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ADVENTURE HOUSE	924 N. LAFAYETTE STREET SHELBY, NC 28150

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V 000	INITIAL COMMENTS A complaint survey was completed on November 14, 2019. On 10/23/19, the number of clients audited was 8 and on 11/6/19, the number of additional clients audited was 8 for a total number of 16 audited clients for this survey. The complaint was substantiated (intake #NC00157116). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1200 Psychosocial Rehabilitation Facilities for Individuals with Severe and Persistent Mental Illness.	V 000		
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	V 109		

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V 109	Continued From page 1 employment system in the State Plan for MH/DD/SAS. (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 record review and interview, the facility failed to ensure 4 of the 6 Qualified Professionals (Executive Director (ED)/QP#1, Associate Director/QP #2, Program Coordinator/QP #3 and Case Manager/QP #5) demonstrated the knowledge, skills and abilities required by the population served. The findings are: Review on 11/12/19 of the ED/QP #1's personnel record revealed: -Hired: 12/15/86; -Education: Master of Science (M.S.) Degree in Psychology; -His written job description was dated and signed 6/30/92 with a reviewed date on 9/23/05; -The review date included a written statement that indicated there were no changes made to his job description by the facility's Board of Directors; -His job responsibilities gave him authority to manage the overall direction, supervision and coordination of the staff and operations which included: -control of staff functions; -the allocation of staff ;	V 109		

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V 109	Continued From page 2 -authority to act on staff problems and/or needs; -ensuring staff were trained and supervised to work with facility clients; -client advocacy with other human service agencies; -the provision of client case management functions (budgeting activities, client referrals to medical and mental health providers, ensuring client engagement in pre-vocational work activities). Review on 11/12/19 of the Associate Director/QP #2's personnel record revealed: -Hired: 11/5/03; -Education: Master of Arts Degree; -Licensed Professional Counselor (LPC) since 7/1/02; -Her written job description was dated and signed on 6/3/13 and designated her with the ED/QP #1's administrative and management job responsibilities in his absence. Review on 11/12/19 of the Program Coordinator/QP #3's personnel record revealed: -Hired 12/1/17; -Education: Bachelor's Degree in Sports Medicine; -Her written and signed job description dated 5/1/18 included her following job duties: -Provide structure, direction and engagement to clients in each of the pre-vocational work units (administrative, kitchen, snack bar and member services) to ensure the required work tasks of each unit was completed; -Secure transitional job placements for clients, learn the client job duties by the employers to assess the appropriateness of jobs for client placements, and train clients on their jobs until clients were able to handle the job alone; -Provide a community support service to clients	V 109		

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which have clients linked to various community resources based on their individual needs and advocate for clients to receive services in the community;
-Document the provision of client services provided through formats such as completion of treatment plans, progress notes and termination summaries;
-Handle "difficult" client cases in which clients have become disruptive and assure appropriate mental health treatment services are made available to clients as needed.

Review on 11/12/19 of the Case Manager/QP#5's personnel record reveled:
-Hired: 6/18/18;
-Education: Master's degree in Vocational Rehabilitation Counseling;
-Her written job description dated 6/18/18 had her providing a community support service which was to:
-be provided to individual clients or groups of clients in "any location;"
-be focused on the strengths, talents and skills of clients;
-to motivate clients to become active in the community;
-assist clients with various "skill building" activities which included development of leisure time interests and activities, substance abuse recovery education and wellness education;
-assist in the development of client treatment plans.

Review on 10/23/19 of a voice mail message and interview on 10/23/19 with Former Client (FC #1) revealed:
-The voice mail message was on his cell phone;
-He placed the message in a conference call format to be reviewed;

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-He forwarded the voice mail message to Surveyor #2's work cell phone;
-The voice message was the voice of the Associate Director/QP #2 with the following statements:
  -"You will not be allowed back at the Clubhouse;"
  -"And we heard from the drug dealer down the street that's related to one of our staff that if you come back down there, he will have you robbed and beaten up;"
  -"So you've kinda reaped what you have sown here. Hate that for you;"
  -"You need to get an assessment for your drug abuse and anger issues before anything of this will change for you. Sorry about that. Bye-bye;"
-FC #1 confirmed the voice of the voice mail message was that of the Associate Director/QP #2;
-She left this message on his cell phone on 10/18/19.

Interview on 10/24/19 with Staff #1 revealed:
-He started work as a Rehabilitation Specialist at the facility on 4/15/19;
-His job duties included helping clients in the kitchen to prepare and serve the breakfast and lunch meals, and to write client weekly and monthly progress notes;
-He had a caseload of 8-12 clients;
-His direct supervisor was the Program Coordinator/QP #3;
-The Program Coordinator/QP #3 handled client or facility issues before the issues went to the ED/QP #1.

Interview on 11/7/19 with the Case Manager/QP #5 revealed:
-She was considered PSR (psychosocial rehabilitation) facility staff;

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V 109	Continued From page 5 -She assumed the Case Manager position on 6/18/18 and had prior work experience as a rehabilitation counselor and specialized in mental health counseling; -The Associate Director/QP #2 was in her position prior to her hire and community support service was included as a service provided by her position at one time to the clients to link them to the community services they needed to support their independence in the community; -Her position was filled with medication management duties for 8 facility clients; -She did not have time to provide additional community support services to other clients; -She helped the Associate Director/QP #2 type up client clinical assessments and treatment plans; -"Most" of the clients served by the facility were diagnosed with Schizophrenia; -"Some" of the clients were "lazy," and "some (clients) were getting ready to decompensate," which meant they were ready to "spiral down and end up in the hospital;" -The clients who tended to decompensate came to the program and sat around and did not want to get up which a client did not have to do. Interview on 10/23/19 with Staff #3 revealed: -The ED/QP #1 reviewed client referrals for admission from the local mental health providers and made the decisions whether a client was admitted to the facility; -She developed the initial treatment plan with new clients and/or their legal guardians; -A Qualified Professional (QP) on staff reviewed and signed each initial and revised client treatment plan; -A QP was responsible for updating client treatment plans. Interview on 10/24/19 with the Program	V 109		

