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	MHL034-334	A. BUILDING: _____ B. WING _____	R 11/15/2019

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NOA HUMAN SERVICES III, INC	1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 11/15/19. The complaint was substantiated (intake # NC00157337). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults whose Primary Diagnosis is a Mental Illness.	V 000		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all	V 107		

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V 107	Continued From page 1 applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure two of three staff had the minimum education for their position (staff #1 and #3) and 1 of 1 House Manager had a signed job description. The findings are: Review on 11/6/19 of staff #1's personnel record revealed: -A hire date of 11/17/17; -A job description for Direct Care Staff; -No evidence of education. Interviews on 11/5/19 and 11/6/19 with staff #1 revealed: -He had never been asked to provide verification of his education;	V 107		

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V 107	Continued From page 2 -He had received his high school diploma. Review on 11/6/19 of staff #3's personnel record revealed: -A hire date of 7/10/18; -A job description for Direct Care Staff; -No evidence of education. Attempts made to contact staff #3 on 11/7/19, 11/8/19, 11/12/19 and 11/13/19 were not successful since the staff didn't return telephone calls. Review on 11/15/19 of the House Manager's personnel record revealed: -A hire date of 7/28/19; -No evidence of a job description. Interviews on 11/8/19 and 11/13/19 with the House Manager revealed he knew what his job duties consisted of but wasn't sure if he had ever signed a job description. Interviews on 11/5/19, 11/6/19, 11/8/19, 11/13/19 and 11/15/19 with the Qualified Professional revealed: -Verification of education for staff #1 and staff #3 was not available; -Staff #1 had informed him on 11/6/19 that he had received his high school diploma; -On 11/6/19 he had requested staff #1 provide verification of education; -He had not been able to contact staff #3 to request verification of his education; -It was the responsibility of the owner to request verification of education when she hired employees. Interviews on 11/6/19 and 11/7/19 with the Owner revealed she was sure that verification of	V 107		

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V 107	Continued From page 3 education for both staff #1 and #3 and a job description for the House Manager was received when the staff were hired but she had no documentation. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type B rule violation and must be corrected within 45 days.	V 107		
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.	V 109		

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V 109	Continued From page 4 (f) The governing body for each facility shall 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 interviews and record reviews, 2 of 2 Qualified Professionals (QP) (the QP and the Owner) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V107). Based on record reviews and interviews, the facility failed to assure two of three staff had the minimum education for their position (staff #1 and #3) and 1 of 1 House Manager had a signed job description. Cross Reference: G.S. 122C-80 Criminal History Record Check Required for Certain Applicants for Employment (V133). Based on record reviews and interviews, the facility failed to request a criminal history check within 5 days of making a conditional offer of employment for 1 of 1 House Manager. Cross Reference: G.S. 130 .0102 Investigating and Reporting Health Care Personnel (V318). Based on interviews and record reviews, the facility failed to assure that the Health Care Personnel Registry (HCPR) was notified timely of	V 109		

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V 109	Continued From page 5 all allegations of abuse by staff. Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record review and interviews, the facility failed to ensure an incident report for a level II or level III incident was completed and submitted within 72 hours of becoming aware of the incident. Review on 11/15/19 of the QP's personnel record revealed: -A hire date of 2/27/16; -All qualifications for a QP were met. Review on 11/15/19 of the Owner's personnel record revealed all qualifications of a QP were met. Finding #1: Criminal record checks of all potential staff were not thoroughly reviewed to determine whether the potential staff were a good match for the clients the facility served and whether they were able to fully complete their job responsibilities. Review on 11/6/19 of staff #1's personnel record revealed: -A hire date of 11/17/17; -A criminal record check dated 12/2/17 included "8/21/17 misdemeanor probation violation, 11/4/16 misdemeanor possession of marijuana up to .5 ounce, 11/4/16 misdemeanor possession of marijuana paraphernalia, 11/4/16 misdemeanor simple possession of schedule III controlled substance, 11/4/16 felony possession of cocaine, 9/10/15 misdemeanor possession of drug paraphernalia, 9/10/15 felony possession of schedule I controlled substance."	V 109		

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V 109	Continued From page 6 Review on 11/6/19 of staff #3's personnel record revealed: -A hire date of 7/18/18; -A criminal record check dated 7/14/18 included "8/8/17 felony submit false information to sex offender registry, 8/8/17 felony failure to submit change of address sex offender, 7/28/16 misdemeanor injury to real property, 7/28/16 misdemeanor breaking or entering, 12/17/13 felony indecent liberties with child." Review on 11/6/19 of the North Carolina sex offender registry revealed staff #3 was convicted of indecent liberties with a 13-year-old child when he was 28 years old and was required to be registered on the sex offender registry until 12/18/2023. Review on 11/5/19 and 11/15/19 of client #1, #3, and #4's records revealed either current or a history of substance abuse disorders. Interview on 11/8/19 with staff #2 revealed he had observed staff #3 at the local recreation center with the clients of the facility. Interviews on 11/5/19, 11/6/19, 11/13/19, 11/15/19 and 11/18/19 with the QP revealed: -He had reviewed the criminal histories of staff #1 and staff #3 on 11/6/19 for the first time and was surprised; -The Owner was responsible for all hiring and he wasn't given the opportunity to provide input. Interviews on 11/6/19 and 11/7/19 with the Owner revealed: -She had no issue with staff #1 being previously convicted of drug related charges when she hired him because it was a year prior; -She had no issue with staff #3 being a registered	V 109		

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V 109	Continued From page 7	V 109		

sex offender when she hired him because he had been convicted 4.5 years prior;
-"Really, I try to look at just months before ...like 3 months before;"
-She refused to acknowledge whether she knew the limitations on location (anywhere children congregated including recreation centers) of where staff #3 was allowed to be;
-Clients were transported to the local recreation center by public transportation and accompanied by staff on Mondays, Wednesdays and Fridays but she wasn't sure whether staff #3 had accompanied the clients to the recreation center.

Finding #2: The facility had no policy regarding individual supervison plans for paraprofessionals and individual supervision had not been provided.

