Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-958	A. BUILDING: _____ B. WING _____	R-C 07/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE SUPPORTIVE HOMES	3905 MARSH CREEK ROAD RALEIGH, NC 27604

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V 000	INITIAL COMMENTS A Complaint and Follow Up Survey was completed July 8, 2019. The complaint was substantiated (Intake #NC00148287). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations;	V 105	RECEIVED AUG 12 2019 DHSR-MH Licensure Sect	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anthony Ikejiaku — TITLE: Administrator — (X6) DATE: 8/6/19

STATE FORM 6899 CWPG11 If continuation sheet 1 of 31

CONSTRUCTION SECTION

AUG 12 2019

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V 105	Continued From page 1 (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record review and interview, the	V 105	The Administrator will ongoing be responsible in making sure that discharge summary is documented and the information →	

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V 105	Continued From page 2 governing body failed to adhere to its discharge policy. The finding is: Review on 06/21/19 of the facility's discharge policy revealed: -Criteria for discharge included a deceased client, client and guardian request termination of services -Procedures included filling out a discharge summary a. Review on 04/10/19 of former client (FC) #10's record revealed: -Admitted: 04/01/18 -Medication Administration Record (MAR) listed 01/27/19 as last date medications given -Diagnosis: Schizophrenia -No evidence of a discharge summary During interview on 05/15/09, the Administrator/Licensee reported FC #10: - Was hospitalized 01/2019 -Told hospital he did not want to return to the group home. b. Review on 04/10/19 of deceased client (D/C) #11's record revealed: -Admitted: 11/05/05 -Client last note dated 02/04/19 indicated he was hospitalized -Diagnoses: Schizophrenia, Hypertension and Hyperlipidemia -No evidence of a discharge summary of documentation regarding the discharge Review on 06/28/19 of D/C #11's death certificate dated 02/25/19 revealed: -Date of Death: 02/21/19 -Cause of Death: collapse left lung due to mass concerning of malignancy	V 105	Placed in a separate page in the client's chart with the reasons for discharge, effort made to assist client find alternative homes and any applicable follow up. Administrator will perform monthly check to ensure that discharge summary is in the chart and according to the policy and procedure.	

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V 105	Continued From page 3 During interview on 04/09/19, the Administrator/Licensee reported D/C #11: -Died while in Hospice Care. Administraor/Licensee had no information regarding death c. Review on 04/10/19 of FC #12's record revealed: -Admitted: 03/26/19 -MAR reflected medications last given 03/27/19 -Diagnoses: Schizophrenia, Asthma, Gastroesophageal Reflux Disease, Hypothyroidism, history of seizures, Hypertension and Hepatitis C -No evidence of a discharge summary of documentation regarding the discharge During interview on 04/09/19, staff #1 reported FC #12: -Was admitted one day to the group..the next day, he called police and asked to be taken to the hospital.. -Requested his medications and paperwork be packed up with him and he was admitted to the hospital -Never returned to the group home d. Review between 04/09/19 and 05/15/19 of the facility records revealed: -No record or documentation for FC #14 During interview on 05/15/19, the Administrator/Licensee reported: -FC #14 left the facility 11/10/18 to be hospitalized at Crisis and Assessment because he refused to take medications. FC #14 was later transferred to a long term facility and did not return.	V 105		

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V 105	Continued From page 4 -He thought FC #14's record was at the group home During interview on 06/21/19, the Qualified Professional/Registered Nurse reported he: -Was responsible for writing the discharge summary for clients -Would seek assistance with what he should document in the discharge summary	V 105		
* V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) 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. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall	V 109		

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V 109	Continued From page 5 develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview, the facility's Qualified Professional/Registered Nurse failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Review on 04/09/19 of the facility's public file maintained by the Divsion of Health Service Regulation revealed: -Change of ownership from the Qualified Professional/Registered Nurse to the Administrator/Licensee occurred 04/05/18 -Qualified Profesional/Registered Nurse remained the same a. See tag V112 for specific information related to system of not identifying presenting problems, strategies and interventions for client's treatment plan. b. See tag V110 for related information regarding supervision of paraprofessionals by a Qualified Professional. c. Cross reference 10A NCAC 27G .0201 GOVERNING BODY POLICIES. (V105) Based on record review and interview, the governing	V 109	Qualified Professional was retrained on the Population Served on 7/26/2019. The Administrator will be responsible in ensuring that QP supervises the para-professional about the Population Served by the facility.	7/26/19 ongoing