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V 109	Continued From page 6 Coordinator/QP #3 revealed: -She did not supervise the Rehabilitation Specialist positions; -Her job duties were to ensure the staff had the supplies (utensils, whiteboards, computers were operational) needed to do their jobs; -Staff and clients did the work of the facility side-by-side which was the clubhouse model; -In the clubhouse model, there was no supervision hierarchy except for the ED/QP #1; -As a QP, her job duties included updating client treatment plan and reviewing weekly client progress notes; -She indicated an awareness about facility clients having walked away from the facility; -It was the client's choice if a client decided to walk away from the program; -If a client had a guardian and the client needed more one-on-one supervision, the facility was not the place for the client; -They did not keep a list of what clients were allowed to leave the program; -The facility averaged 44 clients a day who came and went from the program; -She and the other facility staff could not watch every client every day; -Some guardians were okay for their clients "to come and go" from the facility. Interviews on 10/24/19, 10/31/19, 11/6/19, 11/8/19 and 11/12/19 with the Associate Director/QP #2 revealed: -10/24/19, Clients' legal guardians were informed at admission that they would be notified by staff if the client they were guardian for walked off from the facility; -This notification from staff occurred if a staff knew for certain a client walked away; -There were 40-50 clients who attended the facility on average a day and not all the clients	V 109		

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could be watched by every staff every moment;
-There was a written incident about FC #2 and his "suspected" marijuana in the restroom on 10/10/19 but the substance was not proven to have been marijuana;
-She did not know whether his guardian was notified about the incident;
-FC #2's legal guardian chose for him not to return to the facility and the guardian's decision was not related to the 10/10/19 incident with the suspicion of the marijuana;
-Because staff were not equipped to provide substance abuse treatment, clients were referred to their local mental health provider for this treatment;
-She made the ED/QP#1 aware of FC #1's statement a couple of months ago in front of his peers and staff that he smoked weed to treat his Bipolar;
-She referred FC #1 back to his local mental health provider for his anger issues and his substance use by his own admission;
-She made this referral to FC #1 when she called him and told him he could not return to the facility;
-She did not produce printed or written staff referrals for clients to their mental health provider for presenting substance abuse issues when requested on 10/31/19;
-She did not communicate with FC #1's mental health provider about these presenting problems because it was FC #1's responsibility to go his therapist to get these issues addressed;
-The focus of the facility was to help him and the other clients keep busy working in one or more of the work units;
-10/31/19, she saw Client #9 and FC #2 walk together to a store located below her office;
-Client #9 bought 2 beers and brought 1 beer back onto the facility and placed it in her locker;

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V 109	Continued From page 8 -Client #9 and FC #2 each had a history of illicit substance use but the facility was built on a clubhouse model that did not address client substance abuse; -She did not notify Client #9's and FC #2's guardians because she did not want to be known as a "snitch;" -Clients #3, #4 and #9's plans may have not been completed or their plans may not have been picked up from the physician's office where they were taken to be signed by a physician for medical necessity; -"We sat down yesterday and split up the remaining ones so one person wouldn't have them all to do at one time;" -She would have the updated treatment plans brought to the facility by the billing specialist; -11/6/19, Client #9's plan was sitting in her files or the plan was on her office desk; -11/8/19, she was the ED/QP#1's designee as Director in his absence; -The ED/QP #1 was sick on this date, 11/8/19, and at the doctor, and had not planned to come into work; -She did not have access to the staff personnel records for surveyor review because she did not know where the key to the personnel file was located; -She had an additional job responsibility as the Quality Assurance/ Quality Improvement (QA/QI) Coordinator; -She assumed this responsibility when their former QA/QI Coordinator retired last Fall; -As QA/QI Coordinator, she had the responsibility to ensure facility policies were reviewed and carried out accurately by the staff and clients; -She left FC #1 a voice mail message on his	V 109		

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cell phone that he was not allowed to return to the facility;
-The ED/QP #1 made the decision for FC #1 not to return to the facility;
-Her voice mail message to him referred him back to his clinical home which was his local mental health provider;
-11/12/19, the client treatment plans might have read the same because they were developed at each client's admission and used for the 1st 30 days for staff to get to know each client better and then update their treatment plan;
-She was certain she had referred FC #1 back to his local mental health provider when she left him a voicemail message on his telephone that he was not to return to the facility, and he needed help with his anger and substance use issues.

Interviews on 10/31/19, and 11/6/19 with the ED/QP #1 revealed:
-10/31/19, "We are a rehabilitation program and not a treatment program;"
-Individuals who came to the facility were diagnosed with severe and persistent mental illnesses;
-Their mental illnesses usually had an onset in their late teens so they had already learned the basic skills like personal hygiene to care for themselves;
-Each individual member (client) needed to have a reason to come to the facility to use the skills they had;
-"Most" of the clients his facility served were clients who had been hospitalized for 1-2 years and after their hospital discharge, found themselves sitting at home all day watching television;
-These were the clients the facility "celebrated" because they had moved from their couch at home to the couch at the facility and had people

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around them;
-Staff focused on existing client strengths, talents and skills;
-A focus on skills they did not have and skills that needed to be developed was to focus on their deficits and diminished a client's dignity;
-The facility operated a "clubhouse model," which meant the clients worked "meaningful work-ordered activities" (pre-vocational tasks) alongside staff which included answering telephones, helping cook the meals, waiting tables, helping staff with attendance paperwork, contacting clients who had been absent 3 or more days from the program;
-Clients signed up to volunteer for their work activities and they were not paid for their work unless they worked in the community in either a transitional employment or in a supportive employment placement;
-Because clients were on medications and had co-occurring medical and mental health conditions, it was not unusual for them to do an hour of work activity and rest most of the day;
-It was a client's choice of what work, educational and group social activities they engaged in as part of their facility plan;
-11/6/19, Client #9 who was incompetent walked away from the facility this morning;
-Staff #2 notified her caretaker who notified Client #9's legal guardian;
-Her legal guardian met her at the facility and told her that if she walked off from the program again, she would have to go into a nursing home;
-Client #9 agreed not to leave the property;
-He could not stop a client if a client chose to walk away from the facility;
-"We communicated with the guardian and the guardian chose for their person to continue in the program;"
-"The guardian begged us to let her continue in

