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V 000	INITIAL COMMENTS An Annual and Follow up survey was completed on 10-7-19. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600C Supervised Living for Adults Whose Primary Diagnosis is a Developmental Disability.	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; (7) quality assurance and quality improvement	V 105		

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V 105	Continued From page 1 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 interview and record review the facility failed to implement policy of monitoring and	V 105		

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evaluating the quality and appropriateness of client care. The findings are:

Review on 9-30-19 of Client #1's record revealed:
- Admitted 11-3-05.
- Diagnoses of Moderate Intellectual Developmental Disability, Bipolar Disorder, and Fragile X Syndrome.
- Skills Assessment dated 3-11-19 revealed: independent when entering and exiting vehicles.
- Person Centered Plan dated 2-19-19 revealed: "high tolerance for pain."

Review on 10-3-19 of Full Time Relief Manager (FTRM)'s Personnel Record revealed:
- Hire date 5-6-19.
- Trainings include: Behavior Intervention Training (BIT) 5-21-19 and Client Rights 5-23-19.
- Incident/Accident and Other Reportable Events form signed by FTRM dated 5-9-19 to include the following competencies:
  - Identify types of situations that are required to be reported.
  - Demonstrate knowledge of required timelines for incident/accident reporting.
  - Demonstrate understanding of agency protocol for the reporting of incidents or accidents.
  - Demonstrate knowledge of information required when reporting incident or accidents.
  - Demonstrate ability to fill out the accident/ injury form.
  - Be able to identify other events that are required to be reported.

Review on 10-3-19 of Incident Report Policy of the facility revealed:
- "The Incident Report must be completed and delivered or faxed to the office within 24 hours and a verbal report (phone call) must be

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made to the Qualified Professional within 24 hours of the incident."

- "However, if the safety and well being of the customer is in question the On-Call Qualified Professional must be contacted immediately."
- "In addition to the incident report the DSP (Direct Support Professional) must write a progress note containing the following information: 1. Description of the event. 2. Actions taken by staff on the behalf of the customers. 3. A customer's condition following the event."
- "The progress note may be faxed with the Incident Report or turned in with the regularly scheduled paperwork."

Review on 10-2-19 of the Level I Incident Report dated 9-23-19 for incident that occurred on 9-22-19 and completed by FTRM revealed:

- Completed at 5:45pm on 9-23-19.
- The vehicle was parked on a slanted hill. When Client #1 got out of the vehicle, the door closed back on his finger.

Review on 9-30-19 of North Carolina Incident Response Improvement System (NCIRIS) report dated 9-26-19 for incident on 9-22-19 completed by the Chief Operations Officer for Client #1 revealed :

- Client #1 opened the door, the van was sitting on an incline, so the door closed back on his finger before he was out of the way.
- Client #1 was treated at a local urgent care on 9-23-19 and was diagnosed with a fractured thumb.

Review on 10-1-19 of Client #1's Progress Notes revealed:

- No progress notes completed on 9-22-19 for the incident.

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V 105	Continued From page 4 -Progress note completed on 9-23-19 for client #1. Review on 10-2-19 of facility communication log revealed: - FTRM utilized the On-Call Procedure to contact the On-Call Qualified Professional for a separate incident that occurred on 9-21-19 to inform them that Client #4 needed some PRN (as needed) medication for pain and indigestion. - There was no documentation of the FTRM utilizing the On-Call Procedure on 9-22-19. Interview on 9-30-19 and 10-1-19 with the FTRM revealed: - Employed at facility approximately 5 months. - When asked if she knew the procedure for completing Incident Reports she responded: "[Group Home Manager] went over it with me when I first started." - Had been trained on to how to write the incident report, time, date, and names. - Sunday, 9-22-19, they went to a fast food restaurant to pick up another client. - Client #1 said he needed to use the bathroom, "He got out of the van and did not secure the door. The door slid down and got his thumb." - "When we got here (facility) he had a small cut and I put peroxide and a Band-Aid on it (thumb)." - "He didn't complain of pain." - FTRM left the facility at 4:00pm. The incident happened at approximately 3:00pm. - The Group Home Manager relieved FTRM at 4:00pm. - FTRM returned to work the following day, 9-23-19, at approximately 12:00pm. - "[Group Home Manager] said [Client #1]	V 105		

