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V 000	INITIAL COMMENTS An annual and follow up survey was completed on July 17, 2019. 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 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies to address client needs affecting 2 of 3 clients audited. (client #1 and #2) The findings are: Finding #1: Review on 7/8/19 and 7/9/19 of client #1's record revealed: -23 year old male admitted 1/4/13. -Diagnoses included Mild Intellectual Developmental Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactive Disorder (ADHD), Bipolar Disorder; Pervasive Developmental Disorder. -12/20/18 Client #1's father was appointed his guardian. -No treatment team meetings documented after 9/20/18. Review on 7/8/19 and 7/9/19 of client #1's Treatment Plan, implementation date 11/1/18, revealed: -Treatment team met on 9/20/18. -The assessment, "What is Working for Me," documented, "[Client #1] enjoys his visits with his dad and looks forward to spending time with him." -The Treatment Plan included one residential goal that addressed elopement behavior and read, "[Client #1] monitored for personal safety in the home and community. Daily with redirections, verbal instructions, monitoring, and assistant from staff, [client #1] will refrain from elopement for long periods of time." No revisions or additions to strategies documented after it was developed on 9/20/18 and implemented 11/1/18. -Treatment Plan documented, "... ISP (individual service plan) team is requesting 20 H/Y (hours/year) of Specialized Consultative Services	V 112		

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(SCS). SCS provides expertise, training and technical assistance in a speciality area to support family members and support staff assist individuals with special needs. [Client #1] continues to display maladaptive behaviors such as elopement, verbal and physically aggressive outbursts and noncompliance."

Review on 7/8/19 and 7/9/19 of client #1's Behavior Plan dated 10/17/18 revealed:
-The facility was to have a reward chart/sheet. The responsibility for keeping and maintaining the reward chart was to "lie with group home staff...staff will be responsible for initialing (or signing) his reward sheet after the specified timeframe has passed."
-Stress management techniques included "Scheduled Worry" to provide a planned time each day to focus the client's "worry" and thus "avoid accumulation."
-There was no documentation of the reward chart, a time for "Scheduled Worry," or other documentation the Behavior Plan had been implemented.

Review on 7/6/19 of Client #1's Elopement/Safety Plan dated 1/23/19 revealed:
-Strategies to implement after the client eloped.
-Reporting requirements when client #1 eloped. The staff were to call "911" and report a "runaway" if he did not return in 30 minutes.
-The Elopement/Safety Plan did not include strategies to prevent an elopement.

Review on 7/8/19 and 7/16/19 of client #1's North Carolina Incident Response Improvement System (IRIS) reports revealed client #1's elopement history:
-Prior to client #1's admission, he eloped on 10/23/12 from his prior facility by taking the facility

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van, driving on a public road, and wrecking the vehicle.
-Between 10/27/18 and 7/11/19 there were 8 IRIS reports that documented 8 elopements as follows:

1. 10/27/18: Client #1 left the facility when staff went to the restroom. The cause of the incident documented the client was worried that his father did not answer his phone calls. Incident prevention actions documented the facility tried unsuccessfully to reach the clients father.
2. 11/17/18: Client #1 took out the trash and eloped. The cause of the incident documented the client was worried about his father. Incident prevention actions documented "Both [client #1] and his father needs to understand that [client #1] copy cat things that people tells him."
3. 11/22/18: Client #1 eloped as staff were on the phone trying to reach the Manager about his threats to elope. The cause of the incident documented the client was upset his father was not able to visit. Incident prevention actions documented "[Client #1's] father needs to communicate more effectively about [client #1's] Triggers. He also needs to understand that [client #1] copy cats him when he gets in trouble... Getting [client #1's father] to limit his problems and issues with [client #1] would assist with some of [client #1's] behaviors."
4. 12/11/18: Client #1 eloped when he went, with permission, to check the mail. The cause of the incident documented staff had asked the client to clean his room. Incident prevention actions documented, "The preventive measure for corrective action is to get additional staffing."
5. 1/17/19: Client #1 eloped from the doctor's office. The cause of the incident documented the client enjoyed running away, sought attention, and it stimulated him. Incident

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prevention actions documented, "The Agency has requested 1:1 for [client #1] because he is a high risk for running away. The Agency submitted a Rate Consideration for additional staffing for 1:1 protection for [client #1]."

6. 1/27/19: Client #1 eloped from the facility. The cause of the incident documented the client had been in "inappropriate conversation about relocating to another group homes in an inappropriate setting." Incident prevention actions documented the client would be relocating to another group home.

7. 6/24/19: Client #1 eloped from the facility and was located by police at a nearby shopping center. The Licensee/Qualified Professional (QP) picked him up and returned him to the facility. After returning to the home client #1's behaviors escalated. Staff contacted the police, stated client #1 was in crisis and they needed assistance because he stated he wanted to harm himself and others. Client was transported to the local hospital. The cause of the incident documented the client stated, "...he just wanted to be slick." Incident prevention actions documented "[Client #1] needs a one on one staff at all times because he will do whatever he thinks is funny to him at the time."