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the program;"
-He acknowledged he reviewed the client screening forms for admission of clients who had mental health diagnoses which were "severe and persistent;"
-He made the final decision whether a client was sent home and/or expelled from the facility;
-He gave clients opportunities to correct their behaviors before he considered expulsion from the facility as long as a client did not interfere with another client at the facility;
-FC #1's threatening behavior was his "life choice" for how he dealt with people and not about his mental health diagnoses;
-If a client used an illicit drug but the client's behavior did not interfere with another client's rehabilitation, there was nothing he could do except send the person home and tell them not to bring the illicit drug or alcohol back onto the facility property;
-"We're a mental health program, not a substance abuse treatment program;"
-If he was assured from a client that they would not bring their alcohol or illegal drugs to the program, he gave the client an opportunity to return to the program;
-FC #1 and Client #3 were involved with the incident with FC #2 getting what was thought to be marijuana from someone who came onto the property of the facility and 1 of the 2 clients (FC #1) chose not to come back after the incident;
-FC #1 was expelled from the program because he made threats to harm Client #5 and not because of his substance use.

This deficiency is cross-referenced into 10A NCAC 27G .1201 Scope (V174) for a Type A1 rule violation and must be corrected within 23 days.

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V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to develop individualized treatment plans for 5 of 8 audited clients (Clients #3, #4, #6, Former Client (FC#1) and FC#2, and failed to implement strategies to	V 112		

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V 112	Continued From page 13 meet the needs of 7 of 8 audited clients (Clients # 3, #4, #6, #7, #9, FC #1 and FC #2). The findings are: Review on 10/24/19 of Client #3's record revealed: -Date of admission: 11/26/18; -Diagnoses: Schizophrenia, Cannabis Use Disorder, Tobacco Use Disorder, Cardiomyopathy, Obesity, Vitamin D Deficiency, and History of Tachycardia; -A 11/26/18 written screening and assessment had him with constricted affect and anxious thoughts that were "impoverished," concrete and delusional, and a need for socialization; -His 11/26/18 treatment plan included the following strategies which staff would assist him with: -activities of interest to him; -one-on-one assistance; -supervision and direction to complete tasks; -feedback related to his interactions with peers; -helping him keep goals in sight and assistance with plans to begin meeting his goals; -participation in social program activities to practice and develop social skills; -provide feedback related to his personal care goals; -assistance with development of new or additional goals; -opportunity for educational goals to be evaluated and/or options examined; -a written statement on the 1st page to "See Clinical Service Plan;" -There was no written clinical service plan attached to or added as an addendum to his 11/26/18 treatment plan; -There was no documentation his legal guardian was involved and/or had reviewed his treatment plan;	V 112		

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V 112	Continued From page 14 -No written and updated treatment plan was produced when requested on 10/31/19 and 11/6/19; -There were no written vocational, transitional and/or supported employment assessments that indicated his vocational level of functioning. Review on 10/31/19 of Client #3's written and signed weekly progress notes from 7/9/19 to 10/8/19 revealed: -His notes were completed by Staff #5, a PSR rehabilitation specialist, and these notes were signed by various Qualified Professional (QP) staff; -During the week of 7/9/19-7/16/19, he expressed his interest to Staff #5, about a transitional employment placement in the local community and he was told by Staff #5 to contact Social Security to find out how the wages from the job placement would affect his current income; -There was no documentation that indicated his vocational skills had been assessed or what skills he needed to be trained on to perform the job; -There was no documentation which indicated staff had evaluated or worked with him on his educational goal; -His participation at the facility had him volunteering in various pre-vocational work tasks that included sweeping and mopping the floors, cleaning the restrooms, making inventory of facility supplies, and showing new clients how to do work tasks; -During the weeks of 7/30/19 and 8/6/19, he was noticed by the Program /QP #3 becoming self-isolated and "more reserved" while at the facility while the staff (not identified) observed he sat around, stared and "slept most of the day;" -He did not participate in the facility's social activities which was a strategy included in his treatment plan to meet his socialization goal.	V 112		

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V 112	Continued From page 15 Review on 10/24/19 of Client #4's record revealed: -Date of admission: 12/18/18; -Diagnoses: Bipolar Disorder with psychotic features, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Developmental Disability Delay, Post-Traumatic Stress Disorder (PTSD), Attachment Disorder with severe mood and behavioral dysregulation, Morbid Obesity, and Type 2 Diabetes; -A 12/18/18 written screening and assessment indicated her hospital admission was related to her elopement behavior and her symptoms of anxiety and depression and her hospital discharge plan recommended a psychosocial rehabilitation (PSR) program for socialization and occupational training; -Her 12/18/18 treatment plan included the following strategies which staff would assist her with: -activities of interest to her; -one-on-one assistance; -supervision and direction to complete tasks; -feedback related to her interactions with peers; -helping her keep goals in sight and assistance with plans to begin meeting her goals; -arrange for participation in social program activities to practice and develop social skills; -provide feedback related to her personal care goals; -assistance with development of new or additional goals; -provide opportunity for educational goals to be evaluated and/or options examined; -a written statement on the 1st page to "See Clinical Service Plan;" -There was no written clinical service plan attached to or added as an addendum to her 12/18/18 treatment plan;	V 112		