Interviews on 11/5/19, 11/6/19, 11/8/19, 11/13/19 and 11/15/19 with the QP revealed:
-It was his responsibility to provide supervision to the staff;
-He was not aware of a facility policy regarding individual supervision plans for paraprofessionals;
-His office was in the facility, so he provided verbal feedback to staff daily but nothing in writing.

Interview with staff #1 on 11/5/19 revealed:
-He had been informed by the Owner that the QP was his supervisor;
-He had never heard of a supervision plan and had participated in no individual or group supervision.

Interviews on 11/6/19 and 11/7/19 with the Owner revealed it was the responsibility of the QP to provide supervision to the staff and she was confident he was doing so appropriately.

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V 109	Continued From page 8 Finding #3: The visitation policy had not been made clear to the staff which resulted in an unauthorized visitor in the facility. While in the facility the unauthorized visitor, client #4 and staff #3 snorted cocaine in client #4's bedroom and then staff #3 had a physical altercation with the visitor. Interviews on 11/5/19 and 11/6/19 with staff #1 revealed: -He was currently working his 2nd 3-day shift in the facility and was not aware of the policy for visitors; -If a visitor arrived, he would call the QP and ask what to do prior to allowing the visitor to spend time with the client. Interview on 11/8/19 with staff #2 revealed: -He was not sure about the policy regarding visitors; -"People (clients) that's been here they can have a visitor for 30 minutes or so but I don't think they (visitors) can actually go into their (clients) rooms;" -If a visitor arrived, he would call the QP and ask if the individual was able to visit with the client; -If he wasn't able to get in touch with the QP he would not allow the visitor to remain in the facility; -"Nobody ever has visitors here." Interviews on 11/8/19 and 11/13/19 with the House Manager revealed: -"More or less, [the QP] sets those guidelines (visitation);" -He was unsure of what the policy or procedure regarding visitation was. Interviews on 11/5/19, 11/6/19, 11/8/19, 11/13/19 and 11/15/19 with the QP revealed: -"Anybody can come and visit as long as they	V 109		

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V 109	Continued From page 9	V 109		

stay in the living room;"
-There were no specific visitation times;
-He was not aware that staff were unclear about the visitation policy.

Interviews on 11/6/19 and 11/7/19 with the Owner revealed:
-"There's no set visiting hours;"
-"1:00 pm - 8:00 pm was the best because the clients usually slept late and there was no reason for visitors to come while the clients were getting up;"
-She typically allowed the QP to manage visitation issues.

Finding #4: Client #3 had returned to the facility from unsupervised time and was intoxicated. The QP was informed but failed to follow up or notify the clients guardian.

Review on 11/5/19 of client #3's record revealed:
-Diagnoses of Moderate Intellectual Developmental Disability, Persistent Depressive Disorder, Cyclothymic Disorder, History of Stroke, Hepatitis C, Contact Dermatitis, Restless Leg, Obesity, Hyperlipidemia, Hepatitis C, Coronary Artery Disease and Degenerative Disease;
-The client was declared incompetent and a legal guardian was appointed on 12/29/10;
-A Safety Contract signed and dated by client #3, the client's guardian and the QP included "any incidents that occur during [client #3's] community time will be reported to the guardian immediately ...agrees not to use drugs or alcohol while traveling in the community."

Interviews on 11/6/19 and 11/7/19 with client #3's guardian revealed:
-He had not been informed that client #3 had returned to the facility on 10/12/19 intoxicated;

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V 109	Continued From page 10 -The guardian was concerned because he had not been immediately notified of the incident; -Client #3 resided at the facility because he needed therapeutic care and the guardian didn't think that appropriate care was being provided; -He was in the process of locating a more appropriate facility for the client. Interviews on 11/5/19, 11/6/19, 11/8/19, 11/13/19 and 11/15/19 with the QP revealed: -Staff #3 had contacted him the day of the incident (10/12/19) to inform him that client #3 had been drinking and was confrontational; -Staff #3 requested the QP visit client #3 but the QP was out of town so he advised the staff to attempt to deescalate the situation; -He had not followed up with staff #3 and thought since staff #3 had not called him back that the staff had been able to handle the situation; -It was his responsibility to notify the clients guardians of incidents; -Client #3 returned to the facility intoxicated regularly and the guardian was not always notified. Review on 11/15/19 of a Plan of Protection revealed: -The Plan of Protection was signed and dated by the QP on 11/15/19; -"What will you immediately do to correct the rule violation in order to protect clients from further risk or additional harm? Staff (#3) has been removed from the facility and will not be returning to this home. Moving forward, criminal background checks and HCPR (Health Care Personnel Registry) will be done on timely manner as required. NOA will introduce para-professional competence for all para-professional. All Level II and III incidents will be reported to IRIS (Incident Response	V 109		

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V 109	Continued From page 11 Improvement System) within recommended time from the day and time reported. -Describe your plans to make sure the above happens: SIC (Supervisor in Charge) will ensure all incident reports are reported into IRIS. SIC will ensure that all background check and documents are complete and accurate before hiring new staff. No new staffs will be hired until all above recommendations are met. SIC will ensure para-professional training is completed and para-professionals are informed of visitation policy." This facility served adult clients with mental health diagnoses. The diagnoses included Schizophrenia, Depression, Moderate Intellectual Developmental Disability, Moderate Cocaine Use Disorder, Marijuana Use Disorder, Alcohol Use Disorder, Traumatic Brain Injury (TBI), Hepatitis C, Coronary Artery Disease, Degenerative Disease, Diabetes, Human Immunodeficiency Virus (HIV), Hypertension, Gastroesophageal Reflux Disease, Vitamin D Deficiency, Hyperlipidemia, and Asthma. A criminal record check was not completed within 5 days of offering conditional employment to the House Manager. When reviewing the criminal history of potential staff, only the 3 months prior to the application were taken into consideration. This resulted in 1 staff that was a registered sex offender and unable to perform his job duties and 1 staff with a history of a variety of drug convictions involved with the treatment of clients with substance abuse disorders working at the facility. The facility had no policy regarding individual supervision plans for paraprofessional staff and the QP was not providing individual supervision. Staff had not been informed of the visitation policy which resulted in unauthorized visitors in the facility. Client #3 had returned to the facility intoxicated	V 109		