8. 7/11/19: After clients #1 and #2 were transported to the corporate office by the Manager, client #1 jumped from the van and ran behind a building. The Manager immediately exited the vehicle to pursue the client, leaving the keys in the ignition. Client #1 returned to the vehicle and drove it from the parking lot. When leaving the parking lot, Client #2 was thrown from the van onto the pavement. There were no other staff present. Client #1 drove the van onto a side street, then onto a nearby 6 lane road into oncoming traffic, and collided with 4 cars. The cause of the incident documented client #1's

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V 112	Continued From page 5 father did not show up for a visit on 7/10/19 and the client's behavior was a result of "broken promises from the father." Incident prevention actions documented "[Client #1] needs higher level of care. [Facility] uses two staff and he still manages to elope and cause harm to others." (See finding #2 for additional information regarding client #2's injuries.) Review on 7/16/19 and 7/17/19 of the facility investigation of the 7/11/19 incident revealed: -Client #1 was returned from the accident scene to the corporate office. Emergency Medical Services (EMS) was called. -Client #1's behaviors escalated. He became aggressive, attempted to elope, and threatened to harm himself and others. -The police handcuffed and transported client #1 to the local hospital. He was admitted and remained in the hospital as of 7/17/19. Review on 7/16/19 of an electronic mail dated 7/3/19 from the Licensee/QP to the Managed Care Organization (MCO) revealed: -The Licensee/QP submitted a Rate Consideration Request to pay for additional staffing. -The rate increase was for additional staff to cover Monday-Friday first shift after the Day Program; second shift until client #1 went to bed/asleep; Saturdays for 10 hours; and, Sundays for 14 hours. Interview on 7/5/19 client #1 stated: -He had been living in the home since 2010. -He had left the home without permission "a lot." -Police would bring him back. -One time he went to the fire station and once to a military base.	V 112		

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V 112	Continued From page 6 Telephone interview on 7/16/19 client #1's Care Coordinator stated: -The Special Consultative Services listed in client #1's Treatment Plan were for a Behavioral Specialist. -The most recent Behavior Plan was done in October, 2018. -For the Behavior Plans to be effective, everyone must apply them consistently. -Team meetings occurred annually at a minimum. -Any member of a Team could call a meeting if they identified a need. Finding #2: Review on 7/8/19 and 7/9/19 of client #2's record revealed: -23 year old male admitted 12/10/10. -Diagnoses included Severe Intellectual Developmental Disorder, Unspecified Disruptive Impulse Control Conduct Disorder, ADHD, Enuresis, Encopresis, Rasmussen's Encephalitis, Constipation, Thoracolumbar Scoliosis to the right, History of Seizure Disorder. -Behavior Plan dated 11/7/18 for target behaviors: Cursing or engaging in other forms of threatening behavior; physical aggression, particularly toward female staff members. The "Integrated Summary" documented client #2's behaviors were a result of his marked intellectual limitations and impulse control issues associated with his traumatic brain injury at 5 years of age. The plan included a reward system to include giving 3 "smiley faces" at the beginning of each day and removed for infractions (engaging in problem behaviors.) A reward documentation sheet was to be signed by staff. -There was no documentation of the reward sheet or other documentation the Behavior Plan had been implemented.	V 112		

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V 112	Continued From page 7 Review on 7/9/18 of IRIS report dated 6/28/19 revealed: -Client #2 and #3 got into a "fight" over the television. -Client #2 scratched and bit client #3. Review on 7/17/19 of client #2's hospital Discharge Summary dated 7/14/19 revealed: -Client #2 had been admitted on 7/11/19 and discharged 7/14/19. -Client #2 was transported via EMS to the Emergency Department "with complaints of being struck by car in parking lot." It had been reported the van was driven by another group home client and it was not clear if client #2 had been struck by the vehicle or fell from the vehicle. The client had a chin laceration and decreased breath sound on the right. -Client #2's chin laceration was sutured in the emergency room. -Client #2 was diagnosed with a "Traumatic Pneumothorax" and a chest tube was inserted into his right lateral chest. -The chest tube was removed 7/13/19. Interview on 7/9/19 Staff #1 stated: -All of the clients had behavior plans. -Staff responsibilities included keeping the clients safe, helping with their hygiene, transporting them to appointments and their day program. -There were no reward sheets for staff to document client's rewards. -The only documentation they did were shift notes. Interview on 7/9/19 Staff #3 stated: -Staff were responsible to read client's behavior plans to become knowledgeable and know the client goals. -His responsibilities for client care were to make	V 112		

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sure the clients's rooms were clean and their hygiene done.
-Client #1 was a "runner." If the client was to elope it was his responsibility to call police.