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V 112	Continued From page 16 -There was no documentation his legal guardian was involved and/or had reviewed her treatment plan; -No written and updated treatment plan was produced when requested on 10/31/19 and 11/6/19; -There were no written vocational, transitional and/or supported employment assessments that indicated her vocational level of functioning. Review on 10/31/19 of Client #4's weekly written and signed progress notes for the period from 9/3/19 to 10/15/19 revealed: -Her weekly notes were completed and signed by Staff #2, a rehabilitation specialist, and signed by the Program Coordinator/QP #3; -She volunteered to work a variety of tasks in 1 of 4 of the facility's pre-vocational work units (kitchen unit); -She declined to work "most days" due to her wanting to socialize with her peers or sit and sleep in her unit; -During the week of 9/3/19-9/10/19, she struggled with her decision-making skills "after getting high with her peers and (she) came back bragging to all her peers about getting high and was very loud and disruptive;" -There was no documentation in her note that indicated how Staff #2 followed up with Client #4 to assist in her decision-making skills and helped her address her substance use behaviors. Review on 10/31/19 of Client #6's record revealed: -Date of admission: 5/15/19 -Diagnoses: Panic Disorder, Asthma, Hypertension and Bone Spurs -She was admitted on 5/15/19 and diagnosed with Panic Disorder, Asthma, Hypertension, and Bone Spurs;	V 112		

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V 112	Continued From page 17 -A 5/15/19 written screening and assessment had her anxiety and panic attacks which were related to situational stressors of homelessness, unemployment and no income; -Her 5/15/19 treatment plan included the following strategies which staff would assist her with: -assistance with activities of interest to her; -one-on-one assistance; -supervision and direction to complete tasks; -feedback related to her interactions with peers; -helping her keep goals in sight and assistance with plans to begin meeting her goals; -arrange for participation in social program activities to practice and develop social skills; -provide feedback related to her personal care goals; -assistance with development of new or additional goals; -opportunity for educational goals to be evaluated and/or options examined; -a written statement on the 1st page to "See Clinical Service Plan;" -There was no written clinical service plan attached to or added as an addendum to her 5/15/19 treatment plan; -No written and updated treatment plan was produced when requested on 10/31/19 and 11/6/19; -There were no written vocational, transitional and/or supported employment assessments that indicated her vocational level of functioning; Review on 10/31/19 of Client #7's record revealed: -Date of admission:4/6/92; -Diagnoses: Schizophrenia-paranoid type, hearing loss-unspecified, and psychosocial problems related to housing, medical/health, psychiatric, medication, and primary support group;	V 112		

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V 112	Continued From page 18 -His 8/14/19 treatment plan included his statements that he wanted to take Adult Basic Education (ABE) classes and he missed the ABE classes previously offered at the PSR program; -He had no education strategies developed in his plan that addressed his educational need. Review on 10/31/19 of Client #9's record revealed: -Date of admission:1/23/18; -Diagnoses: Schizophrenia, Mild Intellectual Developmental Disability (IDD), Diabetes, Tobacco Use Disorder, Obesity, Vitamin D Deficiency, and Nighttime enuresis; -A 1/23/18 written screening and assessment had her with difficulty staying focused and her needs for socialization and occupational training; -A 1/23/18 written treatment plan included: -assistance with activities of interest to her; -one-on-one assistance; -supervision and direction to complete tasks; -feedback related to her interactions with peers; -helping her keep goals in sight and assist with plans to begin meeting her goals; -arrange for participation in social program activities to practice and develop social skills; -provide feedback related to her personal care goals; -assistance with development of new or additional goals; -opportunity for educational goals to be evaluated and/or options examined; -a written statement on the 1st page to "See Clinical Service Plan;" -A 9/9/19 written treatment plan had her with: -a history of substance abuse and inappropriate verbal and physical aggressive behaviors; -active mental health symptoms of affective flattening, alogia (thought disorder and auditory hallucinations), avolition (severe lack of initiative	V 112		

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to accomplish purposeful tasks), and hallucinations;
-behaviors that included begging for cigarettes, begging and stealing food from the facility, wearing her same clothes "for days," and being evasive with staff redirection of behaviors;
-continued presenting problems of medication compliance, personal hygiene, socialization and coping skills;
-While her 1/23/18 treatment plan included staff strategies with one-on-one assistance in completion of her work tasks and supervision, her 9/9/19 plan did not have strategies that addressed her continued and presenting problems such as elopement, personal care, and stealing behaviors;
-There was no documentation (client or legal guardian signature) in her 9/9/19 plan that indicated she or her legal guardian were involved and/or had reviewed her 9/9/19 treatment plan.

Reviews on 10/24/19 and 11/8/19 of Former Client (FC #1)'s record revealed:
-Date of admission: 8/15/19;
-Date of discharge: 10/18/19;
-Diagnoses: Bipolar Disorder-unspecified, PTSD, Vitamin B-12 Deficiency, and Anger issues;
-A 8/15/19 written screening and assessment had him with mood lability (rapid and exaggerated changes in mood where strong emotions like irritability or temper occur) and a request for support with finding and obtaining employment;
-His 8/15/19 written treatment plan included the following strategies which staff would assist him with:
-activities of interest to him;
-one-on-one assistance;
-supervision and direction to complete tasks;
-feedback related to his interactions with peers;
-helping him keep goals in sight and assistance

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with plans to begin meeting his goals;
-participation in social program activities to practice and develop social skills;
-provide feedback related to his personal care goals;
-assistance with development of new or additional goals;
-opportunity for educational goals to be evaluated and/or options examined;
-a written statement on the 1st page to "See Clinical Service Plan;"
-There was no written clinical service plan attached to or added as an addendum to his 8/15/19 treatment plan;
-No written and updated treatment plan was produced when requested on 10/31/19 and 11/6/19;
-11/8/19, a written client termination notice completed and signed by the Executive Director/Qualified Professional (ED/QP #1) had FC #1's facility admission date as 10/15/19 and a last contact date of 10/16/19;
-The ED/QP #1's written explanation for FC #1's termination from the facility was due to anger and substance abuse issues.

