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	MHL036-239	A. BUILDING: _____ B. WING _____	10/15/2019

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FAIRVIEW HOME	1009 FAIRFIELD DRIVE GASTONIA, NC 28054

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on October 15, 2019. The complaint was substantiated (Intake #NC00156213). 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	On 6/25/2019 DC#3 was seen by his psychiatrist and was prescribed Valium 10mg QAM. The guardian was contacted for consent and stated she needed to speak with her father about the medication. The medication was delivered and 6/26/2019 and placed in pending orders in the Acuflo EMAR system. The QP and AD attempted several times to get in touch with the guardian to gain a consent or declination of consent. On 7/3/2019 AD contacted the guardian and she stated she needed to speak with her father (former guardian) before she would decide. On 7/5/2019 the AD spoke with DC#3 father about the medication and he stated he and the guardian had spoken and she would be giving consent. Due to the lack of a decision the medication was left in pending orders and the medication remained in the home. Due to the holiday weekend the pharmacist believed this was an oversite on the part of GRS Nursing staff and approved the medication that had	11/1/19
V 106	27G .0201 (A) (8-18) (B) 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: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for facility areas including special client activity	V 106		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendy Thrasher — TITLE: Assistant Director — (X6) DATE: 11/4/2019

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V 106	Continued From page 1 areas; and (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to implement their policy regarding use of medications. The findings are: Review on 10/15/19 of facility policy titled "Nursing: Protocol for medications changes in the group home" dated 5/1/18 revealed: -"When medication changes occur in the group home; there should be a written or verbal order by a physician. The nurse should be notified of any changes in the physician's orders i.e. (example) from a doctor's visit. When this dose has been approved by the team it will be started as soon as possible. The guardian should be notified of the medications and their consent should be obtained. The new medication should be obtained from the pharmacy and the nurse should be notified that the medication was brought to the group home. Staff should notify nursing when the new medications arrive at the homes. The nurse will verify the doctor's order with the pending orders in the E-mar (electronic medication administration record) system. Nursing will click on the pending order checking the start date and ending date and the correct name and dose of the medication. Nursing will click on the approval tab when this has been verified. After verification a phone call to the facility will be made to tell the staff a new mediation has been ordered. The	V 106	remained in pending orders for 11 days. GRS' Medication Administration Procedures have been changed to address failure of gain consent for a medication in a timely manner. Failure to gain consent for a medication within 72 hours of an order the following will occur, 1) Nursing will remove the medication from pending orders in he Acuflo EMAR System; 2) Nursing will removed the medication from the home until such time as consent has been granted or declined. The nursing staff and QP's were trained in the revised GRS Medication Administration procedures on 11/1/19. The QP and Nursing staff will monitor and act appropriately when consent is not obtained within 72 hours.	11/1/19

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V 106	Continued From page 2 staff should call nursing when this medication is delivered by the pharmacy. The med (medication) cards are placed in the med cart under the correct time of day that it is to be administered. A note should be left for the following shift that there has been a change." Review on 10/7/19 of Deceased Client #3's (DC#3) record revealed: -Admission date of 11/8/1996; -Deceased 9/19/19; -Diagnoses of Autism Disorder, Severe Intellectual Developmental Disability, Intermittent Explosive Disorder, Seizure Disorder, Elevated Cholesterol, Neurodermatitis, Seasonal Allergies, Onchomycosis, Bladder Spasms; -July, 2019 Medication Administration Record revealed DC#3 was administered Diazepam 10mg 1 tablet on 7/6/19 at 8am by the House Manager. -Medical consult report dated 8/16/19 revealed DC#3 was taken to a doctor appointment by facility staff accompanied by DC#3's Legal Guardian/Sister. DC#3 was agitated. DC#3's Legal Guardian/Sister was concerned regarding the use of Valium and wanted to explore increasing current medications prior to starting new medications. Review on 10/15/19 of Pharmacy's Medication Error Report dated 7/8/19 involving DC#3 revealed: -"GRS (Gaston Residential Services) (Licensee) had an unapproved med (medication) in pending while they were waiting for family approval to administer the medication. Pharmacy noticed the medication in pending and approved the medication thinking it was in pending due to a billing issue. Being approved by the pharmacy allowed the medication to be administered before	V 106		