Interview on 7/16/19 the Group Home Manager (GHM) stated:
-He believed client #1's elopement on 7/11/19 was a result of the client's disappointment the prior night when his father failed to show up for a visit. His father called 7/10/19 at 1 pm and said he was coming to see him. Client #1 and his father talked about his father needing socks, and the client had put his socks in a bag for his father. His father never showed up.
-He (GHM) had worked at the facility since November 2018, so he had not known client #1 for a very long time.
-The only strategy they did when client #1 was disappointed, was to watch him closer.
-He had no specific training on client #1's Behavior Plan and or how to help him when he was worried over his father. They gave rewards to the clients. When asked for examples of rewards, the GHM stated they got their $66 each month on their "card" and would get to go out to shop, or out to eat.
-On 7/11/19 he had taken the clients to their psychiatrist medication management appointment. This was not an appointment with their therapist. Following the appointments, they went to the office and turned in prescriptions, then returned to the facility. Client #1 was "acting normally." He (GHM) was called to come back to the office and pick up a new staff who was "in training." Upon arrival, client #1 "jumped out," and he (GHM) made a "split second" decision to run after the client. Client #1 ran behind the building, then came around the building and "jumped in the van." Client #1 put the van in

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V 112	Continued From page 9 "drive" and drove into some bushes. He then put the van in reverse. That was when client #2 fell from the van. He (GHM) was behind the building when client #1 "took off in the van." The office staff found out about the incident when he got back to office and saw client #2 lying on the ground. He notified the staff inside the office and they called "911." He (GHM) and the Licensee/QP drove after client #1. By the time they got to client #1 he had hit 4 cars and a bystander had pulled the key out of the ignition. -He had heard "through the grape vine" that in the past client #1 had taken a van and "ran it into a house or something." -They staffed with 1 person on each shift. Staff were awake staff at night. -He was working alone 7/11/19 when the elopement occurred. Interview on 7/9/19 the Licensee/QP stated: -There were no reward sheets or other Behavior Plan documentation. -Client #1 liked to go to the hospital. -He was taken to the hospital following his elopement on 6/24/19. He was at the hospital Emergency Room for 1 day and released. Continued interview on 7/16/19 the Licensee/QP stated: -Client #1 had several elopements since September 2018. -There had been no changes or revisions to client #1's plan, goals, or strategies since it was developed and implemented 11/1/18. -Client #1's father had recently been named his guardian. There had been no Treatment Team meetings to include the father since he became the guardian. -Client #1 was supposed to move to another facility closer to his father. This had not	V 112		

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V 112	Continued From page 10 happened because the MCO took too long to approve a single case agreement needed by the accepting facility. -They had put a safety/elopement plan in place for client #1. -Her understanding of "Consultative Services" listed in client #1's treatment plan was for his Behavior Plan. She did not know what else these services included. The Behavior Plan had not been revisited since September 2018. -She had submitted a request for additional funding for increased staffing following the 6/24/19 elopement. Increasing the staff was contingent on receiving the additional funding. She thought she had submitted an earlier request, but did not know what happened with that. -She did not plan on taking client #1 back after he was discharged from his current hospital stay. He was currently admitted to the behavioral unit in the local hospital. -She had issued the father/guardian verbal notice of discharge. -She had been told by the MCO "Navigator" that she (Licensee/QP) would have to participate in finding another facility placement for client #1 for him to be discharged prior to a 60 day notice. -She had found a provider that was willing to consider admitting client #1. They were scheduled to go to the hospital and do an assessment. Review on 7/16/19 of the Plan of Protection dated 7/16/19 and completed by the Licensee/QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? [Client #1] Legal Guardian and the Team has been given a 60-day Discharge Notice. The Provider has consulted with the Legal Guardian to	V 112		

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assist with finding a new provider. The Team will meet on 7.16.19 at Behavioral Health with [another provider] to screen [client #1] for a new placement.
-Describe your plans to make sure the above happens. [Client #1's] Care Navigator ([name]) is assisting with locating and attending for [client #1's] Discharge Plan. The current Provider will continue to work with the Team to find an higher level of Care or new placement."

Over the past 9 months, between 10/27/18 and 7/11/19, client #1 had 8 elopements documented. Prior to admission, client #1 had an elopement episode that involved driving and wrecking a facility van. Four (4) elopements by client #1 between 10/27/18 and 7/11/19 were documented to be a result of disappointments that he did not get to visit with his father, or the client was worried for the father's well being. Neither of these factors had been identified in his current Treatment Plan or Behavior Plan. There was no documentation client #1's Behavior Plan had been implemented, which included strategies to support client #1 when he had worries. Additional staff had been identified as needed to prevent client #1 from eloping in 3 of the 7 elopements between 10/27/18 and 6/24/19. The facility continued to have 1 staff on duty at the facility and with clients during transports. According to the Licensee/QP there had been no Treatment Team meetings for client #1 since 9/20/18, and there had been no updates to his treatment plan elopement prevention strategies. The Treatment Team would have included the client's father as of 12/20/18, as he had become client #1's legal guardian. The elopement prevention strategies in client #1's plan did not include vehicle safety and precautions. Client #2 had a history of dysfunctional behaviors in the group home that