Review on 10/31/19 of Client #FC #2's record revealed:
-Date of admission: 9/3/19;
-Date of discharge: 10/11/19;
-Diagnoses: Schizophrenia, Major Neurocognitive Disorder with behavioral disturbance, Cannabis Use Disorder-moderate, Obesity, and Hyperlipidemia;
-A 9/3/19 written screening and assessment had his needs for close redirection, socialization skills, and supervision;
-His 9/3/19 treatment plan included the following strategies which staff would assist him with:
-activities of interest to him;

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V 112	Continued From page 21 -one-on-one assistance; -supervision and direction to complete tasks; -feedback related to his interactions with peers; -helping him keep goals in sight and assistance with plans to begin meeting his goals; -participation in social program activities to practice and develop social skills; -provide feedback related to his personal care goals; -assistance with development of new or additional goals; -opportunity for educational goals to be evaluated and/or options examined; -a written statement on the 1st page to "See Clinical Service Plan;" -There was no written clinical service plan attached to or added as an addendum to his 9/3/19 treatment plan; -His 8/29/19 clinical treatment plan indicated the plan was from his former placement; -No written and updated treatment plan was produced when requested on 10/31/19 and 11/6/19; -There were no written vocational, transitional and/or supported employment assessments that indicated his vocational level of functioning; -There was no written discharge or termination summary. Review on 10/31/19 of FC #2's weekly progress notes for the period from 9/3/19 to 10/15/19 revealed: -From 9/10/19-10/8/19, he participated in the kitchen unit work tasks and attended the program's social activities held weekly on Tuesdays; -From 10/8/19-10/15/19, he went from participating in his unit work and attending the facility's social activities to not participating in his work unit except when asked;	V 112		

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V 112	Continued From page 22 -The same note had that he did not return to the facility after he and 2 peers met an unidentified person in the facility parking lot to buy an illicit substance and was confronted about this behavior by Staff #5 and told this behavior was unacceptable. Observations on 10/24/19 of the facility between 10:00 AM-12:45 PM revealed: -Between 10:00-10:20 AM, there were 7 clients present in the living room with 1 female client having fully occupied 1 of the 2 sofas by laying on the sofa while the other 6 clients were seated on the other furniture that included a 2nd sofa and 3 individual chairs; -There were no social conversations between these clients observed; -No staff were present in the living room during this period of observation; -A work unit assignment task board was posted on a white board in the living room and had several tasks (lunch preparation, wash dishes, mopping, sweeping, stocking drinks) that needed to be filled; -11:00 AM, 2 female clients (1 client was Client #11) were sitting in chairs against the wall in the snack bar kitchen with Client #11 observed to be nonverbal with a fixed stare toward the countertop and the other female other client looking at her cell phone; -The countertops and sink in this kitchen were absent of work activities and no staff were present in the kitchen with the 2 clients; -11:10 AM to 11:20 AM , Client #3 seated by himself on a small chair or bench beside a bookshelf; -The bookshelf was in a corner of a room and was designated the Education Center; -There were written educational materials on the bookshelf that included a local community	V 112		

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college course directory from 2017-2018;
-Client #3 watched peers and staff walk through the room;
-He did not initiate conversation unless he was spoken to by staff;
-He was not engaged by staff (Program Coordinator/QP #3 or Staff #2)to look through or read the educational materials.
-At approximately 11:23 AM in the administrative work unit, which was a pre-vocational work unit upstairs, a male client was observed seated at a round table with his headphones on and a mobile device plugged into a computer;
-He had papers laid to one side of the computer which appeared to be client attendance sheets;
-There was no staff in this upstairs work unit engaged with this client;
-Observations during the walk through had staff (the Associate Director/QP #2, the Program Coordinator/ QP #3, Staffs #2 and #7) walking around downstairs and present with clients in the snack bar, dining room/kitchen, and member banking services pre-vocational units;
-Observation at 11:30 AM in the kitchen of an interaction between the Program Coordinator/QP #3 and a female client who guided Surveyors #1 and #2 of a walk-through tour of the facility revealed:
-The Program Coordinator/QP #3 told the female client to prepare her a plate of lunch after she finished her tour;
-The client responded she did not have money to pay for her lunch and she was okay not to have lunch;
-The Program Coordinator/QP #3 tried to assure the female client it was okay to prepare her a lunch with the client having responded again she was okay and did not have the money for lunch;
-At 12:45 PM, 2 clients were sleeping in the living

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room with 1 client on each of the 2 sofas;
-1 of the female clients sleeping was the same female client seen sleeping on the couch at 10:00 AM;
-5 additional clients were in this room with 3 clients seated in chairs and 2 clients walking around;
-One of the male clients had his arm around a female client and they were engaged in conversation while the other clients did not converse until Surveyors #1 and #2 initiated conversations with them about their lunch;
-There were no staff present in the living room.

-Observation on 11/6/19 at 12:25 PM of a male client's escalated behaviors in the facility's outside designated smoking area revealed:
-Approximately 8-10 clients were seated outdoors in this area when the male client stood directly in front of another client who was seated, and he increased the volume and tone of his voice toward the client;
-The male client's tone of voice escalated to include profanity toward the seated client around a "girlfriend" issue and made a verbal threat to hurt the person if he "got a hold of her;"
-The male client's verbal behavior continued for about 10 minutes before he was observed walking away from the other client;
-No staff were observed present to de-escalate the male client when he began his verbal behaviors toward his peer.

Interview on 10/23/19 with Client #3 revealed:
-He began coming to the facility almost 1 year ago;
-He came to the facility to get to know people;
-His daily routine included arriving at the program at 8:00 am, sitting around, helping clean the 3 bathrooms, sitting around, and waiting until 3:00

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to go back home on the van;
-He did not want to work but he wanted to go to school to get his high school degree because he had a 7th grade education;
-There were no education classes at the facility;
-He did not know where he could take classes to get his high school degree;
-He did not stay for the facility's social activities on Tuesdays after 3:00 pm because he had kids to take care after he left for the day;
-His kids were his toy characters he kept at his home.