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V 105	Continued From page 5 woke up, his hand was swollen, and he was complaining of pain. [Group Home Manager] did say his hand was swollen." Interview on 9-30-19 and 10-1-19 of Group Home Manager revealed : - Reported to work on 9-22-19 at approximately 4:00pm and "nothing was said" (referring to the incident involving Client #1's hand). - On the morning of 9-23-19, "He (Client #1) said it hurt. I could see that it was swollen." - On the morning of 9-23-19, the Group Home Manager attempted to call FTRM to obtain information about Client #1's hand but was unsuccessful. - She asked Client #1 about his hand but she was not able to understand his explanation. Interview on 10-2-19 with Qualified Professional/Program Manager revealed: - First learned of incident on 9-23-19. - Spoke with the Group Home Manager between 9-10:00am. At this time, she instructed the Group Home Manager to take Client #1 to the doctor. This deficiency is cross referenced into 10A NCAC 27G .5603 Operations (V291) for a Type A1 rule violation and must be corrected within 23 days.	V 105		
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.	V 110		

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V 110	Continued From page 6 (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: (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 interview, observation and record review, 2 of 3 paraprofessionals (Full Time Relief Manager (FTRM) and Group Home Manager) failed to demonstrated knowledge, skills, and ability required by the population served. The findings are: Review on 10-3-19 of FTRM's Personnel Record	V 110		

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revealed:
- Hire date 5-6-19.
- Trainings include: Behavior Intervention Training (BIT) 5-21-19 and Client Rights 5-23-19.
- Incident/Accident and Other Reportable Events form signed by FTRM dated 5-9-19 to include the following:
  - Identify types of situations that are required to be reported.
  - Demonstrate knowledge of required timelines for incident/accident reporting.
  - Demonstrate understanding of agency protocol for the reporting of incidents or accidents.
  - Demonstrate knowledge of information required when reporting incident or accidents.
  - Demonstrate ability to fill out the accident/ injury form.
  - Be able to identify other events that are required to be reported.

Review on 10-2-19 of Group Home Manager's Personnel Record revealed:
- Hired at this facility 10-8-18.
- Trainings include: Policies and Procedures 10-17-18, Abuse and Neglect 9-17-13, Rights and Incident Reports 10-17-18.

Review on 10-1-19 of Progress Note dated 9-23-19 and signed by the Group Home Manager revealed:
- "Group Home Manager was made aware by customer this morning that his left hand was sore and hurting. Group Home Manager administered 2 Tylenol PRN and and made an ice pack.
---------- FTRM came in on duty today and stated that [Client #1] closed his hand in the door while out in the community. GHM (Group Home Manager) notified QP (Qualified Professional/Program Manager), GHM was

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instructed to have FTRM to complete incident report and visit an urgent care."

Review on 10-2-19 of Progress Note dated 9-23-19 and signed by the FTRM revealed:
- "While out in the community Sunday 9-22-19 customer was not paying attention and let the door close back on his finger.... The van was parked on a slanted hill."

Review of Client #1's September 2019 MAR revealed:
- 9-23-19, 8:15am, 2 Tylenol 500mg administered for pain in Client #1's left hand.

Observation on 9-30-19 of Clients #1's left hand at approximately 11:00am revealed:
-Cast on his left hand.

Interview on 9-30-19 of Client #1 revealed:
- He shut his hand in the van door.
-"It hurt. It hurt real bad."

Interview on 9-30-19 and 10-1-19 of FTRM revealed:
- Employed at facility approximately 5 months.
- Client #1 got his hand caught in the van door.
- "He didn't complain of pain."
-FTRM left the facility at 4:00pm. The incident happened at approximately 3:00pm.
- Left the facility without documenting or verbally telling the Group Home Manager of the incident.
- The Group Home Manager relieved the FTRM at 4:00pm.
- The FTRM returned to work the following day, 9-23-19, at approximately 12:00pm.
- "[Group Home Manager] said [Client #1]

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woke up (9-23-19), his hand was swollen, and he was complaining of pain. [Group Home Manager] did say his hand was swollen."

-Upon arriving on shift at approximately 12:00 pm, 9-23-19, she was instructed by the Group Home Manager to go to the day program and pick up Client #1 and take him to a local urgent care.

- The assessment at an urgent care revealed a "broken thumb and they put a splint on it." Originally the FTRM stated that the urgent care made the follow up appointment for Orthopedic Care and later stated that she made the follow up appointment.

- The FTRM stated, "I feel like I dropped the ball and should have told [Group Home Manager]." The FTRM stated this on multiple occasions during her interviews.

Interview on 10-1-19 with Activity Director of Day Program revealed:

- The Group Home Manager transported Client #1 to the day program and they arrived at approximately 9:30am on 9-23-19.

- When Client #1 was dropped off, the "[Group Home Manager] indicated that she had made an appointment for him to be seen by a doctor later that day."

- When Client #1 was dropped off at the day program, the Group Home Manager stated that she wasn't on duty over the weekend. The Group Home Manager stated, "He (Client #1) hadn't complained much about it (his hand)."