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V 109	Continued From page 6 body failed to adhere to its discharge policy. d. Cross reference 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V367). Based on record review and interview, the facility failed to report all Level II and Level III incidents to the Local Management Entity/Managed Care Organization (LME/MCO). Interview on 06/24/19, the Qualified Professional/Registered Nurse reported he: -Visited the group home weekly -Would be responsible for submitting the incident reports, developing treatment plans and completing discharge summary for clients. -Provided supervision of paraprofessional staff	V 109	Administrator will ensure that discharge Summary are documented and placed on Chart QP shall report ALL Level II and Level III incidents to the LME as soon as the QP is aware of the incident	ongoing ongoing
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:	V 110		

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V 110	Continued From page 7 (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 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview, two of two current paraprofessional staff (#1 and Administrator/Licensee)failed to demonstrate knowledge, skills and abilities required by the population. The findings are: a. Review on 05/15/19 of staff #1's personnel record revealed: -Hired: 04/2018 -Title: Paraprofessional During interview on 04/09/19, staff #1 reported: -No clients had been discharged from the facility between November 2018-April 2019. -No issues (no police calls, hospitalizations) with clients at the group home -She can't recall information. "I'm older and awaiting to go to a doctors appointment when [Division of Health Service Regulation arrived]. My mind on something else. I apologize." -The client records and information are at the	V 110	QP retrained ~~staff on~~ Paraprofessional and Administrator on the Population Served. ~~The~~ on 8/5/19 The QP will be responsible for training paraprofessionals and ensuring all trainings are complete.	8/5/19 ongoing

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V 110	Continued From page 8 office with the Qualified Professional/Registered Nurse. He came yesterday to pick up those items. -No clients refused medication. All took their medication, no issues -Former Client (FC) #12 came one day, he called police and was taken to the hospital the next day. "I gave him medications the first day and the second day and then I packed it up and gave it to the police the paperwork- Medication Administration Record and the medications. That it was in 03/2019." She did not recall the name of the hospital but thought FC #12 was going to come back to the group home. Review on 04/10/19 of Former Clients and Deceased Client records revealed: -FC #10: Medication Administration Record (MAR) listed 01/27/19 as last date medications given -FC #13: Discharged: 03/20/19 per note released with his mother -D/C #11: last progress note dated 02/04/19 indicated he was hospitalized During interview on 05/15/19, staff #1 reported: -She did not work at the facility between 11/12/18-02/28/19. -Upon her 02/2019 return, FC #10 was not at the facility as he had been discharged During interview on 06/24/19, the Administrator/Licensee reported he felt: -Staff #1 may not have understood the questions or been familiar with terms such as clients, consumers, former -May have been a language barrier that staff #1 did not understand During interview on 06/24/19, the Qualified Professional/Registered Nurse reported:	V 110		

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V 110	Continued From page 9 -He would address with staff how to communicate regarding general information regarding clients b. Review on 04/10/19 and 05/15/19 of the facility's records revealed the following staff were employed between December 2018-April 2019: -Staff #1: February 28, 2019-April 2019 -Former Staff #2: December 2018-February 2019 -Administrator/Licensee: periodically entire time frame Unsuccessful attempts were made to contact Former Staff #2 during the course of the survey. Review on 04/10/19 of former client (FC) #10's record revealed: -Admitted: 04/01/18 -January 2019 Medication Administration Record (MAR) listed medications such as Lisinprol (used to treat high blood pressure) as well as psychotropic medications Clozaril, Risperdone and Klonopin...01/27/19 noted as last date medications given....no indication medications were missed, refused or not administered -Diagnosis: Schizophrenia -No notes to document any behaviors of nakedness, no property destruction, no notation of occurrences between peers and staff, police calls for walking in the streets or concerns Review on 04/12/19 of a list of police calls for FC #10 to the facility address or by name between December 2018-February 1, 2019 revealed: -01/26/19 at 11:27:02 AM: call for mental commitment -01/26/19 at 11:27:20 AM: call for Public Indecent Exposure	V 110		