Interview on 10/23/19 with Client #4 revealed:
-She came to the facility when she was 18 years old and she was 24 years old;
-Her goal was to be reunited with her family;
-She did not know if she had goals at the facility;
-She volunteered in the kitchen work unit and helped prepare the meals and cleaned the tables and countertops;
-She denied she had a history of walking off from the facility and/or had used illegal substances in the past.

Interview on 10/23/19 with FC #1 revealed:
-He started the facility for the psychosocial program with his wife about 3 months ago;
-They were referred by their local mental health provider;
-He volunteered for work tasks in the kitchen unit at the program;
-One of his goals was to eventually get a job in the community because he had past work experience at a fast food restaurant;
-He participated in the facility's social activities (bowling, parties at the facility) every Tuesday;
-He openly said during a "house" (facility) meeting held about 3 weeks ago with both clients and staff present at the meeting that he smoked "weed"

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(marijuana) to self-treat his Bipolar Disorder;
-The day after he made this announcement, the ED/QP #1 held a house meeting the next day and said he did not care if members (clients) stepped out briefly and got high and came back but they were not to bring back anything illegal on his property;
-The ED/QP#1 or other staff never talked with him individually about his substance use;
-His use of marijuana was known to staff at his admission because he had a substance abuse assessment through his mental health provider on 8/1/19 that cost him $98.00 and he started at the facility on 8/15/19;
-He was not going to pay another $98.00 for a substance abuse assessment to be told he used marijuana;
-His local psychiatrist saw him on the previous day, 10/22/19, and was told he did not have anger issues and there was no need to change his medications;
-He believed his expulsion from the facility on 10/18/19 had to do with his verbal threats he made through social media texts toward Client #5 which occurred outside program hours and was about Client #5's relationship with his (FC #1)'s daughter;
-He sent another social media message to Client #5 before he returned to the facility on 10/16/19 to let him know he was not going to harm him and he would be left alone;
-When he returned to the facility on 10/16/19, Client #5 screamed that if he (FC #1) was not made to leave the program, he would leave and not return;
-Neither the Associate Director/QP #2 or the ED/QP #1 was willing to call a meeting with him and Client #5 to try and understand what had happened between them and work their issues out;

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V 112	Continued From page 27 -On 10/18/19, the Associate Director/QP #2 left him a voice mail message that informed him he could not return to the facility because he had substance abuse and anger issues, which she had known about; -Since he was expelled from the program, he has been sitting at home, playing his gaming system and watching television programs. Interview on 10/25/19 with FC #2's legal guardian revealed: -She removed him from the facility because he was not being engaged by staff to develop his work skills and not helped by staff to pursue courses for his high school equivalency; -Before his admission, she and a psychiatric social worker visited the program and saw evidence there was staff to teach job training skills and a room with computers which staff said were used by the clients to work on their education; -She and the social worker made the admissions staff (Staff #3) aware of FC #2's difficulty with information retention and his need for a program that had structure where he would be helped by staff to keep him focused on routine tasks, to learn skills and to be supervised; -The facility had written copies of FC #2's mental health records at his admission; -She was familiar with treatment plans and FC #2 had an initial treatment plan, which she reviewed and signed; -His plan included one-on-one assistance with his facility activities with staff supervision but these services were not provided; -About a week before FC #2's removal from the program, she called a meeting at the facility with PSR staff, FC #2, his mental health therapist, and Local Management Entity (LME) Care Coordinator because FC #2 was walking away	V 112		

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from the facility unsupervised and he gave her no evidence he was working on his education;
-As FC #2's legal guardian, was not notified when he walked off from the program so that she could get someone on her own to find him.

Interview on 10/24/19 with Staff #7 revealed:
-He managed the transitional employment program which had designated job placements in the community where staff were trained how to perform the job first, followed by staff training of a client in the job and supervising their work, and staff worked the job in the event of a client's absence;
-A client's job skills were developed while staff trained the client on-the job;
-The facility had 3 transitional employment placements in the local community;
-Client #3 and FC #1 were not assigned to work in the transitional employment program;
-Clients interested in transitional employment placements would have to be able to pass a pre-employment drug test and Clients #3 and FC #1 indicated they could not pass a drug test.

Interview on 10/24/19 with the Program Coordinator/QP #3 revealed:
-She assisted the Associate Director/QP #2 as a QP with updating client treatment plans after 30 days of a client's admission and annually thereafter;
-She reviewed and signed the client weekly progress notes completed by the 4 to 5 rehabilitation specialists as did other QPs such from the Associate Director/QP #2 to QP #6.

Interviews on 10/24/19, 10/31/19, 11/6/19 and 11/12/19 with the Associate Director/ QP #2 revealed:
-10/24/19, FC #2 no longer participated in the

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program because his legal guardian was looking for him a placement out of the county because of his missed facility attendance;
-His having left the program was not related to a 10/10/19 incident where FC #2 was suspected to have had an illegal substance in his possession;
-She did not disclose information about a meeting with FC #2's legal guardian or the guardian's concerns related to his treatment plan;
-No discharge summary had been completed for FC #2;
-He was not considered discharged because his 30 days had not expired;
-His last day at the facility was on 10/10/19 or 10/11/19;
-Her concern was about FC #1 who was "volatile" and had "horrible anger issues," to the point he was going to hurt someone;
-FC #1 needed more training than what the facility could provide to manage his anger and his substance abuse issues by his own admission;
-His mental health referral said he had explosive anger and PTSD and when something bothered him, he would not "let it go" and he did not want help from staff with a solution;
-He needed more services than what the facility could provide, and she told him he needed to go back to his mental health provider to get help with his anger issues and substance abuse;
-10/31/19, Clients #3, #4 and #9's plans may have not been completed or their plans may not have been picked up from the physician's office where they were taken to be signed for medical necessity;
-"We sat down yesterday and split up the remaining ones so one person wouldn't have them all to do at one time;"
-She would have the updated treatment plans brought to the facility by the billing specialist;

