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	mhl001-073	A. BUILDING: _____ B. WING _____	R 09/27/2019

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on September 27, 2019. The complaint was unsubstantiated (Intake #NC00155279). 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 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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V 111	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that an assessment was completed prior to the delivery of services affecting one of one former client (FC #3). The findings are: Review on 9/25/19 of FC #3's record revealed: -Admission date of 8/1/19. -Diagnoses of Schizoaffective Disorder, Moderate Intellectual Developmental Disability, Intermittent Explosive Disorder, Major Depressive Disorder, Hypothyroidism, Rhabdomyolysis and Allergic Rhinitis. -Discharge date of 9/20/19. -No evidence of an admission assessment completed for FC #3 prior to the delivery of services. Interview on 9/27/19 with the Qualified Professional revealed: -He did the admission assessment for FC #3 when she was admitted to the home. -He just recently attempted to find a copy of the admission assessment via the computer program. -He was not able to assess the admission assessment via the computer program. -He thought a co-worker possibly changed the password for the program. -He confirmed the facility failed to complete an admission assessment for FC #3 prior to delivery of services.	V 111		

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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 observation, record review and interviews, the facility failed to develop and implement strategies to address the needs and behaviors for one of two clients (#1). The findings are:	V 112		

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V 112	Continued From page 3	V 112		

Review on 9/25/19 of client #1's record revealed:
-Admission date of 12/18/10.
-Diagnoses of Mild Intellectual Developmental Disability, Schizoaffective Disorder-Depressed Type, History of Arnold-Chiari Malformation, Borderline Diabetes, Hypertension and Dermatomyositis.
-Admission Assessment dated 10/23/12 had the following: Client #1 had a history of walking out of the house and standing in the road. Client #1 will be in a home that does not have traffic.
-Individualized Service Plan dated 4/1/19 for client #1 had no strategies to address indecent exposure, suicidal ideations and walking away from the facility.
-Individualized Behavior Support plan was implemented on 5/21/19. The plan had no strategies to address indecent exposure, suicidal ideations and walking away from the facility.

Observation of the group home on 9/26/19 revealed:
-There was heavy traffic along the highway next to the home.

Review of facility records on 9/26/19 revealed:
Incident reports for client #1 had the following information:
(1). 9/3/19-"[Client #1] insulted [Former Client #3] causing her to retaliate. [Client #1] then went outside and began to take her clothes off in front of [Name of group home]. She then returned to [Elizabeth Street] and asked could she go to jail. Staff informed her that she would go if someone notified the police. A neighbor called the police. The police arrived along with [The Manager] who was able to convince her to go inside..."
(2). 8/25/19-"[Client #1] woke up agitated that no one picked her up to go to church, began to threaten to leave, walked away wearing bedroom

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V 112	Continued From page 4 slippers, returned from taking a short walk just a few yards beyond the driveway, then asked to be hospitalized..Staff called the police and [Client #1] spoke with a female officer, then asked to be taken to the hospital before she harms staff and housemates. [Client #1] did tell police that she felt like hurting herself. [Client #1] was transported to hospital for assessment." (3). 6/7/19-"Staff arrived on shift to [Client #1] cursing and fussing due to be angry. [Client #1] stated she was going to hurt staff and residents... [Client #1] stood on the sidewalk and pulled her pants and underwear down. Staff attempted to prompt [Client #1] to put clothes back on but [Client #1] combated with more cursing and fussing. Neighbors noticed incident and called the police...Police arrived and [Client #1] continued making threats stating that she was going to kill everyone in the house and that she wants to go to the state hospital...[Client #1] was upset that she was not allowed to make phone calls or go out on activities. These were due to her previous behaviors. [Client #1] was transported to [Name of local hospital]. [Client #1] was discharged within 1 Hour because the hospital didn't see this as a crisis. [Client #1] returned and walked away again. [Client #1] stripped out on the street. Police returned a placed her under arrest for indecent exposure..." (4). 5/23/19-"[Client #1] left facility walking away without permission. [Client #1] laid down of sidewalk and refused to comply with prompts from staff. [Client #1] was upset that she was not given permission to go on an outing. [Client #1] was transported to [Name of mental health services] because she was picking in an open womb and threatening suicide. [Client #1] was then transported to [Name of mental health services] by [local police department] to be assessment..."	V 112		

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V 112	Continued From page 5 Review of records on 9/26/19 revealed: -There were police reports that corresponded with all of the above incidents. Interview with client #1 on 9/26/19 revealed: -She was arrested about 2-3 months ago. -She was arrested due to indecent exposure. -She walked away from the home and stood by the road next to group home. -She pulled up her dress and pulled down her underwear. -Police officers showed up and asked her to get dressed. -She refused to get dressed and was arrested by the police officers. -She thought she was in jail for about 3-4 days. -She had walked away from the home several times. -She would normally walk to the road near the group home. -Staff would normally come out to the road and ask her to come back into the home. -She would often refuse to stop standing by the road. -Staff had called the police several times because she was standing near the road. -She told staff and/or the police officers she felt like harming herself on more than one occasion. -She felt like saying she wanted to hurt herself would get her to the hospital quicker. -The police would normally take her to the crisis center or hospital. -She thought she had gone to the crisis center and/or hospital 2-3 within the last few months. Interview with staff #1 on 9/27/19 revealed: -Client #1 just recently had an incident in August 2019. -She thought client #1 was upset because no one	V 112		