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V 110	Continued From page 10 During interview on 04/10/19, a crisis and assessment therapist reported: -FC #10 was admitted to the facility based crisis by the group home on 01/27/19 on an involuntary commitment (IVC) status -Per the IVC paperwork dated 01/26/19 signed by the Administrator/Licensee listed 1. refuses medications..2. fights staff and residents spitting on them as well 3. destroying property 4. jaywalking on busy road 5. talking to self all night, no sleep 6. sometimes nude in the house 7. leaving the house late at night police was called 8. paranoid as reasons for the commitment -FC #10 was interviewed and denied all behaviors listed on the IVC except nudeness in the house "because he felt like it." FC #10 also acknowledged he would go outside the house at night because he could not sleep and was bored. - Therapist reviewed the January 2019 MAR for FC #10 and did not notice any documentation to support FC #10 refused or spit out medications -Contact was made with the group home for FC #10 to return to the group home..The Administrator/Licensee initially said "no." An inquiry was made to the Administrator/Licensee about a 30 day discharge notice but was told no discharge notification had been issued by the group home for FC #10. In the interim, FC #10 did not want to return back to the group home. Due to legal immigration issues, FC #10 did not have Medicaid so it was difficult find residential placement. FC #10 remained at crisis and assessment until he was transferred to a psychiatric hospital. Review on 05/03/19 of FC #10's records from the psychiatric hospital revealed: -Admitted: 01/30/19 -Discharged: 02/22/19	V 110		

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V 110	Continued From page 11 Review on 05/03/19 of the psychiatric hospital discharge summary signed 04/04/19 revealed: -"Contextual Factors: The patient's low income and homelessness contributed to his admission as did his having been barred from his previous group home because of his threatening behavior towards other residents." -PRECIPITATING FACTORS: The patient had been living in a group home and was noncompliant with medication. He became increasingly psychotic. The patient was assaultive towards other residents in the group home and was discharged from the home and is unable to return. On presentation to the hospital, he asks to be placed in another group home." The patient reported medication compliance, "but his clear relapse into psychosis suggests he was noncompliant. -COURSE IN HOSPITAL: ...The patient improved throughout the course of his hospital stay and showed good progress towards treatment goals. In spite of the patient's behavior in the group home, he was not noted to exhibit violent behaviors or expressed violent ideation in the hospital. He did not exhibit behaviors or express ideas of self-harm in the hospital." During interviews between 04/10/19 and 06/24/19, the Administrator/Licensee reported: -When he called the police on 01/26/19, the police suggested IVC paperwork to have FC #10 taken to Crisis and Assessment. -He did not indicate FC #10 could not return to the group home. He clarified to the intake person at the crisis center, FC #10 could return once he was well. It was FC #10 who did not want to return to the group home. -In regards to items noted on the IVC paperwork...	V 110		

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V 110	Continued From page 12 (a) medication refusal: other clients reported to staff. As staff did not see, they did not document the suspected "spitting out of medications." He did not disclose the "spitting out of medication" with the Qualified Professional/Registered Nurse prior to the IVC paperwork or FC #10's 01/26/19 admission to crisis and assessment. (b) fights staff and residents spitting on both: FC #10 had ther tendency to stand in personal space of others and agitation, "aggression in front of the staff in their personal space, he pushed the staff, a time he was naked in the living room to the bathroom on the day of the IVC. (c) destroying property- FC #10 slammed door hard and broke it (d) jaywalking on busy road - occurred months prior..one day Administrator/Licensee and his family were driving in the car and saw FC #10 crossing the street but walking in the middle of the road. The poloce were not called. Dangers of jaywalking was discussed with FC #10. (e) when he completed IVC paperwork, he was documenting occurrences within a few months not specifically relevant to that immediate time or within a two week time frame of the commitment During interview on 06/24/19, the Qualified Professional/Registered Nurse reported he: -Thought the Administrator/Licensee "did not do anything wrong with the IVC paperwork" for FC #10 -May have referenced reasons that occurred within a month's time frame to complete the IVC paperwork -Could not locate in FC #10's record documentation to support other clients reports of the "spitting out" medications. Staff could not	V 110		

