her to come on the property. - On 6/4/19 FC #4 was discharged from the hospital after having surgery to her ankle and wrist. - On 6/4/19 she was able to pick up FC #4's belongings from the group home. - She discovered after leaving the group home on 6/4/19 that FC #4's medications (Zoloft, Remeron and Invega) were not in the belongings returned by the group home. - The Owner/staff #5 told her she had returned client #4's medications (Zoloft, Remeron, and Invega) to the pharmacy.	V 291		

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V 291	Continued From page 19 - When she attempted to have FC #4's medications filled at another pharmacy, the pharmacist held the regular medications (Zoloft, Remeron, and Invega) and the pain medication (Norco) until the pharmacy could contact FC #4's medical doctor due to the request for refills was too early. - FC #4 went two days without her regular medications: Zoloft, Remeron, Invega and her pain medication Norco. Interview on 7/3/19 with FC #4 revealed: - She was staying at her new facility in another part of the state after her hospital discharge and surgery on 6/4/19. - She went without her pain medication for 3 days and only had ibuprofen to take. - Reported her pain level on a scale from 1-10 (10 being the worst pain) after taking ibuprofen, was still a "10." Interview on 7/3/19 with the Owner/staff #5 revealed: - She returned FC #4's medications to the pharmacy when FC #4 was having surgery. - She decided on her own to mail back FC #4's medications to the group home pharmacy and prior to mailing back the medications did not discuss this with the group home pharmacist or FC #4's legal guardian. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule violation and must be corrected within 23 days.	V 291		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities	V 364		

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V 364	Continued From page 20 § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a	V 364		

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V 364	Continued From page 21 violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and	V 364		

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V 364	Continued From page 22 vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00	V 364		

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V 364	Continued From page 23 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the	V 364		

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V 364	Continued From page 24	V 364		

renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.

This Rule is not met as evidenced by:
Based on interviews and record review the facility failed to ensure privacy during telephone calls affecting 3 of 3 current clients (Clients #1, #2, and #3) and 1 of 1 former client (FC #4) and restricted access to personal possessions affecting 1 of 1 former client (FC #4). The findings are:

Finding #1

Interview on 6/26/19 with client #1 revealed:
- Client phone calls were being monitored by staff.
- " ...yes they (staff) monitor our calls. They (staff) have us sit in the living room when we make calls and watch us."

Interview on 6/27/19 with client #2 revealed:
- She would not respond to questions about her phone calls being monitored by staff.

Interview on 6/26/19 with client #3 revealed:

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V 364	Continued From page 25 - "Every time we (clients) are on the phone we are being monitored (by staff)." Interview on 7/3/19 with FC #4 revealed: - "Yes, she (the owner/staff #5) monitored my calls to my guardian and told me what to say to her (legal guardian)." - "[The owner/staff #5] would be there every time I would make a phone call" Interview on 6/26/19 with staff #3 revealed: - "Yes, we do (monitor the client phone calls). I learned that (to monitor calls) when I first started here. We were told to be in the same room." - "We only monitor [client #2] phone calls. We don't monitor the other clients calls." Interview on 7/3/19 with staff #1 revealed: - Staff sit in the same room with client #2 when she makes phone calls. Interview on 7/3/19 with the Owner/staff #5 revealed: - There was no policy in place about monitoring phone calls but "one of the three (clients) has to be monitored due to her (client #2) court situation. We pay attention to all of the client calls unless they are not in the room." - Could not provide documentation or a treatment plan addressing the reason client #2's phone calls were to be monitored. Finding #2 Review on 6/27/19 of former client #4's record revealed: - Admission date: 5/1/19 - Admission Assessment dated 5/1/19: "History of AWOL (absent without leave) to prostitute self and use crack, cocaine, chain smoker ..."	V 364		

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V 364	Continued From page 26 - No documentation about restricting cigarettes by the Qualified Professional. - No strategies to address restriction of cigarettes. - No evaluation by the Qualified Professional to restrict cigarettes. - No detailed reason for the restriction of cigarettes by the Qualified Professional. - No notification to the legal guardian about the restriction of cigarettes. Interview on 7/3/19 with FC #4 revealed: - She smoked 20 cigarettes a day. - After she was admitted to the group home the owner/staff #5 limited her to 3 cigarettes a day. She never agreed to have her cigarettes reduced to 3 a day. - On 5/12/19 she ran away to prostitute to obtain cigarettes. When she returned the owner/staff #5 took the rest of her cigarettes and told her she could not smoke because she ran. Interview on 7/3/19 with the Owner/staff #5 revealed: - When FC #4 was admitted to the group home she reduced FC #4 to 5 cigarettes per day. - She ignored the request of the legal guardian to give FC #4 more cigarettes. - " ...told her (FC #4) she could do 5 cigarettes a day. [LG] wanted us to give her more." - After FC #4 ran away to prostitute to get cigarettes on 5/12/19 she took away all of FC #4's cigarettes. - On 5/13/19, FC #4 attempted to run away again to get cigarettes. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule	V 364		