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V 109	Continued From page 12 from his unsupervised time and the QP failed to follow up on the incident or notify the clients' guardian. Incident reports and Health Care Personnel Registry reports had not been submitted timely. Education for 2 para-professional staff had not been verified and the House Manager had no job description. This is detrimental to the health, safety and welfare of the clients and constitutes a Type B rule violation. If the violation is not corrected within 45 days, and administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 109		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned	V 133		

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V 133	Continued From page 13 on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the	V 133		

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conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.
(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:
(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.
The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.
(d) Limited Immunity. - A provider and an officer

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or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:
(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.
(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.
(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article

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V 133	Continued From page 16 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)	V 133		

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V 133	Continued From page 17 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to request a criminal history check within 5 days of making a conditional offer of employment for 1 of 1 House Manager. The findings are: Review on 11/15/19 of the House Manager's personnel file revealed: -A hire date of 7/28/19; -A criminal history check was requested on 8/5/19. Interviews on 11/8/19 and 11/13/19 with the House Manager revealed he knew he had begun working in either July or August 2019, but he wasn't able to be more specific. Interview on 11/15/19 with the Qualified Profession revealed it was the responsibility of the Owner to hire staff and to ensure all new hire information was completed prior to the staff beginning work. Interview on 11/15/19 with the Owner revealed the hire date and the start date were different for the House Manager but she was unable to provide the start date for the House Manager. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type B rule violation and must be corrected within 45 days.	V 133		

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V 318	Continued From page 18	V 318		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that the Health Care Personnel Registry (HCPR) was notified timely of all allegations of abuse by staff. The findings are: Review on 11/8/19 of the Incident Response Improvement System (IRIS) revealed: -The Owner had submitted the information to IRIS; -The original submission of the form was completed on 10/21/19 and updates were completed on 10/24/19 and 10/25/19; -"Date of Incident: 10/12/19;" -"Date Provider Learned of Incident: 10/18/19;" -"Has consumer been adjudicated incompetent: Unknown;" -In the Allegations of Abuse, Neglect or Exploitation section, Physical Abuse was checked; -"Level of Incident: Level III;" -"This happened due to argument between staff	V 318		

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V 318	Continued From page 19 (#3) and client (#3) over a mail from [public transportation] but addressed to client;" -"Client (#3) was advised mail will be handed to him if need be after the appropriate office has seen the info (information) from [public transportation] concerning client, client got angry went outside with a tree branch and tried hitting staff (#3) from behind;" -"Staff (#3) said he heard rapid footsteps towards him and saw [client #3] with the raised tree branch it landed on staffs hand and he tried to pry it away from client as he tried to hit him again, in doing so client lost his balance and bumped into the kitchen counter/stove causing a bruise to his side;" -"Staff (#3) said he apologized to client as he was only trying to get the object away from him being that he was backed into a corner in the kitchen and could leave that space immediately;" -"Staff (#3) has been advised to immediately remove him/herself from these situations once a client gets agitated and they are not able to descalate the situation ...call another team member preferably admin (administration) so we can immediately try to talk with the client or release the mail in this case to him as soon as we know whats in the mail;" -"Did not contact the police because I was advised to wait on County DSS (Department of Social Services)/Adult Protective Services ...staff involved has been suspended pending the completion of this incident, Facility/County and State;" Update on 10/22/19 by the local management entity (LME) included "per a conversation with the provider, an investigation was completed to rule out staff abuse ...provider to resubmit with the following: (1) a summary of the incident in the provider comments section ...(2) addition of the incident type-consumer behavior, aggression (3)	V 318		

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V 318	Continued From page 20 addition of the incident type-abuse/neglect (4) deletion of the incident type-death (5) deletion of the incident type - restrictive intervention (6) completion of the HCPR section (7) addition of an uploaded copy of the investigation report/summary (8) addition of DSS and HCPR updates to include if they investigated and their results (9) change of the answer to the question was the consumer treated by a licensed health care professional for the incident - from yes to no and (10) addition of a comment stating whether or not the staff was placed on suspension during the investigation;" -Update on 10/24/19 by the Owner included "there was an argument between staff [#3] and client [#3] over a mail from the [public transportation] ...staff advised client he will get the letter after it goes through the appropriate office ...client got angry went outside and came back with an object, a tree branch, threatening to kill/break open staff's skull ...client (mistake and should read staff) got hit with the object because according to him he was prepping dinner and didn't see it coming, he then tried to pry the pbject away from client as he made to hit staff again ...in this process, client lost his balance and bumped into the stove/kitchen counter causing a bruise to his side;" -Update on 10/24/19 by the Owner included "staff (#3) is suspended pending the conclusion of this investigation;" -Update on 10/25/19 by the Owner included "investigating injury of unknown origin ..." Interviews on 11/5/19, 11/6/19, 11/8/19, 11/13/19 and 11/15/19 with the Qualified Professional (QP) revealed it was the responsibility of the Owner to submit information to the HCPR. -Interviews on 11/6/19 and 11/7/19 with the	V 318		

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V 318	Continued From page 21 Owner revealed: -Staff #3 was still suspended even though she had completed her investigation and determined he had not abused client #3; -She had planned to keep staff #3 suspended until the county and state completed an investigation to ensure they agreed with her determination; -She had been notified by the QP of the incident on 10/18/19 and had submitted an incident report to the IRIS on 10/21/19; -She thought she had 3 days from the time she was informed of the incident to submit information to the IRIS/HCPR; -It was an oversight on her part that the HCPR section was not completed on the original submission of the report. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type B rule violation and must be corrected within 45 days.	V 318		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health,	V 364		

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V 364	Continued From page 22 developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits	V 364		

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V 364	Continued From page 23 otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10) Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to:	V 364		

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V 364	Continued From page 24 (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being	V 364		

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V 364	Continued From page 25 held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be	V 364		