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V 110	Continued From page 13 have documented FC #10 "spit out medication because it was third hand information." Had the Qualified Professional/Registered Nurse been aware of concern FC #10 was "spitting out medications", he would have staff increased supervision, assured FC #10 consumed water with medications and increased conversation with FC #10 during medication time. , -Did not agreed with the identified deficient practice nor the Type B violation. "This can't be a standard?" Review on 06/24/19 of the facility's Plan of Protection dated 06/24/19 submitted by the Qualified Professional (QP)/Registered Nurse revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The QP will retrain staff on his/her expectations. Will retrain staff on client needs, on IVC, on documentation and reporting incidents to the QP -Describe your plans to make sure the above happens. The QP will be responsible for retraining staff." FC #10 has diagnosis of Schizophrenia. The Administrator/Licensee secured IVC papers that identified 8 reasons for the involuntary status for FC #10. Neither the facility's documents or police records reflected any behaviors listed on the IVC paperwork. FC #10 was transferred from a crisis facility to a psychiatric hospital. Homelessness and lack of funding resources were the reasons his stay at the psychiatric hospital was extended. This practice is detrimental to the health, safety & welfare of FC #10. The deficiency constitutes a Type B rule violation and must be corrected within 45 days. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per	V 110	QP retrained Administrator and paraprofessional on client safety, documentations and on the need to notify QP of incidents in the facility for documentations 8/5/19 ongoing QP will review ALL IVC informations by the Administrator. Ongoing QP will document client behaviors and document Level II and Level III incidents. Medication refusals/ spitting and client aggression shall be documented and same reported to client's Psychiatrist. QP will be responsible. ongoing	

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V 110	Continued From page 14 day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 110		
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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure one of one deceased clients	V 112		

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V 112	Continued From page 15 (#11)'s treatment plan was revised at least annually as well as develop and implement strategies to meet the client needs. The findings are: a. Cross reference 10A NCAC 27G.5603. Supervised Living Scope. Based on record review and interview, the facility failed to assure the treatment plan for one of one deceased clients (D/C #11) be reviewed at least annually to ensure the client continued to be capable of unsupervised time in the community. (V290) b. Review on 04/09/19 of deceased client (D/C) #11's record revealed: -Admitted: 11/05/05 -Last progress note dated 02/04/19 indicated hospitalization -Diagnoses: Schizophrenia, Hypertension, BPH (Benign prostatic hyperplasia- a common, non cancerous enlargement of the prostate gland) and Hyperlipidemia per FL-2 dated March 2018 -Age 73 -Treatment plan dated 04/01/18 listed goals/strategies to remain physically and mentally healthy (take prescribed medication, attend therapy and psychiatric appointments, decrease illness). No changes to his Treatment plan -12/06/18 pretyped document that D/C #11 and D/C #11's Guardian/Sister "were notified of the T count and the diagnosis of lung cancer for Mr [D/C #11]. [D/C #11] has stated that he does not want to proceed with any treatment. [D/C #11's Guardian/Sister]... will not force him to have any treatment. There is no liability on Divine Supportive Home for injury or death pertaining to this specific diagnosis as Mr [D/C #11] has been made to understand the risk of not receiving treatment [D/C #11] and...[D/C #11's	V 112		