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V 112	Continued From page 6	V 112		

picked her up for church.
-Client #1 got upset and walked out of the home.
-Client #1 stood near the road and refused to come back into the home.
-Client #1 threatened to harm staff and the other clients.
-Client #1 also possibly threatened to harm herself during that incident.
-She called the police department and management about client #1's behaviors.
-Client #1 also had 2-3 incidents of indecent exposure when she worked with her.
-Client #1 would normally get upset and walk away from the home.
-Client #1 would stand near the road by the group home.
-Client #1 would pull up her dress and pull down her underwear.
-Client #1 was arrested for indecent exposure a few months ago.
-Client #1 spent several nights in jail as a result of being arrested for indecent exposure.
-The road near the group home was very busy and client #1 should not be standing near the road.
-She confirmed client #1 had no strategies to address her indecent exposure, suicidal ideations and walking away from the facility.

Interview with the Manager on 9/26/19 revealed:
-Client #1 had a history of walking away from the home, indecent exposure and suicidal ideations.
-He thought client #1 had gone to the hospital and/or crisis center 2-3 times within the last few months.
-Client #1 would normally get upset, walk out of the home and stand near the road next to the home.
-Staff would normally call the police department.
-Client #1 would sometimes tell the police officers

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V 112	Continued From page 7 she felt like harming herself and they would take her to the crisis center. -Client #1 was arrested around May or June 2019 due to an incident. -Client #1 was arrested for indecent exposure. -Client #1 was in jail for about 3-4 days. -Staff called him and informed him of the incident. -He actually went to the home and saw client #1 exposing her body. -Client #1 had pulled up her dress and had her underwear pulled down. -Staff and the police officers tried to convince client #1 to cover herself. -Client #1 refused and was arrested by the police officers. -Client #1 had at least one other indecent exposure incident a few weeks ago. -Client #1 got upset, walked out of the home and stood near the road. -Client #1 was more cooperative during that incident. -He thought a neighbor called the police department. -Staff and the police officers convinced client #1 to cover herself. -He confirmed client #1 had no strategies to address her indecent exposure, suicidal ideations and walking away from the facility. Interviews with the Qualified Professional on 9/25/19 through 9/27/19 revealed: -Client #1 had a history of walking away from the facility, indecent exposure and suicidal ideations. -Client #1 would normally display those behaviors whenever she could not get her way. -Client #1 had gone to the crisis center and/or hospital several times due to her behaviors. -Client #1 would normally tell staff or the police officers she felt like harming herself. -The police officers would take client #1 to the	V 112		

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V 112	Continued From page 8 hospital and/or crisis center. -The hospital and/or crisis center normally would not admit client #1. -Client #1 was arrested a few months ago as a result of an indecent exposure incident. -Client #1 had been going to court for the last few months for that incident. -Client #1 just recently had an Individualized Behavior Support plan implemented in May 2019. -He noticed the agency failed to address the indecent exposure, suicidal ideations and walking away from the facility. -The agency that completed the Individualized Behavior Support plan barely knew client #1. -The previous agency that completed the Individualized Behavior Support plan knew client #1 for at least ten years. -The previous agency had addressed the indecent exposure, suicidal ideations and walking away from the facility. -He confirmed client #1 had no strategies to address her indecent exposure, suicidal ideations and walking away from the facility. Review on 9/27/19 of a Plan of Protection written by the Qualified Professional dated 9/27/19 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?: "Call ISP (Individualized Support Plan) Meeting to update service and treatment plan. Train staff and update and document training in personnel files. Train staff how to follow policy of elopement, suicidal ideations, indecent exposure in regard to [Client #1's] behaviors." Describe your plans to make sure the above happens. " Continue to document a incidents and follow update, service and treatment plan. Ongoing training of [Name of facility] personnel for compliance in regard to	V 112		

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V 112	Continued From page 9 service plan. Continue oversite." Client #1 had a history of walking away from facilities, suicidal ideations and indecent exposure. Client #1 had four separate incidents involving walking away from home, indecent exposure and/or suicidal ideations. The local police department responded to all four incidents. Client #1 was arrested on 6/7/19 and put in jail due to an incident of indecent exposure in the neighborhood. There was heavy traffic along the highway during my observation. Client #1's Individualized Behavior Support was implemented in May 2019, however there were no strategies to address walking away from home, indecent exposure and/or suicidal ideations. This violation constitutes a Type B violation which is detrimental to health, safety or welfare of clients. If the violation is not corrected within 45 days, administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 112		