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V 112	Continued From page 12 caused disturbance or disruption of daily routines and had adversely impacted staff and peers. The Behavior Plan was to augment his current treatment and decrease target behaviors, such as cursing or engaging in other forms of threatening behavior or physical aggression that were disruptive to the facility and other clients. As evidenced by the altercation with his peer on 6/28/19, client #2 did engage in physically aggressive behaviors. Failure to implement client #1's Behavior Plan, update elopement prevention strategies, or increase staff resulted in the most recent elopement of client #1 on 7/11/19 when he took the facility van. His erratic driving resulted in a life threatening injury to client #2 as he was thrown from the vehicle, and a motor vehicle accident involving 5 vehicles. This deficiency constitutes a Type A1 rule violation for serious harm 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 administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted	V 114		

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V 114	Continued From page 13 under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to hold fire and disaster drills quarterly on each shiftand under conditions that simulate fire emergencies. The findings are: Interview on 7/5/19 the Group Home Manager stated: -The facility shift hours were: -Monday-Friday: 8 am-4 pm; 4 pm-12 mn;12 mn-8 am -Saturday-Sunday: 8 am-8 pm and 8 pm-8 am Review of fire and disaster drills from 7/1/18 - 6/30/19 revealed: -Quarter: 1/1/19-3/31/19 - No fire or disaster drills documented on the week day 12 mn-8 am or week end 8 am-8 pm shifts. -Quarter:10/1/18-12/31/18- No fire or disaster drills documented on the week end 8 pm-8 am shift. -No separate documentation of disaster drills from fire drills during the past 12 months audited. The form used to document had check boxes for the the staff to check which included an option for "Fire Drill" and one for "Natural Disaster." Staff checked both "Fire Drill" and "Natural Disaster" for each documented "Emergency Drill." -The type of "Natural Disaster" for which a drill was to have been done was not documented. -There was no separate documentation of the time the "Natural Disaster" drills were held from	V 114		

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V 114	Continued From page 14	V 114		

the times the fire drills were held. There was only one start time and one "Time Completed" documented. Times from start to finish ranged from 2 minutes to 20 minutes. An example would be a "Fire Drill" and "Natural Disaster" drill on 12/1/18, Time Started: 8:00a Time Completed: 8:15."

Interview on 7/10/19 client #1 stated:
-They practiced fire drills. They would go outside.
-He could not identify any disaster drills. When asked if they practiced for tornados his response was, "No."

Interview on 7/10/19 client #2 stated:
-They practiced fire drills. They would go outside to the mailbox.
-They did not practice or discuss any other types of drills.

Interview on 7/9/19 Staff #1 stated:
-She had been employed in the facility about 10 months.
-They knew the fire and disaster drills were always done on the first day of every month.
-When she held the drills she would call the clients into the living room and talk about what they would do if there was a fire. They would talk about tornados.
-After the discussion she would have the clients return to their rooms.
-After returning to their rooms, she would wait for a while, then call the fire drill and see how quickly they would evacuate.
-The clients would come out quickly and meet at the meeting place by the mailbox.

Interview on 7/9/19 Staff #3 stated:
-He would have the clients practice a fire drill.
-He did not "technically do" a disaster drill. They

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V 114	Continued From page 15 would discuss what they would do in the event of a disaster, such as crouch under a table, lay in the tub, or get in a doorway. -He had no problems getting the clients to evacuate the home in a reasonable time.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 16 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure: (1) medications were administered by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person affecting 2 of 3 staff audited (Staff #3, Staff #4); (2)medications were given as ordered by the physician, (3) medications were recorded immediately after administration, and MARs current, affecting 3 of 3 clients audited (clients #1, #2, #3). The findings are: Finding #1 a: Review on 7/8/19 and 7/9/19 of client #3's record revealed: -21 year old male admitted 3/7/16. -Diagnoses included Intellectual Developmental Disorder, Post Traumatic Stress Disorder (PTSD), and Fetal Alcohol Syndrome. Review on 7/8/19 and 7/9/19 of client #3's medication orders revealed: -Risperidone orders were as follows (used to treat certain mental/mood disorders, such as schizophrenia, bipolar disorder, irritability associated with autistic disorder.): -3/18/19 order for Risperidone 1 mg (milligram), 2 tablets at 7 am daily and 1 tablet at 7 pm daily. -4/15/19 order for Risperidone 2 mg, 1 tablet at 7 am and 1 tablet at 7 pm daily. -4/25/19 order for Risperidone 1 mg, 1 tablet at 7 am and 1 tablet at 7 pm daily. -5/13/19 order for Risperidone 2 mg, 1 tablet at 7 am and 1 tablet at 7 pm daily. -Primidone orders were as follows	V 118		