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V 106	Continued From page 3 family consent was obtained;" Interview on 10/9/19 with DC#3's Legal Guardian/Sister revealed: -Staff at the facility administered Valium to DC#3 without consent. Interview on 10/8/19 with DC#3's Local Management Entity Care Coordinator revealed: -DC#3's Legal Guardian/Sister would not consent for the use of Valium. Interview on 10/10/19 with the Qualified Professional revealed: -DC#3's behaviors increased since late 2018; -Physician recommended the use of Valium to address the increase in DC#3's behaviors; -DC#3's Legal Guardian/Sister did not grant consent for the use of Valium; -Valium was administered on 7/6/19 as a result of the "error on pharmacy staff;" -The policy for a new medication is for it to be placed on pending status on the E-mar while the nurse obtains consent from the client's guardian; -The pharmacy removed the pending status from DC#3's E-mar; -Facility staff administered Valium to DC#3 because the pending status of the medication had been removed from the E-mar; -Valium was only administered one day and then discontinued when the error was discovered. Interview on 10/10/19 with the House Manager revealed: -When a medication appeared on the E-Mar and it was delivered to the facility, it was administered; -When consent has not yet been granted to administer a medication, it is marked "pending" on the E-mar; -Legal guardians and nursing must approve all	V 106		

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V 106	Continued From page 4 medications prior to "pending" status being removed. Interview on 10/15/19 with the Assistant Director and Executive Director revealed: -Acknowledged the concern with the administration of DC#3's Valium.	V 106		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	The plan on page 6 states that DC#3 current living environment and services appear to be working well for him. It continues to be successful for DC#3 to remain in a "low ratio setting" with consistent and familiar staffing. It goes on to say, "this is evidenced by the decrease in inappropriate behavior " episodes." GRS QP reported that he told the surveyor that DC#3's PLAN required 1 to 1 staff based on the way it was written. GRS QP states that staffing ratio (1 to 1) was NOT discussed during the plan meeting in June 2019. DC#3 had developed to the point of no longer needing 1 to 1 staff as evidenced by several prior years of behavior data. In times of crisis or elevated behavioral needs, the staffing ratio was lowered either	10/23/19

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V 112	Continued From page 5 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to implement treatment strategies affecting 1 of 1 deceased client (DC#3). The findings are: Review on 10/7/19 of DC#3's record revealed: -Admission date of 11/8/1996; -Deceased 9/19/19; -Diagnoses of Autism Disorder, Severe Intellectual Developmental Disability, Intermittent Explosive Disorder, Seizure Disorder, Elevated Cholesterol, Neurodermatitis, Seasonal Allergies, Onchomycosis, Bladder Spasms; -Treatment Plan revealed team meeting date of 6/7/19 with plan implementation effective 9/1/19. " ...[DC#3] requires 24-hour supervision with specialized trained staff including overnight awake staff trained in [DC#3]'s specific behavioral needs ...[DC#3] needs prompts to slow down while eating and chew his foods. [DC#3] still needs to be monitored closely in kitchen for safety ...[DC#3]'s behavioral needs are extreme...his behaviors are severe and requires a controlled environment and requires one-on-one staffing ..." Interview on 10/8/19 with DC#3's Local Management Entity Care Coordinator revealed: -Most current treatment plan revealed one-on-one staffing which was not something new to Gaston Residential Services (GRS) (Licensee); -One-on-one staffing was discussed at the annual meeting held in June, 2019; -GRS was aware of the level of supervision DC#3 required. Interview on 10/8/19 with Staff #4 revealed: -Was the only staff member with Client #1 and	V 112	by engaging the other persons served outside of the home or by adding staff into the home during parts of the day, sometimes creating a 1 to 1 staffing ratio. The BSP defines the targeted behaviors as aggression, leaving supervised area, self-injurious behavior, and agitation. These behaviors were not displayed on the day of death. Review of all the PCPs (annual plans) for all the people served in the Supported Living section was completed by October 18, 2019 by the QP's. Correction requests were submitted to the LME and are in the process of being approved and completed by the LME. -The Assistant Director met with the House Managers to review schedules and staffing needs on October 16th and 23rd.	10/18/19 10/23/19