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V 364	Continued From page 26 documented in writing in the client's record. This Rule is not met as evidenced by: Based on interviews and record review, the facility restricted the rights of 1 of 4 audited client (client #3) by restricting his ability to receive sealed mail. The findings are: Review on 11/5/19 of client #3's treatment plan dated 10/24/19 did not identify treatment or habilitation needs to restrict access to mail. Interviews on 11/5/19, 11/6/19, 11/8/19, 11/13/19 and 11/15/19 with the Qualified Professional (QP) revealed: -Clients are not provided their mail until it had been reviewed by him; -This was to ensure that all checks were intercepted, and the facility received all important information regarding the clients. Interviews on 11/6/19 and 11/7/19 with the Owner revealed: -It was the responsibility of the QP to review all mail that clients received prior to the clients receiving the mail; -This was to ensure that all checks were intercepted, and the facility received all important information regarding the clients.	V 364		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 367		

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V 367	Continued From page 27 (a) Category A and B providers shall report all level II incidents, except deaths, that occur during 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	V 367		

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V 367	Continued From page 28	V 367		

information;
(2) reports by other authorities; and
(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.

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V 367	Continued From page 29 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an incident report for a level II or level III incident was completed and submitted within 72 hours of becoming aware of the incident. The findings are: Review on 11/8/19 of the Incident Response Improvement System (IRIS) revealed: -The Owner had submitted the information to IRIS; -The original submission of the form was completed on 10/21/19 and updates were completed on 10/24/19 and 10/25/19; -"Date of Incident: 10/12/19;" -"Date Provider Learned of Incident: 10/18/19;" -"Has consumer been adjudicated incompetent: Unknown;" -"Level of Incident: Level III;" -"This happened due to argument between staff (#3) and client (#3) over a mail from [public transportation] but addressed to client;" -"Client (#3) was advised mail will be handed to him if need be after the appropriate office has seen the info (information) from [public transportation] concerning client, client got angry went outside with a tree branch and tried hitting staff (#3) from behind;" -"Staff (#3) said he heard rapid footsteps towards him and saw [client #3] with the raised tree branch it landed on staffs hand and he tried to pry it away from client as he tried to hit him again, in doing so client lost his balance and bumped into the kitchen counter/stove causing a bruise to his side;" -"Staff (#3) said he apologized to client as he was only trying to get the object away from him being that he was backed into a corner in the kitchen	V 367		

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V 367	Continued From page 30 and could leave that space immediately." Interview on 11/6/19 with the Qualified Professional (QP) revealed: -It was his responsiblity to report all incidents to the Owner; -It was the responsibility of the Owner to submit incident reports to IRIS. Interviews on 11/6/19 and 11/7/19 with the Owner revealed: -She thought the QP had been notified of the incident on 10/16/19 but wasn't sure; -She was notified of the incident by the QP on 10/18/19; -It was the responsibility of the QP to investigate incidents and provide her with the results; -Based on the results from the QP and her own investigation if necessary, she submitted information to IRIS; -She was aware that level II and level III incidents were required to be submitted to IRIS within 72 hours but she thought that was within 72 hours of her being informed of the incident, not the QP being informed. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type B rule violation and must be corrected within 45 days.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.	V 512		

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V 512	Continued From page 31 (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on interviews, record reviews and observations, 1 of 3 staff (#3) subjected 2 of 4 audited clients (#3 and #4) to serious abuse and neglect. The findings are: Review on 11/6/19 of staff #3's personnel record revealed: -A hire date of 7/10/18; -A job title of Direct Care Staff; -Trainings on Alternatives to Restrictive Intervention, Client Rights and Special Populations were completed on 7/13/18. Attempts made to contact staff #3 on 11/7/19, 11/8/19, 11/12/19 and 11/13/19 were not successful as staff didn't return telephone calls. Review on 11/5/19 of client #3's record revealed:	V 512		

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V 512	Continued From page 32 -An admission date of 11/2/15; -Diagnoses of Moderate Intellectual Developmental Disability, Persistent Depressive Disorder, Cyclothymic Disorder, History of Stroke, Hepatitis C, Contact Dermatitis, Restless Leg, Obesity, Hyperlipidemia, Hepatitis C, Coronary Artery Disease and Degenerative Disease; -The client was declared incompetent and a legal guardian was appointed on 12/29/10; -A treatment plan dated 10/24/19 included a goal of "[Client #3] will learn how to control his behavior in the home and community and stop getting agitated when told NO within the next 12 months as evidence by staff and legal representative;" -A Safety Contract signed and dated by client #3, the client's guardian and the QP included "any incidents that occur during [client #3's] community time will be reported to the guardian immediately ...agrees not to use drugs or alcohol while traveling in the community;" -The results of a Psychological Evaluation dated 10/2/18 included "test results indicated significant language impairment including receptive, expressive, and repetition ...he (client #3) will have problems remembering information he is told due to language impairment, not memory impairment ...the degree of language impairment places him (client #3) at high risk for being taken advantage of;" -An Adult Guardianship Functional Assessment dated 9/8/14 included "[Client #3] in the past depended on his mother and sister for all his needs due to his inability to communicate effectively...both have passed away..." Finding 1: Review on 11/6/19 of a handwritten statement not signed or dated that the Qualified Professional	V 512		

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V 512	Continued From page 33 (QP) indicated was completed by staff #3 revealed: -"[Client #3] took the mail from where it was stored;" -"I noticed the mail was from [public transportation];" -"I advised him (client #3) I needed to give the mail to the QP so he can handle it accordingly;" -"Client (#3) refused and got into argument with me, cursing at me, calling me names, and threatening to kill me;" -"At that point I contacted the QP and he advised me to calm the client down and descalate the situation;" -"I tried doing so but client would not calm down;" -"So I walked away from him in an attempt to calm the situation down;" -"While I was in the kitchen cooking dinner client (#3) came in with a tree branch;" -"I turned around and noticed it and I try to get branch away from his hands;" -"In this process client lossed his balance and fell against the stove;" -"I asked client was he ok but he didn't answer and went to his room;" -"I forgot to call QP afterwards." Interview and observation on 11/5/19 at 2:03 pm with client #3 revealed: -Observed as the client expressed frustration by yelling and hitting the table due to his inability to process the questions that he was being asked; -The client pointed out the shelf in the kitchen where his mail was lying (on 10/12/19); -He took the mail off the shelf and went outside to inform staff #3 that he had taken it; -"He (staff #3) started arguing;" -"I didn't understand;" -"I got really mad;" -Staff #3 "jerked" the mail out of his hands;	V 512		