- "I gave him some ice. He sat in my room close to my desk so that I could keep an eye on him." "He said it hurt a little bit, I was surprised he didn't complain more."

- "I noticed it was larger than normal. I iced it 15 minutes, off for 30 minutes, and back on for 15 minutes."

-"After he iced it you could really see that it

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was swollen from the inside."
- He got picked up around 12:30pm which was a little bit early.
- She thinks it was the FTRM that picked him up from the day program.

Interview on 9-30-19 and 10-1-19 with the Group Home Manager revealed:
- Reported to work on 9-22-19 at approximately 4:00pm and "nothing was said" (referring to the incident involving Client #1's hand).
- On the morning of 9-23-19, "He (Client #1) said it (his hand) hurt. I could see that it was swollen."
- On the morning of 9-23-19, the Group Home Manager attempted to call the FTRM to obtain information about Client #1's hand but was unsuccessful.
- She asked Client #1 about his hand but she was not able to understand his explanation.
- "I gave him Tylenol and an ice pack and I took him to the day program."
- "When he came back from the day program he was still in pain. My supervisor (Qualified Professional/Program Manager) said to take him to urgent care."
- There had been no calls from the day program of Client #1 complaining of pain.
- When FTRM came in at 12:00pm the Group Home Manager told her to go pick up Client #1 at that time and take him to an urgent care. The Group Home Manager had the paperwork ready for the FTRM to take with her to the appointment.

Interview on 10-2-19 with the Qualified Professional/Program Manager revealed:
- Received a call from the Group Home Manager between 9:00am-10:00am.

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V 110	Continued From page 11 - "She (Group Home Manager) said [Client #1] was hurting. I told her to get him to the doctor." - The Qualified Professional was not aware that Client #1 had gone to the day program that morning. - "I don't think [Group Home Manager] knew the details at that time." - "You don't need permission to take someone to the doctor." - When asked what would be your expectation after giving instructions to take someone to the doctor, she replied, "That he would go to the doctor." This deficiency is cross referenced into 10A NCAC 27G .5603 Operations for a Type A1 rule violation and must be corrected within 23 days.	V 110		
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	V 118		

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V 118	Continued From page 12 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. This Rule is not met as evidenced by: Based on interview, observation, and record review the facility failed to maintain an accurate MAR affecting 1 of 5 clients (Client #1). The findings are: Observations on 10-2-19 at approximately 3:00pm revealed: - Client #1's medication card for Hydrocodone/APAP empty; all 10 tablets administered. Review on 10-2-19 of Group Home Manager's Personnel Record revealed: - Hired at this facility 10-8-18. - Trainings include: Medication Administration Training 3-5-19. Review on 10-1-19 of Client #1's physician orders revealed: - Hydrocodone APAP (acetaminophen) order signed 9-23-19 for 10 tablets.	V 118		

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V 118	Continued From page 13 Review on 10-2-19 of Controlled Medication Count sheet revealed: - Script was written for Hydrocodone/APAP; Take 1 tablet by mouth 3 times daily as needed for pain. Quantity of 10 tablets. - Medication Count Sheet revealed 10 initial pills. - Medication Count Sheet revealed medications were dispensed on 10 occasions, until count amount remaining was 0. Review on 10-1-19 of Client #1's September MAR revealed: - Client #1 received Hydrocodone/APAP 12 times according to the documentation on the September MAR. Interview on 10-2-19 with Group Home Manager revealed: - It was a documentation error. Client #1 did not receive Hydrocodone APAP 12 times; he received it 10 times. She does not know why the MAR was showing documentation of Hydrocodone APAP being given 12 times.	V 118		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.	V 291		

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V 291	Continued From page 14 (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on interviews, observations, and record reviews, the facility failed to ensure coordination of care was maintained between the facility operator and the qualified professionals who were responsible for treatment/habilitation effecting 1 of 5 clients (Client #1). Cross Reference 10A NCAC 27G .0201 Governing Body Policies (V105) Based on interview and record review the facility failed to implement policy of monitoring and evaluating the quality and appropriateness of client care. The findings are: Cross Reference 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) Based on interview, observation and record	V 291		

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V 291	Continued From page 15	V 291		

review, 2 of 3 paraprofessionals (Full Time Relief Manager (FTRM) and Group Home Manager) failed to demonstrated knowledge, skills, and ability required by the population served. The findings are:

Review on 9-30-19 of North Carolina Incident Response Improvement System (NCIRIS) report dated 9-26-19 for incident on 9-22-19 completed by the Chief Operations Officer for Client #1 revealed :

- Client #1 opened the door, the van was sitting on an incline, so the door closed back on his finger before he was out of the way.
- Client #1 was treated at local urgent care on 9-23-19 and was diagnosed with a fractured thumb.