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V 364	Continued From page 27 violation and must be corrected within 23 days.	V 364		
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 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	V 367		

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(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 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

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V 367	Continued From page 29 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 report all Level II incidents to the LME (Local Management Entity) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 6/26/19 of the Incident Response Improvement System (IRIS) revealed: - There was not a report that FC #4 fell down the stairs and went to the hospital. Interview on 7/3/19 with the owner/staff #5 revealed: - She did not complete an IRIS (Incident Response Improvement System) report when FC #4 fell down the group homes stairs and was taken to the hospital for possible injuries. - "When I asked the hospital if I needed to do an IRIS report they said no they would do the report if one needed to be done." This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 368	G.S. 122C-63 Assurance for continuity of care	V 368		

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V 368	Continued From page 30 § 122C-63 ASSURANCE FOR CONTINUITY OF CARE FOR INDIVIDUALS WITH MENTAL RETARDATION (a) Any individual with mental retardation admitted for residential care or treatment for other than respite or emergency care to any residential facility operated under the authority of this Chapter and supported all or in part by state-appropriated funds has the right to residential placement in an alternative facility if the client is in need of placement and if the original facility can no longer provide the necessary care or treatment. (b) The operator of a residential facility providing residential care or treatment, for other than respite or emergency care, for individuals with mental retardation shall notify the area authority serving the client's county of residence of his intent to close a facility or to discharge a client who may be in need of continuing care at least 60 days prior to the closing or discharge. The operator's notification to the area authority of intent to close a facility or to discharge a client who may be in need of continuing care constitutes the operator's acknowledgement of the obligation to continue to serve the client until: (1) The area authority determines that the client is not in need of continuing care; (2) The client is moved to an alternative residential placement; or (3) Sixty days have elapsed; whichever occurs first. In cases in which the safety of the client who may be in need of continuing care, of other clients, of the staff of the residential facility, or of the general public, is concerned, this 60- day notification period may be waived by securing an emergency placement in a more secure and safe facility. The operator of the residential facility shall notify the	V 368		

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area authority that an emergency placement has been arranged within 24 hours of the placement. The area authority and the Secretary shall retain their respective responsibilities upon receipt of this notice.

(c) An individual who may be in need of continuing care may be discharged from a residential facility without further claim for continuing care against the area authority or the State if:

(1) After the parent or guardian, if the client is a minor or an adjudicated incompetent adult, or the client, if an adult not adjudicated incompetent, has entered into a contract with the operator upon the client's admission to the original residential facility the parent, guardian, or client who entered into the contract refuses to carry out the contract, or

(2) After an alternative placement for a client in need of continuing care is located, the parent or guardian who admitted the client to the residential facility, if the client is a minor or an adjudicated incompetent adult, or the client if an adult not adjudicated incompetent, refuses the alternative placement.

(d) Decisions made by the area authority regarding the need for continued placement or regarding the availability of an alternative placement of a client may be appealed pursuant to the appeals process of the area authority and subsequently to the Secretary or the Commission under their rules. If the appeal process extends beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange a temporary placement in a State facility for the mentally retarded pending the outcome of the appeal.

(e) The area authority that serves the county of residence of the client is responsible for

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assessing the need for continuity of care and for the coordination of the placement among available public and private facilities whenever the authority is notified that a client may be in need of continuing care. If an alternative placement is not available beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange for a temporary placement in a State facility for the mentally retarded. The area authority shall retain responsibility for coordination of placement during a temporary placement in a State facility.
(f) The Secretary is responsible for coordinative and financial assistance to the area authority in the performing of its duties to coordinate placement so as to assure continuity of care and for assuring a continuity of care placement beyond the operator's 60-day obligation period.
(g) The area authority's financial responsibility, through local and allocated State resources, is limited to:
(1) Costs relating to the identification and coordination of alternative placements;
(2) If the original facility is an area facility, maintenance of the client in the original facility for up to 60 days; and
(3) Release of allocated categorical State funds used to support the care or treatment of the specific client at the time of alternative placement if the Secretary requires the release.
(h) In accordance with G.S. 143B-147(a)(1) the Commission shall develop programmatic rules to implement this section, and, in accordance with G.S. 122C-112(a)(6), the Secretary shall adopt budgetary rules to implement this section. (1981, c. 1012; 1985, c. 589, s. 2.)