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V 112	Continued From page 6 DC#3 on 9/19/19; -DC#3 passed away on 9/19/19; -Worked alone with Client #1 and DC#3 for the most part; -Client #1 and DC#3 were very challenging due to their behaviors; -Very hard for one person to care for both Client #1 and DC#3; -Client #1 and DC#3 required continuous supervision; -Did not know if Client #1 or DC#3 required one-on-one supervision. Interview on 10/8/19 with Staff #5 revealed: -Prior to Staff #5's arrival to the facility on 9/19/19, Staff #4 was the only staff with Client #1 and DC#3. Interview on 10/10/19 with the House Manager revealed: -Only one staff worked per shift with additional staff coming in to assist during the day; -DC#3 did not have a designated one-on-one staff. Interviews on 10/7/19 and 10/10/19 with the Qualified Professional revealed: -DC#3 required one-on-one staffing due to the higher intensity of services required and his behavioral issues; -Unsure of how many staff work each shift and deferred this question to the Assistant Director. Interview on 10/15/19 with the Assistant Director and Executive Director revealed: -DC#3 developed to a point when he no longer needed one-on-one staffing; -Not sure why it was indicated in the current treatment plan that DC#1 required one-on-one staffing;	V 112	The staff needs for each location is being met. The review of staffing needs is ongoing and part of the agenda of the weekly House Mangers meeting. -The Assistant Director met with the House Managers to ensure they understood the staffing needs of the individuals who live in their location. This was completed by October 22, 2019. -The Assistant Director met with the QP's on October 17, 2009 and reviewed the QP responsibility to ensure the plans written by the LME are accurate and reflect the actual current needs of the person served. The QP's are responsible for monitoring the plans for accuracy and staffing ratio's. QP's will ensure the plans are accurate and convey the correct information before signing. The QP will relay this information to the House Managers. The House Manager will ensure the correct staff ratios are maintained.	10/22/19 10/17/19

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V 112	Continued From page 7 -The one-on-one staffing noted in DC#3's current treatment plan was more of a historical marker and should have only been for when it was required as DC#3 was allowed alone time in his bedroom; -Believed DC#3 received adequate staff supervision. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 112	The AD will monitor to ensrue the staffing needs are being met.	
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which	V 289	The plan on page 6 states that DC#3 current living environment and services appear to be working well for him. It continues to be successful for DC#3 to remain in a "low ratio setting" with consistent and familiar staffing. It goes on to say, "this is evidenced by the decrease in inappropriate behavior " episodes." GRS QP reported that he told the surveyor that DC#3's PLAN required 1 to 1 staff based on the way it was written. GRS QP states that staffing ratio (1 to 1) was NOT discussed during the plan meeting in June 2019.	10/23/19

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V 289	Continued From page 8 serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).	V 289	DC#3 had developed to the point of no longer needing 1 to 1 staff as evidenced by several prior years of behavior data. In times of crisis or elevated behavioral needs, the staffing ratio was lowered either by engaging the other persons served outside of the home or by adding staff into the home during parts of the day, sometimes creating a 1 to 1 staffing ratio. The BSP defines the targeted behaviors as aggression, leaving supervised area, self-injurious behavior, and agitation. These behaviors were not displayed on the day of death. The QP stated the staffing ratio needs were not discussed during the plan. The QP told the surveyor that DC#3's PLAN required 1 to 1 staffing based on the way it was written. The QP's are responsible for monitoring the plans for accuracy and staffing ratio's. QP's will ensure the plans are accurate and convey the correct informaiotn before signing.	

