STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G042	A. BUILDING _____ B. WING _____	08/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETION DATE
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical	E 020		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 020	Continued From page 1 Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness, which included specific plans where to relocate the clients in the facility in case of an emergency evacuation. The finding is: Review on 8/13/19 of the facility's emergency preparedness plan dated 4/2019 did not include an agreement with alternate lodging specific to where the clients would evacuate in the event of an emergency Interviews on 8/13/19 with management staff revealed the emergency preparedness plan (EMP) was a template to be used as a guide in developing the facility's EMP. When asked where clients would be relocated, the qualified intellectual disabilities professional (QIDP) stated a local entity would be used. She stated there was no written agreement or contact person, however she said the entity was aware. During an interview on 8/13/19, management staff acknowledged the plan does not include all of the components outlined in the emergency preparedness plan including an agreement with a local entity that may be used for lodging should the clients need to evacuate from the facility.	E 020		

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W 153	Continued From page 2	W 153		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: The facility failed to ensure 1 of 1 allegations of possible sexual exploitation was reported immediately to the state Health Care Personnel Registry (HCPR) in accordance with North Carolina General Statutes (NCGS) as evidenced by interviews and review of the facility's incident reporting system. The finding is: During record review of client #1's chart on 8/12/19, it was revealed that an incident report had been completed when clients #1 and #5 were found on 7/11/19 at 4:11 pm, fully dressed in a locked bathroom by two of the staff (who were not present during the survey). Client #1 admitted to trying to engage in a sexual act. Client #5 was examined by the nurse, the following day, who did not find any injuries, to suggest abuse. Further review revealed that the incident report was completed by the direct care staff on 7/12/19 and the report was reviewed by the qualified intellectual disability professional (QIDP) on 7/15/19 and the administrator on 7/16.19. The QIDP indicated on the report, that per staff, based on the clients being alone in the bathroom for 2-3 minutes, it was determined no inappropriate behaviors occurred. No statements were collected from client #1, the other clients or staff	W 153		

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W 153	Continued From page 3 to elaborate details leading up to the incident. An additional review on 8/13/19 of the facility's Services Manual, dated May 2005, outlining procedures for abuse investigations stated that "The administrator or designee will begin each investigation within 24 hours of an allegation of abuse, neglect, or exploitation, or an injury of unknown origin. All instances of alleged or suspected abuse, neglect or exploitation should be reported to DSS (Department of Social Services) as specified in G.S. (general statute) 108 A, Article 6 or G.S. 1A, Article 44." During an interview on 8/12/19 with the qualified intellectual disabilities professional (QIDP), regarding the 7/11/19 incident report, she acknowledged that was told that she did not need to do a full investigation. The QIDP stated prior to this incident, direct care staff were to keep clients #1 and #5 in visual supervision at all times. Further interview revealed although clients #1 and #5 were not in staff's visual supervision when the incident on 7/11/19 occurred, the facility did not investigate possible improper supervision by direct care staff. Additional interview revealed the allegations on 7/11/19 of improper supervision by direct care staff of clients #1 and #5 were not reported to HCPR.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 154		

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W 154	Continued From page 4 failed to launch a thorough investigation for 2 of 4 audited clients (#1 and #5), involved in an incident, potentially affecting clients safety. The finding is: The facility did not collect statements from the clients or staff, to help determine how the lack of supervision originated. During record review of client #1's chart on 8/12/19 and client #5's chart on 8/13/19, it was revealed that an incident report had been completed when clients #1 and #5 were found on 7/11/19 at 4:11 pm, fully dressed in a locked bathroom by two of the staff (who were not present during the survey). Client #1 admitted to trying to engage in a sexual act. Client #5 was examined by the nurse, the following day, who did not find any injuries, to suggest abuse. Further review revealed that the incident report was completed by the direct care staff on 7/12/19 and the report was reviewed by the qualified intellectual disability professional (QIDP) on 7/15/19 and the administrator on 7/16.19. The QIDP indicated on the report, that per staff, based on the clients being alone in the bathroom for 2-3 minutes, it was determined no inappropriate behaviors occurred. No statements were collected from client #1 or staff to elaborate details leading up to the incident. There was no evidence that the QIDP had attempted to interview client #5, through his communication device. An additional review on 8/13/19 of the facility's Services Manual, dated May 2005, outlining procedures for investigations stated that "The administrator or designee will begin each investigation within 24 hours of an allegation of	W 154		