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V 112	Continued From page 30 -11/6/19, Client #9's plan was sitting in her files or the plan was on her office desk; -11/12/19, The initial client treatment plans might have read the same because they were developed at each client's admission and used for the 1st 30 days for staff to get to know each client better and then update their treatment plan; Interviews on 10/31/19 and 11/6/19 with the ED/QP #1 revealed: -10/31/19, Staff #3, a rehabilitation specialist, received the written client referrals for facility admission; -He reviewed each client referral and gave his approval or denial for admission; -Individuals accepted to the program were diagnosed with a severe and persistent mental illness; -Onset of mental illness usually occurred in individuals in their late teens to early adulthood so they had already learned their basic skills like personal hygiene to care for themselves; -The population who needed basic skill development was the Developmentally Disabled (DD) population; -Clients with mental illnesses needed a place and reason to come to use the skills they already had learned; -"We do not teach skills here;" -He did not admit individuals to the program if they were "active" substance users or had a diagnosis of a developmental disability; -If a client had an active substance use problem, they were referred to their local mental health provider; -He provided no written or printed referrals in which clients were referred by staff to local mental health and/or substance abuse treatment providers for specific mental health and/or substance abuse behaviors or needs;	V 112		

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V 112	Continued From page 31 -His facility's electronic client record system was not capturing client referrals made by the staff; -FC #1 talked openly about his smoking marijuana for treatment of his Bipolar at a facility meeting where both staff and clients were present; -He told the clients in a house meeting they did not need to use illicit substances to self-treat their mental health diagnoses; -His regret was he did not talk individually with FC #1 about his substance use and educate him about possible consequences of self-treating his Bipolar with illicit substances; -FC #1 was advised by the Associate Director/QP #2 to go to his local mental health provider for his substance use; -11/6/19, the electronic client record system used by the facility had "wiped out" 100% of last week's client progress notes completed by staff; -Staff (the Rehabilitation Specialists and QPs) were working this week to re-write client progress notes. This deficiency is cross-referenced into 10A NCAC 27G .1201 Scope (V174) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and	V 115		

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V 115	Continued From page 32 (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the safety and welfare of 5 of 8 audited clients (Clients #3, #4 and #9, Former Client (FC #1) and FC #2). The findings are: Review on 10/24/19 of Client #3's record revealed: -Date of admission: 11/26/18; -Diagnoses: Schizophrenia, Cannabis Use Disorder, Tobacco Use Disorder, Cardiomyopathy, Obesity, Vitamin D Deficiency, and History of Tachycardia; -A written statement dated 11/20/18 from his guardian representative that he was not allowed to leave the facility without being accompanied by a staff member because he would get lost if he	V 115		

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walked off;
-His 11/26/18 treatment plan strategies included his need for one-on-one assistance, supervision and redirection to complete his tasks.

Review on 10/24/19 of Client #4's record revealed:
-Date of admission: 12/18/18;
-Diagnoses: Bipolar Disorder with psychotic features, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Developmental Disability Delay, Post-Traumatic Stress Disorder (PTSD), Attachment Disorder with severe mood and behavioral dysregulation, Morbid Obesity, and Type 2 Diabetes;
-She had a legal guardian;
-A 6/17/16 written treatment plan indicated she had been a client at the facility prior to her 12/18/18 admission;
-A 11/27/18 written hospital assessment had her with a history of elopement (walking away) and aggressive behaviors that precipitated a psychiatric hospital admission from 9/5/17 to 12/12/18;
-Her written weekly progress note dated 9/3/19-9/10/19 indicated that when she returned to the facility with peers after having left the facility, she was under the influence of a mood-altering substance.

Review on 10/31/19 of Client #9's record revealed:
-Date of admission:1/23/18;
-Diagnoses: Schizophrenia, Mild Intellectual Developmental Disability (IDD), Diabetes, Tobacco Use Disorder, Obesity, Vitamin D Deficiency, and Nighttime enuresis;
-She had a legal guardian;
-Her 9/9/19 treatment plan included her history of substance abuse and her continued problems

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with personal hygiene, socialization and coping skills, as well as behaviors that included stealing cigarettes and food from the facility;
-A 11/6/19 written staff note indicated she walked off from the facility "again;"
-The facility notified her caretakers of this elopement incident;
-Her guardian representative, who met with her at the facility, informed Client #9 that her consequence of a reoccurrence of elopement from the facility was nursing home placement.

Reviews on 10/24/19 and 11/8/19 of Former Client (FC #1)'s record revealed:
-Date of admission: 8/15/19;
-Diagnoses: Bipolar Disorder-unspecified, PTSD, Vitamin B-12 Deficiency, and Anger issues;
-His 8/15/19 written screening and admission identified he had anger issues and mood lability;
-His written discharge notice had he was terminated from the facility due to anger and substance abuse issues.

Review on 10/31/19 of Client #FC #2's record revealed:
-Date of admission: 9/3/19;
-Diagnoses: Schizophrenia, Major Neurocognitive Disorder with behavioral disturbance, Cannabis Use Disorder-moderate, Obesity, and Hyperlipidemia;
-His 9/3/19 written screening and assessment had him with being "social," but did not recognize social cues and needed redirection to maintain focus and boundaries.