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V 112	Continued From page 17 -D/C #11 was a former boxer and despite the lung cancer diagnosis was in good health -The" treatment plan addressed behaviors not medical issues" or changes in client's health status -D/C #11's May 2018 FI-2 noted BPH on it that indicated the cancer diagnosis -Was not sure how he would develop strategies for medical issues such as Diabetes and Asthma -Was not in agreeance with deficiencies regarding treatment plan or unsupervised time related to D/C #11 - "This can't be a Type B violation?" Review on 06/24/19 of the facility's Plan of Protection dated 06/24/19 submitted by the QP/RN revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? When there is a change in health status of a client in the home, the treatment plan will reflect those changes in the health status. The unsupervised time in the community will reflect the same health status -Describe your plans to make sure the above happens. The QP will be responsible for ensuring that treatment plans reflects the health status of the client. QP will reassess unsupervised time in the community to meet the health status" D/C #11's medical records between May 2018-February 2019 FI-2 indicated diagnoses of a benign prostrate cancer and later lung cancer. D/C #11 refused any type of treatment for the lung cancer diagnosis. No changes were made to his treatment plan or level of unsupervised time to address his change in health status. The group home's records indicated no health related changes with D/C #11. However, two physician's	V 112		

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V 112	Continued From page 16 Guardian/Sister] will hold harmless Divine Supportive Homes the outcomes of not accepting treatment, specifically chemotherapy and radiation for cancer." This document was signed by D/C #11's Guardian/Sister. -No evidence of treatment teams notes/meetings in the record to address changes in health Review on 06/28/19 of a D/C #11's death certificate dated 02/25/19 revealed: -Date of Death: 02/21/19 -Cause of Death: "collapse left lung due to mass concerning of malignancy" During interview on 06/24/19, the Licensee reported D/C #11's cancer diagnosis was noted on the March 2018 FL-2 During interview on 06/25/19, the Medical Record department at D/C #11's physician's office reported: -07/03/18, he was seen for signs symptoms of coughing wheezing.. a chest X-ray was ordered and further testing warranted -07/10/18, CT scan was necessary -A referral was made to Pulmonary specialist that diagnosed the lung cancer...Not sure of the specific date but information noted in the record -BPH (enlarged prostate) was noted in his record prior to July 2018. The Lung Cancer diagnosis was not identified until after July 2018 During interviews between 06/21/19 and 06/24/19, the Qualified Professional (QP)/Registered Nurse (RN) reported: -No changes were needed or required to D/C #11's treatment plan -D/C #11 did not exhibit any medical concerns prior to his hospitalization 02/07/19.	V 112	QP is responsable to ensure that treatment plans reflect the health of clients both medical and psychiatric QP had reassessed All the clients in the house to ensure that their treatments are current and reflects their health status. ongoing	

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V 112	Continued From page 18 notes mention gait or stability as concerns after December 2018 which resulted in a walker being prescribed for assistance with ambulation. D/C #11 fell at a local super center store during his unsupervised time. As a result of the fall, he was hospitalized. These systemic failures resulted in serious neglect and constitute a Type A1 rule violation and must be corrected within 23 days. An administrative penalty in the amount of $2000.00 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. This is a recited violation.	V 112	Administrator will Perform quarterly audit to ensure that treatment plans reflect current health status of ALL the clients.	ongoing
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance	V 290		

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V 290	Continued From page 19 abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure the treatment plan for one of one deceased clients (D/C #11) be reviewed at least annually to ensure the client continued to be capable of unsupervised time in the community. The findings are: Review on 04/09/19 of deceased client (D/C) #11's record revealed: -Admitted: 11/05/05 -Last progress note dated 02/04/19 indicated	V 290	QP and Administrator will ensure that unsupervised time out in the community reflects client's health Status	ongoing