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V 368	Continued From page 33 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to notify the area authority serving the client of intent to discharge an intellectually disabled client at least 60 days prior to discharge affecting 1 of 1 former client (FC #4). The findings are: Review on 6/27/19 of former client #4's record revealed: - Admission date: 5/1/19 - Went to the local hospital for suicidal ideation and had ankle/wrist surgery: 5/24/19 - Discharged from local hospital and placed in new facility: 6/4/19 - Facility's discharge date on discharge form: 6/17/19 Interview on 7/2/19 with FC #4's legal guardian (LG) revealed: - The facility provided her notice on 5/17/19 for FC #4's discharge date to be 6/17/19. Review on 6/27/19 of FC #4's Discharge Summary form dated 5/17/19 revealed: - Facility's discharge date on discharge form: 6/17/19 This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule violation and must be corrected within 23 days.	V 368		
V 541	27F .0104 Client Rights - Stor. & Protect of Cloth/Poss	V 541		

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V 541	Continued From page 34 10A NCAC 27F .0104 STORAGE AND PROTECTION OF CLOTHING AND POSSESSIONS Facility employees shall make every effort to protect each client's personal clothing and possessions from theft, damage, destruction, loss, and misplacement. This includes, but is not limited to, assisting the client in developing and maintaining an inventory of clothing and personal possessions if the client or legally responsible person desires. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to make every effort to protect each client's personal clothing from loss, affecting 1 of 1 former client (FC #4). The findings are: Review on 6/27/19 of former client #4's record revealed: - Admission date: 5/1/19 - Went to the local hospital for suicidal ideation and had ankle/wrist surgery: 5/24/19 - Discharged from local hospital and placed in new facility: 6/4/19 - Facility's discharge date on discharge form: 6/17/19 Interview on 7/3/19 with FC #4 revealed: - After her belongings were picked up on 6/5/19 she noticed that some items were missing. - "There was towels and wash cloths and a charger for my electronic cigarette missing, shoes missing and some clothes missing." Review on 7/3/19 of FC #4's "Agape Search and Seizure" form dated 6/4/19 revealed: - On 5/2/19 at 4:16 pm the following items were	V 541		

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V 541	Continued From page 35 documented as "new admit": 48 shirts, 19 pants, E Pen, 2 coats, 1 razor, cell phone, cigs. (cigarettes), ID (Identification), eye drops. - On 6/4/19 at 8:00 am the following items were documented as "returned items": 50 shirts, 21 pants, E pen charger, cell phone, cigs (cigarettes) = 2 1/2 packs, nicotine gum, 1 bible, 2 books, picture of children, towels, wash cloths, bed linen, teddy bear. Interview on 7/3/19 with staff #1 revealed: - All of FC #4's items were packed and given back to her. - "Yes (all items were provided), I packed everything myself and I took it out to her (the Legal Guardian's) vehicle." Interview on 7/3/19 with the Owner/staff #5 revealed: - At discharge some of FC #4's belongings were not provided. - "(All items were provided) except for a bedroom shoe and one or two other items." - She did not provide the missing items to FC #4. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule violation and must be corrected within 23 days.	V 541		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736		

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V 736	Continued From page 36 This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe manner. The findings are: Observations on 6/26/19 at approximately 1:13 pm of group home back deck area: - Back deck area located off the kitchen area is approximately 5 feet off the ground with stairs immediately on the right side of the deck. - The stairs had 6 steps. - A metal table was observed near the steps with a metal chain connected to the bottom area of the metal table. Review on 7/1/19 of Former Client (FC) #4's medical records: - Client #4 was seen at a local hospital on 5/13/19. - "Patient states she fell down 6 stairs this afternoon ...Patient complains of right ankle and right wrist pain." - "Findings: Displaced fracture of the distal right radius, with fracture extension to the articular surface (ulnar aspect)." - "Findings: Displaced fractures of the medial malleolus and distal fibula, as detailed on the plain film report of the RIGHT ankle." Interview on 7/3/19 with FC #4 revealed: - "On the May 13th (2019) I fell and broke my ankle and arm. I was on the back porch and there was this cast iron table in front of the stairs. I sat on it and it didn't catch me, I was not balanced and I didn't have my feet on the stairs yet, the table fell over and the table rolled down the stairs with me."	V 736		

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- The owner/staff #5 had chained the table to the top of the stairs on the deck to prevent her from running away again.
- "The table was there with chains because I ran away. It was chained up to the railing."