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V 512	Continued From page 34 -"Until he (staff #3) took my mail never no problem or anything;" -"I called him real good names;" -"He (staff #3) just laughed at me...he just laughed a lot;" -Staff #3 entered the facility via the side door; -"I found a big stick outside;" -The client entered the facility via the side door; -Staff #3 was in the kitchen facing the client when he entered; -"I was going to knock him down, but I didn't get to;" -"He (staff #3) pushed me down;" -Observed as the client demonstrated how staff #3 used both his hands and pushed him in the chest causing him to fall backwards into the stove; -"He (staff #3) knocked me out;" -"I was all the way flat;" -The client pointed to his ribs on the left side and indicated that he had been bruised during the incident; -Staff #3 told the client he was sorry several times, but he ignored him and went to his bedroom; -Staff #3 never asked him if he was hurt or if he needed medical attention. Interviews on 11/6/19 and 11/7/19 with client #3's guardian revealed: -He was informed of the incident regarding client #3 and staff #3 on 10/16/19 by client #3 during a therapy appointment; -The incident occurred on 10/12/19; -Staff #3 took client #3's mail from him and refused to return it; -"Client (#3) picked up a stick and hit staff (#3) with the stick;" -"Client (#3) was pushed by staff (#3) and client's rib got hurt on the stove;"	V 512		

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V 512	Continued From page 35 -"Client (#3) stated it took the wind out of client and that was the end of the altercation;" -The guardian had observed and taken pictures of a purple and yellow bruise on client #3's left rib cage; -The House Manager that transported client #3 to the therapy appointment verified that he was aware of the incident and was completing an investigation; -Staff #3 had been suspended until the investigation was completed; -He had not been informed that client #3 had returned to the facility on 10/12/19 intoxicated; -The guardian was concerned because he had not been immediately notified of the incident; -The guardian was also concerned that staff #3 had taken mail out of client #3's hands, laughed at him and then pushed him; -Client #3 had not received medical care regarding the bruise on his ribs as of 10/16/19 so the guardian informed the House Manager that he wanted him to be medically evaluated; -Client #3 resided at the facility because he needed therapeutic care and the guardian didn't think that appropriate care was being provided; -He was in the process of locating a more appropriate facility for the client. Review on 11/6/19 of a picture taken on 10/16/19 by client #3's guardian revealed a long yellow and purple bruise on the client's left ribs. Interview on 11/4/19 with client #1 revealed: -He was in his bedroom when the incident with client #3 and staff #3 occurred (10/12/19); -"I heard them fussing;" -"All of a sudden a loud noise and [staff #3] saying I'm sorry, I'm sorry;" -He did not hear staff #3 ask client #3 if he needed medical care;	V 512		

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V 512	Continued From page 36 -"He's (staff #3) short tempered;" -Staff #3 had not worked since the incident. Interview on 11/5/19 with client #2 revealed: -He didn't see the incident between client #3 and staff #3; -"I heard a noise that sounded like something fell;" -He did not hear staff #3 ask client #3 if he needed medical care; -He had seen a large bruise under client #3's left arm a couple of days after the incident. Interview on 11/6/19 with client #4 revealed: -He had been sitting on the porch during the incident; -He saw staff #3 jerk mail out of client #3's hand; -He heard client #3 yelling at staff #3; -Staff #3 started laughing at client #3 "like he was making fun of him;" -Client #3 picked up a stick and went inside the facility. Interview on 11/8/19 with staff #2 revealed: -"When I came in on Tuesday (10/15/19) morning, [client #3] said that he and [staff #3] had gotten into it;" -Client #3 had not given him additional information about the incident; -"I told the QP and he told everybody else." Review on 11/6/19 of a Report of Incident/Accident signed and dated by the Owner on 10/16/19 revealed: -"Date notified: 10/16/19;" -"Resident's condition before incident: Disoriented;" -The guardian was notified on 10/16/19. Review on 11/6/19 of a receipt for $3.00 from a	V 512		

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V 512	Continued From page 37 medical practice printed on 10/18/19 at 5:10 pm. Review on 11/6/19 of an In-House Investigational Document signed and dated by the House Manager revealed: -"Date of Investigation: 10/16/19;" -"Date Occurred: 10/12/19;" -Based on an interview with client #3, he was not doing well because he was sore; -Client #3 had an argument with staff #3 resulting in the client going outside the facility to get a stick; -Client #3 attempted to hit staff #3 with the stick but the staff caught it and took it away from him; -Client #3 lost his balance and bumped into the stove; -Based on an interview with client #1, he had not seen the incident but heard client #3 yelling about his mail and staff #3 saying he was sorry a couple of times; -Based on an interview with client #2 he had not seen the incident but heard a lot of arguing then staff #3 saying he was sorry a couple of times; -Based on an interview with staff #3, client #3 had removed mail with the client's name on it from a shelf in the kitchen so he took the mail from the client; -Client #3 got upset, went outside to get a stick and tried to hit staff #3 with the stick; -Staff #3 caught the stick and took it away from client #3 which caused the client to fall against the stove; -"Summary of your Investigation: Staff [#3] should have called someone from the administrative team when the incident occurred...he forgot because of the events occuring...none of the clients saw the incident...they only heard...staff tried to walk away but was cornered in the kitchen...staff [#3] is suspended pending the outcome of this investigation."	V 512		