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V 290	Continued From page 20 he was hospitalized on that date -Diagnoses: Schizophrenia, Hypertension, BPH (enlarged prostrate) and Hyperlipidemia per FL-2 dated March 2018 -Age 73 -Treatment plan dated 04/01/18 listed the following goals and interventions inclusive of maintain residential placement with supports (adhere to rules receive assistance with signing in/out for community as needed, outings unsupervised when deemed appropriate)...will access community independently without incident unsupervised for 4 hours a day..unsupervised time will increase or decrease based on compliance with residential facility rules and appropriateness while in the community...remain physically and mentally healthy as evidenced by completing with the following (take prescribed medication, attend therapy and psychiatric appointments, decrease illness. No changes noted to his unsupervised time or changes to the treatment plan -No unsupervised time sign in/out sheets noted -No documentation of client's health by staff between November 2018-February 2019 -12/04/18 doctor's visit "History of Present Illness...The patient does not feel well and has decreased energy level. The patient has been non-compliant with instructions...Since the last visit, pt. (patient) has been feeling weak, wt. (weight) has gone down by about 7 lbs.... Unstable Gait...Today's Impression: Probably secondary to weight loss due to lung cancer and reduced oral intake. pt, has been prescribed a walker" -Letter dated 04/16/10 signed by D/C #11's guardian "As legal guardian of [D/C #11] I give my approval that my brother can have time to go out around 6 hours per day..."	V 290	QP and Administrator will ensure that unsupervised time in the Community reflects Client's health status ongoing Staff will ensure client's Sign in/out sheets are ~~provided to~~ signed by Clients when accessing the community unsupervised. ongoing Staff will document changes to Client health and notify providers promptly. Administrator will be responsible. ongoing	

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V 290	Continued From page 21 Review on 06/28/19 of a D/C #11's death certificate dated 02/25/19 revealed: -Date of Death: 02/21/19 -Cause of Death: "collapse left lung due to mass concerning of malignancy" Review on 06/17/19 of D/C #11's 12/04/18 visit with his Primary Care Physician revealed the following: -Here for a follow up visit -He has been non-compliant with instructions. -Since the last visit, client has been feeling weak, wt (weight). has gone down by about 7 lbs.... Reported not feel well and has decreased energy level -"Today's Impression-Unstable Gait: Probably secondary to weight loss due to lung cancer and reduced oral intake. Prescribed a walker." Review on 05/10/19 of D/C #11's 02/07/19 Psychiatrist visit for Haldol injection at 10:00 AM revealed: -SPO2 (peripheral capillary oxygen saturation, an estimate of the amount of oxygen in the blood) is 91% Physical Exam: "Vital signs were reviewed. The patient was able to ambulate to and from the office without significant difficulty. His gait is slow. He sat comfortably, breathing normally and in no apparent distress. He was able to move all extremities spontaneously, symmetrically and with full apparent strength. Interval History: He returns for scheduled follow-up. He continues to refuse treatment or evaluation for his weight loss, low oxygen levels and likely lung cancer. Has refused to continue with pulmonary specialist. He denies smoking, but is seen smoking outside of clinic prior to appointment. He reports he is doing fine.	V 290		

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V 290	Continued From page 22 Endorses sometimes feeling tired and achy. Endorses urinary incontinence-which is noted by staff report as well. Staff note also states that he at times seems weak and shaky. He asks for more valium, and to leave appointment as soon as possible. Discussed that his symptoms of weakness are likely due to untreated cancer; he continues to refuse treatment or evaluation for this. Expresses understanding that not treating this condition could be fatal." Review on 04/18/19 of an Emergency Management System report dated 02/07/19 at 5:09 PM revealed the following about D/C #11: -Dispatched for a fall at national discount super center store. -Upon arrival found D/C #11 conscious, alert, and breathing lying supine outside of a store. "Bystanders state he was walking when he fell back wards onto the ground. Bystanders state that this is the second time today he has fallen. Pt (patient) has difficulty speaking/answering questions. Unable to determine if that is baseline. Pt states he does not hurt anywhere and that he falls "all the time." Pt complains of lightheadedness. Blood pressure, SPO2 and Blood sugar are within normal limits. Heart rate and Temperature are elevated...Pt is Alert to person, place, and event... Skin is warm, dry, and color appropriate. Physical exam notes ABCs (Airway, Breathing, Circulation) to be intact... Chest wall is stable with/ no elevated work of breathing. Pt was assisted to stretcher, secured with seatbelts", loaded into vehicle to local hospital emergency room. Review on 04/17/19 of the local hospital report revealed the following about D/C #11's 02/07/19 hospitalization: -transferred to palliative care service 02/11/19	V 290		