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W 154	Continued From page 5 abuse, neglect, or exploitation, or an injury of unknown origin. Signed statements must be secured whenever possible from all persons involved. If possible, interviewing of all involved should be completed within 24 hours. The Human Rights Committee must be informed of the results of all investigations and the actions taken." During an interview with the QIDP on 8/12/19, regarding the 7/11/19 incident report, she acknowledged that was told that she did not need to do a full investigation. The QIDP also indicated that she did not contact the human rights committee (HRC) but planned to discuss the incident at the HRC meeting at the end of this month.	W 154		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to: ensure a pattern of interactions supported the active treatment plan for 2 of 4 audited clients (#1 and #5) and to assist with de-escalating inappropriate client behaviors. The findings are:	W 249		

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1. Direct care staff did not implement client #1's behavior support plan (BSP) as written.

a. During an observation of the clients in the home on 8/12/19 at 4:15 pm, it was observed that client #3 had a fresh handprint marks on his left cheek that weren't seen earlier at the day program. Client #3 told the surveyor that he was hit by client #1. Client #1 was asked if he had caused client #3's injury and he admitted that he hit client #3 at the day program today.

b. During evening observations in the home on 8/12/19 at 5:50 pm, client #1 was permitted to sit next to client #3 on the living room couch. There were no verbal prompts by staff for client #1 to create some distance with seating.

c. During the dinner observation in the home on 8/12/19 at 6:00 pm, there were three chairs on both sides of the rectangular dining room table. Client #1 sat in the middle chair while client #4 sat in the right chair whereas staff F sat in the left chair. Client #1 and Client #4 were sitting in very close proximity to each other during the meal. There were no verbal prompts by staff for client #1 to create some distance with seating.

d. During the breakfast observation in the home on 8/13/19 at 7:20 am, client #1 sat next to client #4, using the middle seat at the dining room table. Client #1's distance was not at arm's length. There were no verbal prompts by staff for client #1 to create some distance with seating.

Review of client #1's BSP with addendum date of 5/10/19, revealed that client #1 had a history of physical and verbal aggression as well as sexually inappropriate behaviors. The plan stated

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that "He should be encouraged to remain at least arm's reach from peers, and if he make any physical contact with a peer staff should intervene."

Review of the incident report, dated 8/12/19, revealed on 8/12/19 at 2:35 pm at the day program, client #3 informed staff C that client #1 slapped him on he left cheek and left a hand print. It was reported that client #1 did not want client #3 to sit next to him.

Review of the debriefing report by the behavioral specialist on 8/12/19 revealed that staff were reminded to continue to be proactive with client #1, refer to client #1's BSP and follow the interventions for physical aggression. Staff should also continue to be aware of client #1's proximity to other peers.

During an interview with staff C on 8/12/19 at 5:35 pm, it was revealed that client #1 did not like client #3 because he claimed that client #3 got in his space at the table in the day program's classroom, so the two clients got into it.

During an interview with staff F on 8/12/19 at 6:05 pm, it was revealed that client #1 had like a "rivalry" toward client #3.

During an interview with the QIDP on 8/12/19 at 11:15 am, it was mentioned that last month, client #1's BSP was revised to help improve supervision and thwart inappropriate behaviors. Staff were expected to keep client #1 in their line of sight and sign off on a document, who's responsible for supervising him. QIDP did not mention if staff had to ensure that client #1 remained at arm's length distance with peers.

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W 249	Continued From page 8 2. Staff failed to redirect clients #1 and #5 to prevent physical altercations between clients. During lunch observations of the clients at the day program on 8/12/19 at 12:30 pm in the dining area, client #1 got up to clear his dishes and was touched by client #5, causing client #1 to get into a defensive stance. Staff B stood next to clients #1 and #5, but did not stand in between the clients to separate them. The house manager was observed telling staff B to get in between the clients. Staff B stood close by, but did not stand between the clients. Client #5 reached out to touch client #1, but client #1 hurriedly moved away from the area to avoid an altercation. Client #1 then returned to the dining area moments later and continued to repack his lunch bag to take home. Client #5 got up from the dining room table and tapped client #1 on his right shoulder blade twice. Client #1 immediately turned around to face client #5 and house manager called client #5's name twice. Client #5 stopped following client #1 and returned to the table to sit. During an interview with staff F on 8/12/19 at 5:45 pm, it was revealed that client #5 used to only touch staff, due to his obsessive compulsive disorder, but started to touch client #1 when he was admitted last year. Interview on 8/13/19 with the QIDP confirmed when possible clients #1 and #5 should be separated within arms reach to prevent altercations.	W 249		