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V 118	Continued From page 17 (anticonvulsant's): -5/13/19 order for Primidone 50 mg, 6 tablets at 7 am and 4 pm. -6/11/19 order for Primidone 50 mg, 4 tablets at 7 am and 4 pm. -3/18/19 order for Sertraline 100 mg, 2 at 7 pm. (antidepressant) -4/3/19 order for Flexeril 5 mg twice daily for 5 days. (muscle relaxant for pain, injury, spasms) -12/10/18 order for a multivitamin daily. Review on 7/8/19 and 7/9/19 of client #3's April 2019 MARs revealed: -Risperidone 1 mg, 2 tablets at 7 am and 1 tablet at 7 pm was documented as administered 4/15/19 - 4/30/19. -Documentation of Sertraline 100 mg, 2 at 7 pm, was entered electronically. No handwritten documentation by staff who administered the medication immediately after it was administered from 4/1/19 - 4/30/19. Staff #1's initials were entered electronically as having administered the Sertraline on 4/20/19 and 4/21/19. -The first dose of Flexeril 5 mg was documented electronically on 4/6/19, 3 days after it had been ordered. -Documentation of Flexeril 5 mg at 7 am and 7 pm from 4/6/19 through 4/10/19 had been entered electronically. No original/handwritten documentation by staff who administered the medication immediately after it was administered. Staff #1's initials were entered electronically as having administered the Flexeril 5 mg at 7 am on 4/6/19, 4/7/19, and 4/10/19. Staff #3's initials were entered electronically as having administered the Flexeril 5 mg at 7 am on 4/8/19 and 4/9/19. Review on 7/8/19 and 7/9/19 of client #3's May 2019 MARs revealed:	V 118		

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V 118	Continued From page 18 -Risperidone 2 mg, 1 tablet at 7 am and 1 tablet at 7 pm daily had been documented from 5/1/19 - 5/12/19. -No Risperidone documented on 5/25/19 at 7 am. -No documentation the daily vitamin had been administered 5/11/19 - 5/16/19. An "X" had been entered on the MAR for 5/11/19 and 5/12/19. Staff #2 had initialed and circled her initials from 5/13/19 - 5/16/19. Staff #2 documented the medication had not been given on 5/13/19 and 5/14/19 because they were out of the medication. Review on 7/9/19 of client #3's June and July 2019 MARs revealed: -Risperidone 2 mg was not documented as given 6/27/19 and 6/28/19. Staff #2 documented they were out of the medication on 6/27/19. -Primidone 50 mg, 6 tablets had been documented as administered from 6/11/19 - 6/30/19 at 7 am and 4 pm. (Note, order changed 6/11/19.) -No documentation the 4 pm dose of Primidone 50 mg (4 tablets) had been administered on 7/8/19. Finding #1 b: Review on 7/8/19 and 7/9/19 of client #2's record revealed: -23 year old male admitted 12/10/10. -Diagnoses included Severe Intellectual Developmental Disorder; Unspecified Disruptive Impulse Control Conduct Disorder; Attention Deficit Hyperactive Disorder (ADHD), combined type; Enuresis; Encopresis; Rasmussen's Encephalitis; Constipation; Thoracolumbar Scoliosis; History of Seizure Disorder. Review on 7/8/19 and 7/9/19 of client #3's medication orders revealed: -3/27/19 order for Clindamycin 300 mg 4 times	V 118		

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V 118	Continued From page 19 daily for 7 days (antibiotic). Order to dispense 28 tablets. -4/8/19 order for Benztropine 2 mg twice daily. -5/6/19 order for Chlorpromazine 200 mg 1 every morning, one at 1 pm, and 2 before bedtime. (used to treat psychotic disorders such as schizophrenia or manic-depression) -5/15/19 for Linzess 290 mcg (micrograms) daily. (Chronic constipation) -Propranolol 10 mg every morning, at 1 pm, and at bedtime daily. (Used to treat tremors, and heart or circulatory conditions such as chest pain, high blood pressure, and heart rhythm disorders. -6/24/19 to discontinue Colace 100 mg daily as needed and Restart after 2 weeks. (Constipation) Review on 7/8/19 and 7/9/19 of client #2's March, April, May, June and July 2019 MARs revealed: -Clindamycin 300 mg was scheduled to be administered at 7 am, 1 pm, 6 pm, and 12 am. The first dose was documented on 3/29/19 at 1 pm. There were only 2 doses documented 3/29/19, at 1 pm and 6 pm. The next 2 days, 3/30/19 and 3/31/19, only 1 dose of Clindamycin 300 mg was documented each day at 6 pm. There was no 7 am dose documented 4/1/19 and no 12 am dose documented 4/5/19. The 28 th dose documented was on 4/7/19 at 7 am, however, Clindamycin 300 mg was documented as given 4/7/19 at 1 pm and 12 am. Clindamycin 300 mg was documented as administered 4/21/19 at 7 am and 6 pm. -Benztropine 2 mg twice daily was scheduled to be administered 7 am and 7 pm. There was no documentation the medication had been administered at 7 am on 4/22/19 or 7 pm on 6/15/19 ("x" documented). -Chlorpromazine 200 mg was scheduled to be administered, 7 am, 1 pm, and 7 pm. There was no documentation Chlorpromazine 200 mg had	V 118		

