STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	09/12/2019

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UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

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V 000	INITIAL COMMENTS A complaint survey was completed on September 12, 2019. The complaint was substantiated (intake #NC00155485). Deficiencies were cited. This facility is licensed for the service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the	V 132		

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V 132	Continued From page 1 investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR). The findings are: Refer to tag V367 for details. Review of facility records on 09/11/19 revealed no documentation the HCPR was notified of client #2's allegation of verbal abuse on 08/24/19 against the facility staff when reported to the Qualified Professional. During interview on 09/12/19 the Qualified Professional (QP) stated he had not reported the allegation to the HCPR.	V 132		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 366		

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V 366	Continued From page 2 (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy;	V 366		

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V 366	Continued From page 3 (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment	V 366		

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V 366	Continued From page 4 area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to document their response to level II incidents. The findings are: Refer to tag V367 for details. Review of facility records on 09/11/19 revealed no documentation the facility documented their response to client #2's allegation of verbal abuse on 08/24/19 against the facility staff when reported to the Qualified Professional.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during	V 367		

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V 367	Continued From page 5 the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and	V 367		

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V 367	Continued From page 6 (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by:	V 367		

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V 367	Continued From page 7 Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Review on 09/11/19 of client #1's record revealed: -26 year old male admitted 04/17/18. -Diagnoses included Intellectual Developmental Disorder, Intermittent Explosive Disorder and Bipolar Disorder. Review on 09/11/19 of client #2's record revealed: -25 year old male admitted 12/20/11. -Diagnoses included Asperger's Syndrome, Tourette's Syndrome, Anxiety Disorder, History of Traumatic Brain Injury (no date identified), and Attention Deficit Hyperactivity Disorder (ADHD). Review on 09/11/19 of client #3's record revealed: -25 year old male admitted 12/20/11. -Diagnoses included Autism Disorder and Intellectual Disabilities Disorder. Review on 09/12/19 of the North Carolina Incident Response Improvement System (IRIS) website revealed: - No Level II incident report for the facility which pertained to the allegation of staff verbal abuse as reported on 08/24/19 to the Qualified Professional (QP) by client #2. Interview on 09/11/19 client #2 stated: -The other clients were "afraid" to talk or "scared" about staff " (who) raised their voice or anything, main staff is (who yell or call names at the clients) [group home manager (GHM)] and [staff #2]; when I have my free time and I have my walk time two houses down and I can hear them (staff	V 367		

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V 367	Continued From page 8 #2 and the GHM) yell. [Client #3] called sh**** because he craps in the bed. [Client #1] plays with himself (masturbates) in the bathroom, but he hasn't been labeled that and they call him sex offender." Interview on 09/11/19 client #1 stated: -When asked if any of the staff yelled at him or used profanity stated, He didn't want staff to "get mad at me." - Client #1 was able to identify staff #1, #2 and the Group Home Manager as staff who yell/name call or use profanity. Client #l was not able to give any specific dates or specific incidents. Interview on 09/11/19 client #3 stated: -When asked if any of the staff yelled at him or used profanity stated, " he was nervous; I have to keep it a secret. I don't want to tell. I'll get in trouble they yell at me but I can't tell you, I'll get in trouble." Interview on 09/12/19 staff #1 stated: -She had not yelled or used profanity or name calling at any of the clients in the facility. Interview on 09/11/19 staff #4 stated: -She had not yelled or used profanity or name calling at any of the clients in the facility. Interview on 09/11/19 the group home manager stated: -She had not raised her voice/yelled at any of the clients in the facility and was not aware of any of the other staff who may have yelled or cursed or name called any of the clients at the facility. -She was aware of two clients, [Client #3], "cries when he does his chores, when we ask him he says we (staff) hurt his feelings, that's what he says and cries. And [client #1] does the same	V 367		

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V 367	Continued From page 9 thing...[client #1] is boo-hoo crying, really, snot and all but [client #3] just noise, no tears. [Client #3] will stop (crying), [Client #1] wants attention. I tell staff to let it run its course. [Client #3] cries over something everyday and all day..." Interview on 09/11/19 and 09/12/19 the QP stated: -On 08/24/19 client #2 stated to him he "didn't like the way staff talks...he wants us to use better tones, but he said it was not happening to him but others..." - He had not completed an IRIS report for client #2's allegation of staff verbal abuse due to when he went to talk to the other clients they did not "offer any concerns." - "I missed it (allegation); it felt more like a grievance than an allegation..."	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.	V 500		

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V 500	Continued From page 10 (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement	V 500		

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V 500	Continued From page 11 over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report to the Department of Social Services (DSS) in the county where services are provided all allegations of resident abuse by health care personnel. The findings are: See Tag V367 for specifics. Interview on 09/12/19 the Qualified Professional stated he had not reported the allegation of abuse to the local DSS.	V 500		