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V 512	Continued From page 38 Interviews on 11/8/19 and 11/13/19 with the House Manager revealed: -He had been informed on 10/15/19 of an incident that involved client #3 and staff #3; -He could not remember if staff #2 or the QP had informed him but he was provided no details other than client #3 was the aggressor and had a big stick; -He had transported client #3 to a therapy appointment on 10/16/19 and the client's guardian met them at the appointment; -Client #3 informed his guardian and the therapist that staff #3 had pushed him; -He had questioned client #3 when he transported him back to the facility and the client informed him that staff #3 had pushed him; -He had interviewed the other clients, but they all said they had not heard or seen anything; -He has asked staff #3 to show him the stick that was used and the staff showed him a stick lying in the yard that was approximately 3" in diameter but he's not sure that was the actual stick that was used; -He's not sure why he indicated on his report that the client lost his balance and fell rather than documenting what client #3 had informed him about being pushed; -He's not sure why he indicated on the In-House Investigational Document he was informed of the incident on 10/16/19 rather than 10/15/19; -"Keep in mind that I had a couple of traumatic brain injuries so my memory recall is not exactly what it once was ...I have terrible issues with memory ...I get my details mixed up sometimes;" -He wanted to believe staff #3 but he had his doubts because client #3 was so adamant about what had happened; -He didn't think that he had enough information to form a conclusion so he had been attempting to	V 512		

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V 512	Continued From page 39	V 512		

contact staff #3 to ask him some follow up questions but "he's being elusive;"
-Even though the owner unsubstantiated the allegation of abuse, he didn't feel comfortable about staff #3 returning to the facility;
-"To be honest, I probably won't put him on the schedule for that house."

Review on 11/6/19 of an In-House Investigational Document signed and dated by a Supervisor in Charge revealed:
-"Date of Investigation: 10/19/19;"
-"Date Occurred: 10/12/19;"
-Client #1 was in his room and heard yelling, saw client #3 with a stick and heard staff #3 say he was sorry;
-Client #2 was in his room and heard yelling and staff #3 say he was sorry;
-According to client #3, he attempted to get his mail from staff #3 but was unsuccessful.
-Client #3 got a stick and informed staff #3 he was going to kill him;
-Client #3 swung the stick at staff #3 and fell to the floor;
-Client #3 went to his bedroom;
-Client #4 observed client #3 fall attempting to hit staff #3 with a stick then heard staff #3 say he was sorry;
-According to staff #3, he blocked client #3 from hitting him and the client slipped and fell to the floor.
-Staff #3 attempted to assist the client, but he refused and went to his room;
-"Summary: Things could have been handled more professionally when [client #3] got the stick...staff (#3) tried to defuse the situation and tried to get the stick from [client #3]...that's when [client #3] fell to the floor...none of the clients saw anything, they just heard yelling between the staff (#3) and client (#3)...at the end of the day, they

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES III, INC	1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106

(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) COMPLETE DATE
V 512	Continued From page 40 are mentally ill clients and staff did try to defuse the situation." Review on 11/6/19 of an In-House Investigational Document signed and dated by the Qualified Professional revealed: -"Date of Investigation: 10/17/19;" -"Date Occurred: 10/12/19;" -He was advised on 10/16/19 by staff #2 that an incident had occurred on 10/12/19 between client #3 and staff #3; -Interview with client #3 revealed he had taken some mail addressed to him and showed it to staff #3; -Staff #3 took the mail from client #3 and laughed at him; -Client #3 got a stick because he wanted to break staff #3's head and knock him out; -While staff #3 was attempting to get the stick from client #3, the client fell; -"I (client #3) did not know what happened but am sore on my side...it hurt;" -According to client #4, he observed client #3 with a stick in his hand and heard a noise but did not see what happened; -"Summary: In all this, clients are entitled to their mails, given to them by staff, after it has been appropriately sorted out...staff could have called a member of the Administration to talk to client (#3) maybe calm him down, but he (staff #3) advised he couldn't at the time because he was backed into a corner and could not get out." Interviews on 11/5/19, 11/6/19, 11/8/19, 11/13/19 and 11/15/19 with the QP revealed: -Staff #2 had informed him of the incident between client #3 and staff #3 shortly after he reported to work for his shift; -He wasn't sure of the date it was reported but he was sure that the date (10/16/19) he indicated on	V 512		

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V 512	Continued From page 41 the In-House Investigational Document was correct; -He was not sure why he indicated 10/16/19 on the In-House Investigational Document when staff #2 reported the incident to him on 10/15/19; -He had interviewed client #3 and he said he had taken the mail with his name on it from the shelf in the kitchen because he thought it was a check; -Client #3 took the mail outside and informed staff #3 that he had taken it; -Staff #3 took the check from client #3 and went inside the facility; -Client #3 said he was trying to bust staff #3's head open; -Client #3 was not sure how he fell; -Staff #3 had not informed him that client #3 hit him with anything; -Staff #3 had contacted him the day of the incident (10/12/19) to inform him that client #3 had been drinking and was confrontational; -Staff #3 requested the QP visit client #3 but the QP was out of town so he advised the staff to attempt to deescalate the situation; -"He (staff #3) should have handled things differently regarding the mail;" -He had asked staff #3 to show him the stick that was used but the staff was unable to locate it; -Staff #3 had been removed from the schedule and suspended without pay since the incident and was going to be moved to a sister facility. Review on 11/6/19 of an In-House Investigational Document signed and dated by the Owner revealed: -"Date of Investigation: 10/18/19;" -"Date Occurred: 10/12/19;" -According to client #3, he took some mail without permission because it was addressed to him; -"Staff (#3) advised him (client #3) mail was from [public transportation] and needed to go through	V 512		

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the QP first before handing it to him (client #3) if need be;"
-Client #3 got frustrated and angry because the mail was addressed to him and he didn't want to wait for the QP to look at it;
-"Staff (#3) regardless took the mail from him with a promise to return it after it has been handled appropriately;"
-Staff #3 took the mail and went into the kitchen;
-Client #3 went outside and got a tree branch because he wanted to kill staff #3;
-Client #3 attempted to hit staff #3 with the tree branch but the staff caught the tree branch and tried to take it away from the client;
-Client #3 lost his balance and bumped into the stove;
-Staff #3 apologized and asked client #3 if he was ok but the client ignored the staff and went to his bedroom;
-"Client (#3) advises he noticed he was sore and reported the incident to the incoming staff on 10/16/19 when he came to work;"
-Based on interview with client #1, he heard client #3 screaming at staff #3 then he heard staff #3 say he was sorry;
-Based on interview with client #2, he heard client #3 yelling and saw him with a stick;
-Based on interview with client #4, staff #3 took some mail from client #3;
-Client #3 got mad and sat down in the living room;
-Client #3 then went outside the facility, grabbed a stick and hit staff #3;
-Staff #3 grabbed the stick and client #3 fell against the stove;
-Staff #3 said he was sorry a couple of times;
-"Summary: I would summarize/conclude from the investigations gathered, there was some physical contact between the staff (#3) and client (#3) while staff was trying to get the tree branch