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V 289	Continued From page 9 This Rule is not met as evidenced by: Based on interview and record review, the necessary care and treatment was not provided to individuals in the facility affecting 1 of 2 clients (Client #1) and 1 of 1 deceased client (DC#3). The findings are: CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on interview and record review, the facility failed to implement treatment strategies affecting 1 of 1 deceased client (DC#3). CROSS REFERENCE: 10A NCAC 27G .5602 Staff (V290) Based on interview and record review, the facility failed to implement staff-client ratios to enable staff to respond to individualized client needs affecting 1 of 2 clients (Client #1) and 1 of 1 deceased client (DC#3). Review on 10/7/19 of Client #1's record revealed: -Admission date of 9/7/03; -Diagnoses of Autism Disorder, Intermittent Explosive Disorder, Profound Intellectual Developmental Disability, Cornelia De Lange Syndrome, Raynaud's Syndrome, Seasonal Allergies. Review on 10/7/19 of DC#3's record revealed: -Admission date of 11/8/1996; -Deceased 9/19/19; -Diagnoses of Autism Disorder, Severe Intellectual Developmental Disability, Intermittent Explosive Disorder, Seizure Disorder, Elevated Cholesterol, Neurodermatitis, Seasonal Allergies, Onchomycosis, Bladder Spasms;	V 289	Review of all the PCPs (annual plans) for all the people served in the Supported Living section was completed by October 18, 2019 by the QP's. Correction requests were submitted to the LME and are in the process of being approved and completed by the LME. -The Assistant Director met with the House Managers to review schedules and staffing needs on October 16th and 23rd. The staff needs for each location is being met. The review of staffing needs is ongoing and part of the agenda of the weekly House Mangers meeting. -The Assistant Director met with the House Managers to ensure they understood the staffing needs of the individuals who live in their location. This was completed by October 22, 2019. -The Assistant Director met with the QP's on October 17, 2009 and reviewed the QP responsibility to ensure the plans written by the	10/18/19 10/23/19 10/22/19 10/17/19

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V 289	Continued From page 10 -Treatment Plan revealed team meeting date of 6/7/19 with plan implementation effective 9/1/19. " ...[DC#3] requires 24-hour supervision with specialized trained staff including overnight awake staff trained in [DC#3]'s specific behavioral needs ...[DC#3] needs prompts to slow down while eating and chew his foods. [DC#3] still needs to be monitored closely in kitchen for safety ...[DC#3]'s behavioral needs are extreme...his behaviors are severe and requires a controlled environment and requires one-on-one staffing ..." Review on 10/7/19 of the facility's Incident Reports revealed: -Incident report dated 9/19/19 regarding DC#3 completed through the North Carolina Incident Response Improvement System revealed: " ... [DC#3] was following staff (Staff #4) around the home as staff was trying to prepare [DC#3] and housemate to leave and run errands. [DC#3] was behind staff, and staff prompted [DC#3] to go get on his shoes so we could leave. [DC#3] appeared to turn to leave and go put on his shoes. So staff went to continue to assist housemate to prepare to leave. [DC#3] suddenly grabbed staff from behind. Staff stumbled and prompted [DC#3] to let her go. Staff continued to prompt [DC#3] as her and [DC#3] was going down into the kitchen floor. Staff realized that [DC#3] was not responding, so staff rolled him over to get him off of her. Staff observed that [DC#3] wasn't breathing and began to perform chest compression. Housemate was standing over [DC#3] and staff making noises. Staff prompted housemate to "Go get the phone!" Staff continued chest compression's, while still prompting housemate to get the phone. Staff continued chest compression's with one hand while returning to her call log to call co-worker to	V 289	LME are accurate and reflect the actual current needs of the person served. The QP will relay this information to the House Managers. The House Manager will ensure the correct staff ratios are maintained. The AD will monitor to ensrue the staffing needs are being met.	

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FAIRVIEW HOME	1009 FAIRFIELD DRIVE GASTONIA, NC 28054

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V 289	Continued From page 11 get help. Staff continued chest compression's until help arrived and 911 and on-call (supervisor) was called. Residential QP (Qualified Professional) arrived and helped w/ (with) CPR (cardiopulmonary resuscitation) until EMT (emergency medical technician) arrived ..." Review on 10/7/19 of the written statement dated 9/20/19 written by Staff #4 regarding the incident on 9/19/19 revealed: -Was in the facility with Client #1 and DC#3 waiting for the carpet cleaning company to finish work at the facility; -Staff #4 was in the common living areas (dining room, living room, sunroom, and kitchen) of the facility with Client #1 and DC#3; -Client #1 went outside on the driveway; -Was watching through the sunroom window to ensure Client #1 was not on the driveway as the carpet cleaning company packed their van and departed from the facility; -Called Staff #5 on the phone to alert Staff #5 to come to the facility as planned; -Prompted DC#3 to put on his shoes for the planned outing; -Turned to help Client #1 as he returned inside; -Was grabbed from behind by DC#3 and fell to the floor with DC#3 falling on top of Staff #4; -Rolled DC#3 off and noticed DC#3 appeared to be vomiting and was not breathing normally; -Straightened DC#3's body on the floor and started chest compressions; -Made continuous prompts to Client #1 to get a phone to call for assistance; -Client #1 eventually retrieved a phone for Staff #4 to call for assistance. Review on 10/7/19 of the written statement dated 9/20/19 written by the Qualified Professional regarding the incident on 9/19/19 revealed:	V 289		