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been administered at 1 pm on 6/8/19 and 6/9/19.
-Colace 100 mg daily as needed had not been transcribed to the July 2019 MAR.
-Linzess 290 mcg daily was scheduled to be administered 7 am. There was no documentation the medication had been administered at 7 am on 4/22/19.
-Propranolol 10 mg was scheduled to be administered at 7 am, 1 pm, and 7 pm. There was no documentation Propranolol 10 mg had been administered at 1 pm on 6/8/19, 6/9/19, or 6/30/19. (The 1 pm doses for 6/8/19 and 6/9/19 were documented, "x".)

Finding #1 c:
Review on 7/8/19 and 7/9/19 of client #1's record revealed:
-23 year old male admitted 1/4/13.
-Diagnoses included Mild Intellectual Developmental Disorder, Oppositional Defiant Disorder, ADHD, Bipolar Disorder; Pervasive Developmental Disorder.

Review on 7/8/19 and 7/9/19 of client #1's medication orders revealed:
-6/6/19 order for Clozapine 100 mg twice daily. (Antipsychotic, schizophrenia)
-5/23/19 order for Depakote DR (delayed release) 500 mg twice daily. (Seizures or acute manic symptoms in patients with bipolar disorder).
-11/29/18 order for Lisinopril 10 mg daily. (High blood pressure)
-11/29/18 order for Metoprolol ER 25 mg daily. (High blood pressure)

Review on 7/8/19 and 7/9/19 of client #2's March, April, May, June and July 2019 MARs revealed:
-There were no April MARs for Client #1.
-Depakote DR 500 mg was scheduled to be administered 7 am and 7 pm. There was no

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V 118	Continued From page 21 documentation the medication had been administered at 7 pm on 6/16/19. -Staff initials were entered electronically to document administration of Lisinopril 10 mg daily and Metoprolol ER 25 mg daily in June 2019. Other medications were documented with initials handwritten on the MARs provided by the pharmacy. Finding #2 a: Review on 7/9/19 of Staff #3's personnel file revealed: -Paraprofessional hired 5/11/18. -Medication training was a computer based instruction, "Medication Management for Individuals with Developmental Disabilities Part 1 and Part 2. Certificate was signed by a Registered Nurse(RN) for 1 hour credit for each Part, to equal 2 training hours. Interview on 7/9/19 Staff #3 stated: -He signed the MARs. He did not sign electronically. -When he forgot to sign the MARs during his shift, he would look back on the days missed to make sure he worked the shift. If he did he would then sign the MAR. He did not do an incident report if he failed to sign the MAR. He did not know if one was done at the office. Finding #2 b: Review on 7/9/19 of Staff #4's personnel file revealed: -Paraprofessional hired 5/28/19. -Medication training was a computer based instruction, :Medication Management in Assisted Living Part 1 and II on 5/16/19. Certificate signed by RN for 1 hour credit for each Part, to equal 2 training hours.	V 118		

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V 118	Continued From page 22 Telephone interview on 7/10/19 Staff #4 stated: -She did her medication training on line. -She had never done this type of work before. -She worked with Staff #1 for 3 shifts to get oriented. -She always documented medication administration by hand writing on the MARs. -She did not document medication administration on the computer. -She worked as the only staff on duty. Interview on 7/9/19 Staff #1 stated: -She only signed the MARs with a pen. She did not sign electronically. -She made a mistake and documented a new medication on the MAR. She was not suppose to wait to give the medication, but was suppose to wait until they received a MAR with the medication printed before signing. -The "x" on the MARs meant they did not have the medication to administer. Interview on 7/8/19 the Licensee/Qualified Professional (QP) stated: -When asked why some of the MARs had handwritten initials to document medication administration and some MARs had been generated with electronic entries, she stated she did the electronic MARs because there were errors on the handwritten MARs. She would have staff return and correct MARs, and example being the staff did not document giving a medication. -When asked how it was determined to be a documentation error or an omission she stated they knew by looking at the bubble packs. There was no documentation when a bubble pack was started. The bubble packs were not always started on the day of the month that corresponded to the beginning bubble	V 118		

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V 118	Continued From page 23 date/number (i.e. " 30"). -The circles around Staff #2's initials meant she did not administer the medication. -They had used an online program for medication training. This vendor had told them they met the requirements for training. -She had not been able to locate client #1's missing MARs.	V 118		
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. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 7/5/19 between 11:15 am and 2:00 pm revealed: -Group Home Manager arrived with the 3 current clients. -Client #2 walked with an unsteady gait and left arm in a contracted position. -Client #3 was walking with a walker, dragging his feet rather than picking up his feet in a stepping motion. -There was no handicap accessible ramp into the home. With assistance from the manager, client #3 was able to navigate up the front steps into the home.	V 736		