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V 512	Continued From page 43 from him (client #3), which more than likely further escalated the situation resulting in the client bumping into the stove causing a bruise to his side...again, staff should have by procedure, shielded self and removed himself from the space but he advised he couldn't because he was cornered and absolutely did the best he could to help remedy the situation...unfortunately client lost his balance which resulted in the bruising to his side...client was taken to the doctor's office 10/18/19, no medications were prescribed and a follow-up recommended if client was not feeling better." Interviews on 11/6/19 and 11/7/19 with the Owner revealed: -Staff #2 had reported that there was an incident that involved client #3 and staff #3; -She interviewed staff #3 and he said client #3 took some mail and he informed the client that he had to give it back; -Staff #3 informed client #3 that the mail was going to be returned to him the following day; -Client #3 was mad and entered the kitchen with a tree branch; -Staff #3 grabbed the branch when client #3 attempted to hit him with it and attempted to take it away from the client; -She asked staff #3 why he didn't deescalate the situation and walk away and he said his back was turned to client #3 and when he turned around, the stick was already midair; -"It happened too fast, he couldn't do anything about it;" -She asked staff #3 why he didn't report the incident to the QP and he said after the incident he prepared supper and administered medications and forgot about it; -She interviewed client #3 and he said he took the mail because he didn't want to wait until the QP	V 512		

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V 512	Continued From page 44 looked at it; -Client #3's intention was to crack open staff #3's skull; -"Sometimes [client #3] will get in your face and scream at you ...he's never attacked anyone ...he's never been physical;" -The staff was still suspended even though she had determined the allegation of abuse was unsubstantiated; -She didn't understand why client #3's guardian was uncomfortable about staff #3 returning to the facility. Finding #2: Review on 11/15/19 of client #4's record revealed: -An admission date of 8/14/19; -Diagnoses included Schizophrenia, Depression, Moderate Cocaine Use Disorder, History of TBI and asthma; -The client had been declared incompetent and a guardian was appointed on 3/8/18. Review on 11/6/19 of an In-House Investigational Document signed and dated by the Owner on 10/9/19 revealed: -"Date Occurred: 10/7/19;" -"Staff [#3] advised that [client #4] had a guest to come over for a visit;" -"He (staff #3) failed to advise the QP that client [#4] had a guest but he let the visitation take place;" -"He (staff #3) then advised after an hour/at some point, he heard voices in client [#4's] room;" -"He (staff #3) knocked on the door and found out that client [#4's] guest was still there;" -"He (staff #3) asked guest to leave, but she wanted to stay longer;" -"When she (visitor) declined, and stated that she	V 512		

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wanted to stay longer, at that point staff (#3) tried forcing her to leave the facility, and a argument ensued;"
-"But, however he (staff #3) was able to get her (visitor) out of the facility;"
-She attempted to interview client #4 but he was upset regarding another issue and declined to talk;
-She interviewed client #4 the following day (10/9/19) and he verified that he had a visitor at the facility but denied that there was an issue during the visit.

Interviews on 11/6/19 and 11/8/19 with client #4 revealed:
-He had a female visitor that arrived at the facility at approximately 9:00 pm on 10/7/19;
-They visited in his bedroom for the entire visit and staff #3 had joined them for approximately the last hour;
-Staff #3 had been snorting cocaine with him in his bedroom;
-Staff #3 got mad at client #4's visitor because she refused to tell him whether she had ever been "a cutter;"
-Staff #3 told the visitor she had to leave but she told him she had to wait until her transportation arrived;
-Staff #3 grabbed her and pushed her against his bedroom wall which caused a hole in the wall;
-The visitor left and called 911;
-Staff #3 instructed all the clients to go to their rooms, turn off the lights and electronics and be quiet;
-When law enforcement arrived, staff #3 didn't open the door or answer his telephone.

Interviews on 11/7/19 and 11/14/19 with client #4's guardian revealed:
-Client #4 had informed her about the incident

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with his visitor the following day (10/8/19);
-She had not been notified of the incident by anyone at the facility;
-Her understanding was that there was aggressive behavior between staff #3 and the visitor;
-Client #4 had a history of telling lies so she was not sure whether he was being truthful or not.

Observation on 11/5/19 at 2:21 pm of client #4's bedroom revealed a hole approximately 2' x 3' in the paneling at the left of the door.

Interview on 11/4/19 with client #1 revealed:
-Client #4's girlfriend had visited the facility and they spent the entire visit in the client's bedroom which was against the rules;
-During the visit, he had observed staff #3 cutting cocaine on the dining room table and then going to the lower level of the facility where the staff bedroom and client #4's bedroom were located;
-He heard yelling and then the visitor left the facility;
-Staff #3 instructed the clients to go into their bedrooms, turn off all lights and electronics and be quiet;
-When law enforcement arrived at the facility, staff #3 didn't open the door or answer the telephone.

Interviews on 11/7/19 and 11/14/19 with client #1's guardian revealed client #1 didn't have a history of telling lies so she had no reason not to believe him.

Interview on 11/8/19 with staff #2 revealed he had never known client #1 to make up things so he had no reason not to believe him.