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V 289	Continued From page 12 -" ...I observed as EMT attempted to revive [DC#3] and overheard the medic who was trying to intubate him state that she couldn't get the tube in due to a great amount of peanut butter being lodged in his throat ..." Review on 10/7/19 of the written statement dated 9/20/19 written by the Registered Nurse/Director of Nursing regarding the incident on 9/19/19 revealed: -" ...Upon entering the house (facility), [DC#3] was noted to be in the kitchen floor, on his back, shirtless, and emergency personnel were administering manual compressions and providing rescue breath via bag valve mask. During my observation of this, I heard the EMTs reporting to each other that [DC#3] remained in asystole. Manual compressions were shortly replaced with the LUCAS device. The EMTs attempted to intubate [DC#3] several times but was unsuccessful and they were stating 'there is too much peanut butter, I can't see anything.' After several attempts of intubation and [DC#3] remaining in asystole, [DC#3] was transferred to a back board by the EMTs, placed on a stretcher, and loaded into an ambulance ..." Interview on 10/8/19 with DC#3's Legal Guardian/Sister revealed: -Received a phone call on 9/19/19 and was told DC#3 collapsed on the floor and no further information was available; -Arrived at the hospital and was informed by the emergency room physician DC#3 had passed away after choking on peanut butter; -DC#3 had a history of eating condiments; -DC#3's behaviors increased over the past year and intensified. Interview on 10/8/19 with DC#3's Local	V 289		

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V 289	Continued From page 13 Management Entity Care Coordinator revealed: -Most current treatment plan revealed one-on-one staffing which was not something new to Gaston Residential Services (GRS) (Licensee); -One-on-one staffing was discussed at the annual meeting held in June, 2019; -GRS was aware of the level of supervision DC#3 required. Interview on 10/8/19 with Staff #4 revealed: -Was the only staff member with Client #1 and DC#3 on 9/19/19; -DC#3 passed away on 9/19/19; -Worked alone with Client #1 and DC#3 for the most part; -Client #1 and DC#3 were very challenging due to their behaviors; -Very hard for one person to care for both Client #1 and DC#3; -Client #1 and DC#3 required continuous supervision; -Was very attentive when Client #1 and DC#3 ate due to choking concerns; -DC#3 would put as much food on his spoon and attempt to swallow the food and would end up gagging because he was eating too quickly; -Did not know if Client #1 or DC#3 required one-on-one supervision. Interview on 10/8/19 with Staff #5 revealed: -Was on her way to the facility from a sister facility in order to assist Staff #4 with switching agency vans; -Received a call from Staff #4 on 9/19/19 at approximately 10:00am telling Staff #5 to hurry up because something was happening with DC#3; -DC#3 was lying on the floor on his back with Staff #4 completing chest compressions when Staff #5 entered the facility kitchen; - Staff #4 was out of breath;	V 289		