Interview on 6/26/19 with client #1 revealed:
- FC #4 had jumped off a table on the back deck because she wanted cigarettes and a lighter. The table was chained by the owner/staff #5 to the deck railing to prevent clients from running away.
- "She (FC #4) jumped off the deck. She jumped off the deck because she wanted cigarettes and a lighter. The table was blocking the stairs so she got on top of the table and jumped off the table ...I heard a boom boom boom. I heard one of the staff members say she just dived off the table."
- "(The table was in front of the stairs) so that they (clients) can't go down the stairs and runaway."
- "There were chains on the table and hooked on one of the pieces of wood beside the stairs."
- "I think [the Owner/staff #5] did a good job of keeping that table there. Who is going to be able to get down the stairs and runaway if the table was there. If there had been a fire we couldn't get out that way."

Interview on 6/27/19 with client #2 revealed:
- She did not see FC #4 fall down the stairs on 5/13/19 but she heard a loud noise.
- 911 was called on 5/13/19 because FC #4 "jumped off the table and broke her arm and leg."
- The reason FC #4 jumped off the table was "all she wanted was a cigarette."
- The owner/staff #5 put the table in front of the stairs "to protect us from going down the stairs."

Interview on 6/26/19 with client #3 revealed:
- On 5/13/19, FC #4 wanted a cigarette and jumped over a table that the owner/staff #5

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chained in front of the deck stairs to prevent clients from running away.
- The table had been chained in front of the deck stairs for approximately two days prior to FC #4 falling down the stairs.
- "She (FC #4) wanted a cigarette. [The owner/staff #5] put the table so that people couldn't run away. [The owner/staff #5] put the table to block the stairs on the back porch. I don't think that is safe. There is a chain around the post around the deck (railing) so the table couldn't move. She (FC #4) jumped over it and fell down the stairs."
"I asked [The owner/staff #5] why is the table there when she put the table there. [The owner/staff #5] said because people keep on running away. You can't stop anyone from running away. That is dangerous to put the table right there because people can get hurt."

Interview on 6/26/19 with staff #2 revealed:
- She was working with staff #3 on 5/13/19.
- On 5/13/19 FC #4 wanted to smoke but had no lighter.
- FC #4 went out the back door to the deck.
- "The next thing I know I hear a boom. I go outside and she was at the bottom of the steps."
- FC #4 told her, that she climbed on top of the table and it flipped her over.
- The table had been located on the deck in front of the stairs.
- "[The owner/staff #5] was already on her way here."
- "The ambulance came and confirmed [FC #4] had broken her ankle and they did not know anything was wrong with her wrist until they took her to the hospital."

Interview on 6/26/19 with staff #3 revealed:
- She worked on 5/13/19 with staff #2 when FC

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V 736	Continued From page 39 #4 fell down the stairs. - "[FC #4] got mad because she couldn't get a cigarette." - "We have down time from 4pm-5 pm every day and she (FC #4) wanted a cigarette during the down time." - "She could have waited for after down time to get her cigarette and I don't understand why she did that." - "She went on the back porch and we heard a big boom and she was down on the bottom of the steps." - "Her foot was bent back the opposite way and it looked like a bone was sticking out." - "The table was sitting right there at the beginning of the steps so that she [FC #4] wouldn't leave and nobody would leave because the previous day she [FC #4] had ran away." - "There was a chain on the table and it was attached so that it could not be moved." - She did not know who chained the table in front of the stairs. Interview on 7/3/19 with the Owner/staff #5 revealed: - She had chained the table that FC #4 fell off from and down the stairs on 5/13/19. - The table was made out of "wrought iron." - "The table is chained on one side because the gusty winds we have. One of my neighbors suggested to me to chain the table and umbrellas." - "It's been chained all over the deck. It was chained beside the steps." - She denied chaining the table beside the steps to prevent the clients from running away. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type A1 rule	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	07/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 736	Continued From page 40 violation and must be corrected within 23 days.	V 736		