Review on 9-30-19 of Client #1's medical report from local urgent care facility dated 9-23-19 revealed:

- " You have a broken (fractured) thumb. This causes local pain, swelling, and often bruising... Thumb fractures may be treated with a splint or cast. This protects the thumb and holds the bone in place while it heals."
- Work/School Release: Client #1 may return to work on 9-25-19. "Restrictions: left hand - no use of injured hand or participation in activities."
- X-ray revealed a definite indentation of left thumb.

Plan of Protection dated 10-4-19 signed by the COO (Chief Operations Officer) revealed:

What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?

Email sent Thursday, 10-3-19, from the Qualified

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V 291	Continued From page 16 Professional/Program Manager revealed: "To avoid delays with processing incident reports please complete reports on the same day the incident occurred and send to me on the same day. You can fwd. (forward) reports to me via email or fax. "1. Program Manager sent email regarding promptly completing incident reports (see attached). 2. All staff of Greywood home will receive the following policies today, 10-4-19, or when they first come on duty: * Incident Reporting * Communication Log Protocol * Health Notes/Progress Notes * On-Call Reporting Program Manager will review policies. Each staff will sign/date indicating understanding of policies. 3. Communication Bulletin will be sent to the home today, 10-4-19, regarding staff reporting/informing and documenting incidents as well as seeking prompt medical attention. 4. Program Manager will visit home today, 10-4-19, and provide supervision to both staff members." Describe your plans to make sure the above happens. "1. Email has already been sent regarding timely completion of incident reports. 2. Chief Operating Officer will send policies with Program Manager to take to the home today, 10-4-19. 3. Chief Operating Officer will send Communication Bulletin today, 10-4-19. 4. Program Manager will visit the home today, 10-4-19."	V 291		

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V 291	Continued From page 17 On 9-22-19 Client #1's hand was injured in the van door at approximately 3:00pm. The Full Time Relief Manager(FTRM) failed to document incident, notify the On Call Qualified Professional per agency protocol, or inform the Group Home Manager when the Group Home Manager relieved her at 4:00pm. On 9-23-19 at approximately 8:00 am the Group Home Manager observed Client #1's left hand as being swollen and Client #1 was complaining of pain. The Group Home Manager administered Tylenol to Client #1, made him an ice pack, and sent him to the day program. Client #1 complained of pain at the day program and the Activity Director alternated ice packs for him. The Activities Director was under the impression that the Group Home Manager had already made a doctor's appointment for Client #1. The Group Home Manager spoke to the Qualified Professional/Program Manager between 9:00 am and 10:00am and was instructed to take Client #1 to the doctor. The Group Home Manager waited until FTRM returned to work at 12:00pm and instructed her to take Client #1 to an urgent care facility where he was diagnosed with a fractured thumb. Client #1 was in pain, with obvious swelling and had his medical care delayed as the Group Home Manager chose to send him to the day program. The Group Home Manager had no knowledge of the incident because FTRM failed to document the incident in the communication log or the progress notes and also failed to verbally communicate the incident. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of 2,000.00 is imposed. If the violation is not corrected within 23 days, an additional penalty of 500.00 per day will be imposed for each day the facility is out of	V 291		

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V 291	Continued From page 18 compliance beyond the 23rd day.	V 291		
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 interview and observation, the facility failed to be maintained in a clean, attractive manner, and free from offensive odor. The findings are: Observation on 9-30-19 at approximately 11:00am revealed: - Supply closet had a dirty door jam. - Air conditioning vents dirty. - Laundry room door jam dirty. - Bathroom #1: trash can overflowing onto floor, toilet base was dirty, dirty bathroom vents, molding around the tub was rotting, walls by the toilet were dirty, liquid trapped under the rubber bathmat which was located on the floor outside of the tub, mold under rubber mat, and an extreme foul smell permeating the bathroom. - Bathroom #2: inside of toilet dirty, base of toilet dirty, the walls and baseboards were dirty, sink and countertop had toothpaste stains and other stains that were unidentifiable, mirror was covered with toothpaste spatter, shower was moldy around the edges, liquid trapped under the rubber bathmat which was located on the floor	V 736		

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V 736	Continued From page 19 outside of the tub, mold under rubber mat, and an extreme foul smell permeating the bathroom. - Side screen door handle was broken and unable to be used. - On the right side of the back yard there was a container filled with broken wood/molding. Grass was dead underneath it. - Dining room kitchen table was covered with crumbs and a sticky substance. Interview on 10-2-19 with the Qualified Professional/Program Manager revealed: - She would ensure that the facilty was cleaned immediately.	V 736		