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V 289	Continued From page 14 -Prior to Staff #5's arrival to the facility, Staff #4 was the only staff with Client #1 and DC#3. Interview on 10/10/19 with the House Manager revealed: -Only one staff worked per shift with additional staff coming in to assist during the day; -DC#3 did not have a designated one-on-one staff. Interviews on 10/7/19 and 10/10/19 with the Qualified Professional revealed: -DC#3 obsessed on food and drinks and was impulsive; -DC#3 required one-on-one staffing due to the higher intensity of services required and his behavioral issues; -Client #1 and DC#3 were home daily without attending day program; -DC#3's behaviors increased since late 2018; -DC#3 was currently undergoing some behavioral challenges and medication changes; -Unsure of how many staff work each shift and deferred this question to the Assistant Director. Attempted interview on 10/9/19 with Client #1 was unsuccessful as Client #1 was non-verbal. Interview on 10/7/19 with the Assistant Director revealed: -Was still waiting for a death certificate for DC#3; -An autopsy was ordered for DC#3 but it could take months for the results of the autopsy; -DC#3 choked on peanut butter; -DC#3 died on 9/19/19. Interview on 10/15/19 with the Assistant Director and Executive Director revealed: -DC#3 developed to a point when he no longer needed one-on-one staffing;	V 289		

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V 289	Continued From page 15 -Not sure why it was indicated in the treatment plan that DC#1 required one-on-one staffing; -The one-on-one staffing noted in DC#3's current treatment plan was more of a historical marker and should have only been for when it was required as DC#3 was allowed alone time in his bedroom; -Believed DC#3 received adequate staff supervision. Review on 10/15/19 of the Plan of Protection dated 10/15/19 written by the Assistant Director revealed: "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -A review of all plans will take place to ensure the information is accurate in regards to staffing that meets the needs of the person. -Review staff schedules to ensure staffing needs are met. -Meet with house managers to ensure they understand the staffing needs of their home. Then do weekly meetings. -Review with QP (Qualified Professional) monitoring of plans written by others to ensure accuracy. Describe your plans to make sure the above happens. -The QP's will review plans for all the people served by GRS (Gaston Residential Services) (Licensee) to ensure staffing needs and other needs are met. They will complete a check off of this processes to be completed by October 18, 2019. -The Assistant Director will meet with the house managers to review schedules to ensure staffing is provided. This will be done October 16 and a follow up meeting will occur Oct. 23. This will be an ongoing meeting.	V 289		

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V 289	Continued From page 16 -The Assistant Director will meet with all HM (House Managers) individually to ensure they understand the staffing needs of their assigned location by Oct 22nd 2019. -The Assistant Director will meet individually with the QP's to provide training of review of plans and provide documentation by Oct 17, 2019." Deceased Client #3 (DC#3) was a 49-year-old who required one-on-one supervision. He resided with the Licensee for over 20 years. He had a history of eating condiments and gagging on food as a result of eating too quickly. He obsessed about food and drinks and was highly impulsive. His diagnoses included Autism Disorder, Severe Intellectual Developmental Disabilities, Intermittent Explosive Disorder, and Seizure Disorder. Client #1's diagnoses included Autism Disorder, Intermittent Explosive Disorder, and Profound Intellectual Developmental Disability. The facility did not implement one-on-one staffing identified in DC#3's current treatment plan. In failing to provide the one-on-one staffing, the necessary ratio to meet Client #1's and DC#3's supervision needs were not maintained. As a result of the lack of necessary supervision, DC#3 was able to ingest peanut butter, choked, and died. Staff #4 had to rely on Client #1 to secure a telephone so Staff #4 could call for emergency assistance. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $8,000.00 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 289		

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V 290	Continued From page 17	V 290	The plan on page 6 states that DC#3 current living environment and services appear to be working well for him. It continues to be successful for DC#3 to remain in a "low ratio setting" with consistent and familiar staffing. It goes on to say, "this is evidenced by the decrease in inappropriate behavior " episodes." GRS QP reported that he told the surveyor that DC#3's PLAN required 1 to 1 staff based on the way it was written. GRS QP states that staffing ratio (1 to 1) was NOT discussed during the plan meeting in June 2019. DC#3 had developed to the point of no longer needing 1 to 1 staff as evidenced by several prior years of behavior data. In times of crisis or elevated behavioral needs, the staffing ratio was lowered either by engaging the other persons served outside of the home or by adding staff into the home during parts of the day, sometimes creating a 1 to 1 staffing ratio.	10/23/19
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on	V 290		