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V 736	Continued From page 24 -Interior design of the home was a split level with 3 steps leading from the kitchen to the hallway that lead to all of the client bedrooms and bathrooms. -There was no ramp from the first level to the second. -There was no hand railing on the right side of the steps going up to the hallway. There was wall damage consistent with a railing having been there in the past. -No stain on bottom step. -The smoke detector in the hall closest to the kitchen was dangling by the wires from the ceiling and making a "chirping" sound. -Bi-fold doors to utility closet in hall had no knobs or handles to open the doors. -Client #2's bedroom: No sheets on the bed. The bed head board was leaning forward. There was a double window on the front side of the home. Group home manager could not open either of the windows. Top, right window had a vertical crack from top to bottom. The edges of the broken pane were displaced, leaving a sharp edge along the break for a distance of about 10 inches. Metal covering over the side jamb had been torn away from the wooden frame, leaving jagged metal edges along the inside jamb where the bottom window should have been able to slide upward. The window frame had numerous gouge marks on the frame. Dirt, dust, and debris particles collected on the inside and outside window sills. -Client #1's bedroom: There was a double window on the front side of the home. Window on the left could not be opened. Window on the right could be raised but would slam shut when released. Dirt, dust, and debris particles collected on the inside and outside window sills. Entertainment Center/Cabinet on the left as one entered his room between the door and front	V 736		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 25	V 736		

windows was tilted. The bottom shelf was dislodged from the left side of the cabinet with nothing to stabilize the frame. The 3 Drawers on the left were stacked unevenly and displaced from the tracks. Drawer in the bedside table was pulled out and hanging down. A 5 drawer dresser had the top drawer pulled out and off the track. The other drawers were resting unevenly on the tracks and partially pulled out. The shoe moldings had been removed from the base boards leaving a unfinished edge around the rooms circumference. Paint splatters were on the floor next to the closet and along the floor's perimeter.
-Client #3's bedroom: The window leading to back yard could not be opened by the Group Home Manager. A single window leading to the side of the home could be opened by the Group Home Manager after applying much effort. When opened the bottom section of the metal multi-track exterior storm window was missing, leaving sharp edges protruding about 3-4 inches perpendicular to both sides of the exterior window sill. One glass storm window was resting, unsecured on the exterior window sill. Fragments of wood, dirt, dust, and debris particles collected on the inside and outside window sills. The 5 drawer dresser was missing the bottom drawer. Wood stained surfaces of a roll top desk and bedside table were worn, revealing bare wood edges.
-Vacant Room: Discolored, light brown, irregular and circular stain on the ceiling approximately 4 feet in diameter.
-Hall bathroom ceiling fan hanging from ceiling leaving an approximately 2 inch gap around the fan.
-Kitchen: Laminate chipped away on edge of the peninsula counter top next to the dining area, approximately 4 inches in length. No left drawer in

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	MHL026-912	A. BUILDING: _____ B. WING _____	R 07/17/2019

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V 736	Continued From page 26 the peninsula kitchen cabinet. Drawer to the right of this opening was used to store eating and cooking utensils. Dirt and debris particles covered the bottom of the drawer and the plastic utensil tray. -Door below sink would not remain closed. Painted surface of cabinet worn, scraped, and had dust build up in the decorative etched facial board below the sink. -Dining Room: The exterior of the window was covered with spider webs and a torn screen. Dirt and debris covered the window horizontal surfaces. Floor covering had torn areas near the closet used for the washer and dryer. Floor would give under foot when walking near the washer/dryer closet and along the kitchen peninsula. -Washer/Dryer closet: Water and clothing were inside the washing machine and the lid was opened. When closed by the Group Home Manager the wash cycle resumed. Approximately 10 minutes later the washer began the spin cycle and water escaped covering the floor in the closet and extending into the dining room. Observations on 7/9/19 at 9 am revealed: -The smoke detector continued to chirp. -The hand railing had been replaced by the steps leading from the kitchen to hallway. -A construction crew was on site and had removed one of the front bedroom windows. -The washing machine had been removed. The flooring in the closet where the washer had been located was blackened in what appeared to be build up of dust and dirt. There was a section of vinyl flooring was torn away about 6 inches in diameter. Interview on 7/5/19 client #3 stated:	V 736		

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V 736	Continued From page 27 -He had lived in the home 4 years. -A ramp would make it better for him to get into the home. -He fell a lot. Interview on 7/5/19 client #2 stated: -He did not know how long the railing had been missing. -He was able to get up and down the steps with the one railing. Interview on 7/5/19 client #1 stated: -He moved into the home in 2010. -He did his own laundry. The washing machine had always leaked. -He had the broken cabinet/entertainment center for a couple of years. Interview on 7/5/19 the Group Home Manager stated: -The Licensee planned to build a ramp. He had replaced the roof but had not "gotten to" the ramp. -He was not aware of the broken window in client #2's room. -He was not aware the windows would not open. -The spring was missing in client #1's window and that was why it would not stay in the open position when raised. -The paint spatters in client #1's room occurred because the room had been painted and the painters did not adequately cover the floor. -He had been told about a week ago the washer was not working properly. He had reported this to the owner. -To him the floor felt "spongy" as if you could fall through if not covered by vinyl. -The Licensee/Qualified Professional (QP) made visits to the home weekly.	V 736		