Review on 11/8/19 of an Incident/Investigation

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V 512	Continued From page 47 Report from law enforcement revealed: -"Date / Time Reported: 10/7/19 11:03 pm;" -"Crime Incident: Simple Assault;" -"Upon arrival I made contact with the victim [visitor], who was standing outside the residence in the street;" -"She advised that she was visiting a friend at the group home, [client #4];" - She reported that staff #3 had been spending time with her and client #4 in the client's bedroom; -She observed staff #3 snort powder cocaine while he was in the client's bedroom; -Staff #3 pointed out some scars on her arm and asked if she used to be a cutter but she refused to answer him; -Staff #3 became angry and informed her she was being rude and had to leave the facility; -She informed staff #3 that she wasn't able to leave until her transportation arrived; -Staff #3 grabbed her and started pushing her to get her out of the room; -"She stated that she was knocked into the bedroom wall and that there was a dent in the wall as a result of her hitting it;" -She had fled the facility and called 911; "I knocked on both the front and the side door to the residence several times but I was unable to get anyone to come to the door;" -"I also tried calling [staff #3] on the phone but he would not answer;" -A follow up interview was completed with the visitor on 10/15/19; -The officer observed pictures on the visitor's telephone of injuries she had received as a result of the incident; -The injuries consisted of very small scratches on her face and minor bruising on her arms. Interviews on 11/5/19, 11/6/19 and 11/8/19 with	V 512		

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V 512	Continued From page 48 the QP revealed: -He had not been made aware of any issues with client #4's visitor; -He had not been made aware that law enforcement had been called to the facility or that staff #3 had been observed with cocaine in the facility. Interviews on 11/6/19 and 11/7/19 with the Owner revealed: -Staff #3 had allowed a visitor of client #4 to visit without notifying the QP; -"He (staff #3) said he let her (the visitor) visit and told her she had 45 to an hour time;" -The visitor wanted to stay longer so there was a disagreement between staff #3 and the visitor; -"He (staff #3) said she (visitor) finally left;" -"He (staff #3) said she (visitor) came around 8:00 pm or a few minutes until 8:00 pm;" -Client #4's guardian wasn't notified of the incident because it had nothing to do with the client; -She had not been informed that law enforcement had been called to the facility or that the staff #3 was observed with cocaine in the facility. Review on 11/15/19 of a Plan of Protection signed and dated by the QP on 11/15/19 revealed: -"What will you immediately do to correct the rule violation in order to protect clients from further risk or additional harm? Staff (#3) has been removed from the facility and will not be returning to this home. Moving forward, criminal background checks and HCPR (Health Care Personnel Registry) will be done on timely manner as required. NOA will introduce para-professional competence for all para-professional. All Level II and III incidents will be reported to IRIS (Incident Response Improvement System) within recommended time	V 512		

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from the day and time reported.
-Describe your plans to make sure the above happens: SIC (Supervisor in Charge) will ensure all incident reports are reported into IRIS. SIC will ensure that all background check and documents are complete and accurate before hiring new staff. No new staffs will be hired until all above recommendations are met. SIC will ensure para-professional training is completed and para-professionals are informed of visitation policy."

This facility serves adult clients with mental health diagnoses. The diagnoses included Schizophrenia, Depression, Moderate Intellectual Developmental Disability, Moderate Cocaine Use Disorder, Marijuana Use Disorder, Alcohol Use Disorder, TBI, Hepatitis C, Coronary Artery Disease, Degenerative Disease, Diabetes, Human Immunodeficiency Virus (HIV) Hypertension, Gastroesophageal Reflux Disease, Vitamin D Deficiency, Hyperlipidemia, and Asthma. Staff #3 failed to use therapeutic methods when communicating with client #3, jerked mail from the client's hands, laughed at him and ultimately got into a physical altercation. Client #3 sustained bruising to his ribs as a result of being pushed by staff #3. Staff #3 failed to obtain medical care for client #3 and to contact the QP. Contradictory dates were provided regarding when the incident was reported. Staff #3 was observed by 2 clients and a visitor cutting and snorting cocaine in the facility on 10/7/19. Staff #3 had a physical confrontation with client #4's visitor which resulted in the staff pushing the visitor into the wall hard enough to cause a hole in the paneling. When law enforcement arrived, staff #3 instructed the clients to stay in their rooms with the lights off and be quiet. He refused to open the door or answer the telephone when

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V 512	Continued From page 50 law enforcement was trying to contact him. This deficiency constitutes a Type A1 rule violation for serious abuse and 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 administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		
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 observation and interviews the facility was not maintained in a safe and orderly manner. The findings are: Observation on 11/5/19 at approximately 2:21 pm revealed the following: -The window in the door of the living room was covered on the inside with 2 sheets of paper and 2 paper towels; -The middle bedroom on the main floor had no window coverings on either window; -The bedroom beside the bathroom on the main floor had 2 light bulbs that were not working; -The bedroom on the lower level had a hole in the wall that measured approximately 2' x 3'; -The light bulb over the kitchen sink was not	V 736		

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V 736	Continued From page 51 working; -There was a light bulb missing in the carport; -There was a bulb missing in the screened in smoking area; -In the yard behind the house was 3 love seats, 1 chair, 3 televisions, a mop bucket, an approximate 5' black plastic tubing, a window pane and a green recycle container filled with bricks and leaves. Interviews on 11/8/19 and 11/13/19 with the House Manager on revealed: -It was the responsibility of the Qualified Professional (QP) to report issues to him and it was his responsibility to correct the issues; -"I'm aware of these issues (issues observed);" -He had never noticed the paper or paper towels on the front door window; -"I'm assuming they were trying to keep cold air out;" -He was not sure why there were no window coverings in the middle bedroom; -He was aware there were light bulbs that were not working and missing and planned on checking on them; -He observed the hole in the lower level bedroom wall last week; -"I haven't scheduled that (repair of the hole);" -"That (hole in the wall) wasn't reported to me;" -He had observed the hole when he was checking the client's room for evidence of him smoking in his room; -The client that resided in the bedroom refused to inform him how the hole occurred; -The items lying in the back yard had been there approximately 2 weeks; -He had asked a staff member that owned a truck to take the items away, but he hadn't had time yet.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-334	A. BUILDING: _____ B. WING _____	R 11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOA HUMAN SERVICES III, INC	1847 WAYCROSS DRIVE WINSTON SALEM, NC 27106

(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) COMPLETE DATE
V 736	Continued From page 52 Interview on 11/6/19 with the QP revealed: -The issues observed except the hole in the lower level bedroom had all been reported to the House Manager; -He was not aware that there was a hole in the wall; -It was the responsibility of the House Manager to correct issues. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		