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V 290	Continued From page 23 per his guardian's and his request with inpatient hospice -"...has a history of lung cancer and now has advanced disease with a 'white out' of his left lung increased shortness of breath and weakness in the last month. He came to the hospital for complaints of weakness and some shortness of breath. He does have underlying schizophrenia per chart but has insight into his disease process and certainly has agency and clearly does not want any more interventions and says he does not want blood draws, procedures..." During interview on 04/17/19, D/C #11's Guardian/Sister reported: -About 6 months before he died, he was diagnosed with cancer.. -He denied he had lung cancer, said he didn't believe he had it. -He refused chemotherapy. "I told the group home, I would sign paperwork saying he didn't want treatment to honor his wishes. I noticed the deterioration and December, we noticed he lost a lot of weight. He was a little weak then. He would say he had a lot of pride...January 2019, we noticed that he couldn't hardly walk or get out of the bed and not change himself. The lady helped him up. He didn't like wearing that diaper but we made a bargain that I would cook his favorites. That seemed to work. The lady washed him up." -"I know my brother can be strong headed and strong will, but they are the caregiver. I don't know why [Administrator/Licensee] left him at the [super center store] but that's neither here nor there at this point. I told [Administrator/Licensee], he couldn't stand by himself. [Administrator/Licensee] said he wanted to be dropped off at [super center store]." During interviews between 05/15/19 and	V 290		

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V 290	Continued From page 24 06/24/19, the Administrator/Licensee reported he: -Was aware D/C #11 was prescribed a walker by the physician. -Requested the physician prescribe the walker because it would assist D/C #11 to walk better. The walker never arrived, when D/C #11 was hospitalized in February, he called the physician to cancel the request. -Did not notice any changes in D/C #11 between December 2018-February 2019 regarding walking, shortness of breath, falls -Was with D/C #11 on 02/07/19 to see the psychiatrist and then they returned home for a few hours. D/C's guardian/sister requested D/C #11 get some exercise. D/C #11 wanted some coffee so he was taken to the super center store. He left D/C #11 at the super center store for an estimated 1-2 hour time frame. When he returned to the store, he did not see D/C #11. After conversation with a few employees, one employee indicated a person from previous shift mentioned of a person falling in front of the store and transported to the nearby hospital. During interviews between 06/21/19 and 06/24/19, the Qualified Professional/Registered Nurse reported: -He visited the group home several times a week -Prior to this interview, he was not aware of the request for D/C #11's walker by the primary care physician. He referenced the 12/04/18 note written by the primary care physician which did not mention a walker for D/C #11. The Administrator/Licensee did not inform him of D/C #11's prescription for a walker. He felt D/C #11 had issues with his "strength" opposed to gait or walking. -He referenced the 04/16/10 letter signed by D/C's #11 guardian as her request for him to have	V 290		

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V 367	Continued From page 30 -FC #13 returned to the group home a few days after 02/04/19 and it was unclear where he had been during the few days he was away from the facility. He did not leave the group home again until March 20, 2019 under the care of his mother. -He did not complete an incident report for 02/04/19 when FC #13 had an unplanned absence over 3 hours because the police said he was not missing. Police said his own guardian and was not court ordered into the group home, therefore, he did not meet the missing person criteria. -Was aware of the IRIS requirement but based his decision not to complete an incident report based on his conversation with the police. During interview between 05/15/19 and 06/26/19, the LME/MCO Quality Improvement Representative reported in all three occurrences, an incident report should have been completed. -Per guidelines, the death of D/C #11 would have been a Level II death and required documentation in IRIS by the facility. As the hospitalization/death occurred in February 2019 and the agency was aware in April 2019 , the timeframe occurred within less than 90 days. -FC #12's situation should have been submitted via IRIS as the police was involved. - FC #13's unplanned absence of 3 hours would have been considered an elopement and should have been reported even if he is his own guardian and police decide not to report him in the police missing person database.	V 367	QP will be responsible for ensuring that ALL Level II and Level III incidents are documented in IRIS. ongoing QP was retrained on occurrences that warrants completion of IRIS on 7/26/19 QP will document incidents on IRIS per guidlines. ongoing	