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V 736	Continued From page 28 Interview on 7/9/19 Staff #1 stated: -She recalled hearing the smoke detector chirping the prior Thursday (would have been 7/4/19). -Having the 2nd hand rail replaced had been especially helpful for client # 3. The handrail had been down for 4 months. Client #3 put all of his weight on the rail when getting up the steps and that had caused the nails to "strip" that were securing the rail in place. Interview on 7/5/19 the Licensee/QP stated: -She was not aware of the facility issues identified by the surveyors. -She visited the home weekly and no one had told her there were problems. -She would see to it these issues were corrected. Review on 7/5/19 of the Plan of Protection dated 7/5/19 and completed by the Licensee/QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Unity Home Care will employ Contractor to repair all windows to assist with egression for fire safety. The Contractor will assure that one window in each room is identified as a fire escape. The Contractor will replace the hand rail to ensure that clients can ambulate safely in the event of a fire. The Group Home Manager will replace the batteries in the fire alarm. He will also put duct tape on the broken window to prevent cuts by clients." -"Describe your plan to make sure the above happens. The Contractor stated that he will complete the above listed items by 7/5/19-7/6/19. The QP and the Group Home Manager will complete an completion walk through. The walk through will ensure that one window in each room will be accessible for egress. The smoke	V 736		

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V 736	Continued From page 29 detector is working." This deficiency constitutes a recited deficiency and must be corrected within 30 days. The facility was a split level ranch requiring clients to access their bedrooms using 3 steps up from the kitchen to the hall. In the event of a fire or other emergency situation that prevented egress via the hall/steps, the clients would have no alternative other than their bedroom windows. Client #3 ambulated with a walker and would drag his feet, rather than lifting his feet. Client #2 walked with an unsteady gait and had limited use of his left arm. The facility did not have ramps inside or outside to facilitate ambulation, and one of the hand rails by the indoor steps had been removed. None of the 3 clients had windows that could either open, remain open, or open without sharp metal edges or broken panes should emergency egress from the windows be required. In addition, the smoke detector in the hallway nearest the kitchen was dangling and chirping. The failure to have ramps and a hand railings to assist client #2 and client #3 to ambulate was detrimental to their safety by increasing their fall risk, and by prolonging the time to evacuate the home in an emergency situation. The facility's failure to have a working smoke detector between the kitchen and the egress hall was detrimental to client safety by not having alarms in place in the event of a fire. The failure to have operable windows in client bedrooms placed all of the clients in an unsafe environment which would be detrimental to their health and safety in the event of an emergency, such as a kitchen fire, that blocked egress through the hallway. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be	V 736		

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V 736	Continued From page 30 imposed for each day the facility is out of compliance beyond the 45th day.	V 736		
V 738	27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on observation and interview, the facility was not kept free from insects. The findings are: Observations on 7/5/19 between 11:15 am and 2:00 pm revealed: -Multiple ants were crawling around the kitchen sink and counter tops. -Client #3's bedroom: The only window that could be opened had a wasp nest in the upper right corner with 3 live wasps visible on the cone. -Vacant Room: Large wasp nest in the upper corner of window over looking the back yard. The top of the nest, approximately 5 inches in diameter was covered with live wasps. -The windows in the dining room were covered between the window and storm window with spider webs. Interview on 7/5/19 client #3 stated: -He had seen ants. -He had an ant get on him. Interview on 7/5/19 the Group Home Manager stated:	V 738		

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V 738	Continued From page 31 -There was a contract with a professional exterminator. -They would come and spray monthly inside and outside the home.	V 738		
V 753	27G .0304(b)(5) Indoor Lighting 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (5) All indoor areas to which clients have routine access shall be well-lighted. Lighting shall be adequate to permit occupants to comfortably engage in normal and appropriate daily activities such as reading, writing, working, sewing and grooming. This Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure all indoor areas used for client services were well-lighted. The findings are: Observations on 7/5/19 between 12 pm and 2 pm revealed: -Clients #3's bedroom had a ceiling fan with no light bulbs. -No bedside lamps. -No other source of lighting in the client's bedroom. Interview on 7/5/19 client #3 stated: -His ceiling light did not work. -The light bulbs had been removed from his	V 753		

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V 753	Continued From page 32 ceiling fan. -It had been months since he had lights. Interview on 7/5/19 the Licensee/Qualified Professional stated: -Client #3 had a lamp in the past. -She would follow up.	V 753		