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V 290	Continued From page 18 duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to implement staff-client ratios to enable staff to respond to individualized client needs affecting 1 of 2 clients (Client #1) and 1 of 1 deceased client (DC#3). The findings are: Review on 10/7/19 with Client #1 revealed: -Admission date of 9/7/03; -Diagnoses of Autism Disorder, Intermittent Explosive Disorder, Profound Intellectual Developmental Disability, Cornelia De Lange Syndrome, Raynaud's Syndrome, Seasonal Allergies. Review on 10/7/19 of DC#3's record revealed: -Admission date of 11/8/1996; -Deceased 9/19/19; -Diagnoses of Autism Disorder, Severe Intellectual Developmental Disability, Intermittent Explosive Disorder, Seizure Disorder, Elevated Cholesterol, Neurodermatitis, Seasonal Allergies, Onchomycosis, Bladder Spasms; -Treatment Plan revealed team meeting date of 6/7/19 with plan implementation effective 9/1/19. " ...[DC#3] requires 24-hour supervision with specialized trained staff including overnight awake staff trained in [DC#3]'s specific behavioral needs ...[DC#3] needs prompts to slow down	V 290	The BSP defines the targeted behaviors as aggression, leaving upervised area, self-injurious behavior, and agitation. These behaviors were not displayed on the day of death. The QP stated the staffing ratio needs were not discussed during the plan. The QP told the surveyor that DC#3's PLAN required 1 to 1 staffing based Review of all the PCPs (annual plans) for all the people served in the Supported Living section was completed by October 18, 2019 by the QP's. Correction requests were submitted to the LME and are in the process of being approved and completed by the LME. -The Assistant Director met with the House Managers to review schedules and staffing needs on October 16th and 23rd.	10/18/19 10/23/19

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V 290	Continued From page 19 while eating and chew his foods. [DC#3] still needs to be monitored closely in kitchen for safety ...[DC#3]'s behavioral needs are extreme...his behaviors are severe and requires a controlled environment and requires one-on-one staffing ..." Interview on 10/8/19 with DC#3's Local Management Entity Care Coordinator revealed: -Most current treatment plan revealed one-on-one staffing which was not something new to Gaston Residential Services (GRS) (Licensee); -One-on-one staffing was discussed at the annual meeting held in June, 2019; -GRS was aware of the level of supervision DC#3 required. Interview on 10/8/19 with Staff #4 revealed: -Was the only staff member with Client #1 and DC#3 on 9/19/19; -DC#3 passed away on 9/19/19; -Worked alone with Client #1 and DC#3 for the most part; -Client #1 and DC#3 were very challenging due to their behaviors; -Very hard for one person to care for both Client #1 and DC#3; -Client #1 and DC#3 required continuous supervision; -Did not know if Client #1 or DC#3 required one-on-one supervision. Interview on 10/8/19 with Staff #5 revealed: -Prior to Staff #5's arrival to the facility on 9/19/19, Staff #4 was the only staff with Client #1 and DC#3. Interview on 10/10/19 with the House Manager revealed: -Only one staff worked per shift with additional	V 290	The staff needs for each location is being met. The review of staffing needs is ongoing and part of the agenda of the weekly House Mangers meeting. -The Assistant Director met with the House Managers to ensure they understood the staffing needs of the individuals who live in their location. This was completed by October 22, 2019. -The Assistant Director met with the QP's on October 17, 2009 and reviewed the QP responsibility to ensure the plans written by the LME are accurate and reflect the actual current needs of the person served. The QP will relay this information to the House Managers. The House Manager will ensure the correct staff ratios are maintained. The AD will monitor to ensrue the staffing needs are being met.	10/22/19 10/17/19

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V 290	Continued From page 20 staff coming in to assist during the day; -DC#3 did not have a designated one-on-one staff. Interviews on 10/7/19 and 10/10/19 with the Qualified Professional revealed: -DC#3 required one-on-one staffing due to the higher intensity of services required and his behavioral issues; -Unsure of how many staff work each shift and deferred this question to the Assistant Director. Interview on 10/15/19 with the Assistant Director and Executive Director revealed: -DC#3 developed to a point when he no longer needed one-on-one staffing; -Not sure why it was indicated in the current treatment plan that DC#1 required one-on-one staffing; -The one-on-one staffing noted in DC#3's current treatment plan was more of a historical marker and should have only been for when it was required as DC#3 was allowed alone time in his bedroom; -Believed DC#3 received adequate staff supervision. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 290		