Review on 10/23/19 of a written North Carolina Incident Response Improvement System (IRIS) report dated 10/16/19 for FC #1 revealed:
-FC #1 "continually threatened to call Raleigh" if staff did not handle situations the way he

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V 115	Continued From page 35 expected; -"Staff" (Associate Director/Qualified Professional (QP #2) reported to the ED/QP #1 that there might be a "drug problem" at the facility; -FC #1 talked openly in front of his peers and the staff at a facility meeting about "smoking pot" (marijuana) to treat his Bipolar; -FC #1 had at least 3 occasions in which he had escalated verbal behaviors toward his peers and/or staff that from 9/20/19 to 10/16/19; -The 1st occasion was on 9/20/19 when he became verbally angry that a peer had "licked" her fingers while grilling hamburgers and continued his anger in a written post on a social media format; -The 2nd occasion was on 10/10/19 when he verbally screamed and blamed Client #4 for having "snitched" on him and his peers, Clients #3, #4 and FC #2, following an incident that occurred earlier in the day on 10/10/19: -An unknown car pulled into the facility parking lot and FC #1, FC #2, and Current Clients #3 and #9 met outside the facility with the occupants of the car which "raised the suspicion" of Qualified Professional (QP#4) because Client #9 had "recently had problems with substances;" -FC #1, FC #2 and Client #3, who were all male, returned inside the facility and went into the men's restroom where a staff (Staff #1) observed FC #2 "stuffing a baggie" in his pocket, which he produced to Staff #1 who believed the content in the baggie was marijuana; -FC #2 placed the baggie with the substance back into his pocket and left the restroom; -Staff #1 reported the incident to QP #4 with no further action indicated by QP#4 with FC #2; -FC #1 began verbally blaming Client #4 for having "told on them," and Staff #7 and QP #4 intervened to relocate Client #4 to a different location within the facility and away from FC #1;	V 115		

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-The 3rd occasion was on 10/16/19 when he was "asked" by Staff #7 to leave the facility and he was instructed to call the ED/QP #1 regarding his facility status;
-Client #5 had received threatening text messages from FC #1 which he made known to staff on 10/14/19 and the threats included name-calling and a threat to harm him;
-On 10/18/19, the ED/QP #1 received a report from the facility's Residential Coordinator who had a family member who dealt illegal drugs and this family member warned that if FC #1, FC #2 and/or Client #3 tried to return to the community which was within walking distance of the facility to buy more drugs, they were endangered of being robbed;
-The report indicated FC #1 was expelled from the facility;
-He was recommended to seek help for his substance use disorder and to be assessed for his "hostile" behavior.

Review on 10/23/19 of internal written facility incident reports from 9/20/19 through 10/23/19 revealed:
-There were written facility incident reports documented by both staff and clients on a form titled "Special Entry Progress Note," which ranged from the period 9/20/19 to 10/17/19;
-FC #1's report signed and dated 9/20/19 included his observation of a female client licking her hands while grilling hamburgers and, as a result, he notified Staff #3, the Program Coordinator/QP #3, and Staff #1 because he considered the behavior unsanitary;
-Staff #3's report signed and dated on 10/17/19 confirmed that on 10/10/19 FC #1, FC #2, and Clients #3 and #9 walked outside to a car that pulled up in the facility's driveway;
-The remainder of her report was about FC #1

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"screaming" at Client #4 for being a "snitch," and Client #4 removed her from the situation by Staff #3;
-Staff #1's undated note confirmed his 10/10/19 observation of FC #2 in the men's restroom and confirmed his observation of the content in FC #2's bag as marijuana;
-After FC #2 placed the bag of marijuana back into his pocket, they left the restroom and Staff #1 notified "other staff" (QP #4);
-There were no additional written reports or documentation which indicated how the facility addressed his possession of an illicit substance;
-Staff #7's report dated 10/16/19 was he "heard" FC #1 threatened Client #5 over the previous weekend;
-He was directed by the ED/QP #1 to send FC #1 home until further notice;
-Client #5's undated report had him at his home when he received a threatening text from FC #1 that FC #1 was going to kick his a*s and put him in the hospital;
-He did not understand the reason for FC #1's threat;
-When he got to the facility, FC #1 and FC #1's wife called him a "baby" and "mfer" and he thought they were mad because he had not come over to their home the past weekend and he was trying to turn FC #1's daughter against him.

Interview on 10/23/19 with FC #1 revealed:
-He admitted to his peers and the staff at a facility meeting that he smoked marijuana to self-treat his Bipolar Disorder;
-He confirmed the 10/10/19 incident about a car having pulled up to the facility after FC #2 made a call on his (FC #1)'s cell phone that "he needed some" (marijuana) but he denied he purchased or used the illicit substance at the facility;
-His threats to Client #5 included profanity and a

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physical threat to harm him;
-The threats occurred outside of the facility, through a social media format, and he sent another message to Client #5 through the same social media before he returned to the facility on 10/16/19 that he had no intentions to harm him.

Interview on 10/23/19 with Client #3 revealed:
-He had a legal guardian;
-He sometimes walked up the street and around the block with his friends from the facility;
-No staff were present with him and his friends when they walked up the street or around the block;
-Client #9 was one of his friends he walked up the street with;
-He denied he had knowledge of illicit substance use at the facility or in the community.

Interview on 10/23/19 with Client #4 revealed:
-She denied ever having walked away from the facility;
-She did not disclose a history of substance abuse;
-She hoped to be returned to a living arrangement with her family soon.

Interview on 10/23/19 with Client #9 revealed:
-She had a legal guardian but hoped to become her own guardian;
-She wanted to leave her placement and be returned to live with her family;
-She had been friends with FC #1 and FC #2;
-She did not know why they no longer came to the facility;
-She denied she had walked off from the program.

Interview on 10/30/19 with Client #3's legal guardian revealed:

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V 115	Continued From page 39 -She was "pretty sure" staff notified her whenever Client #3 walked away from the facility; -She understood from the staff that clients who attended the facility could sign themselves out and walk to the local store; -She asked who wrote the 11/20/18 statement that Client #3 was not allowed to leave the facility unless accompanied by a staff; -She confirmed Client #3's name, date of birth, and date of admission; -She had 40 people in her caseload to case manage and Client #3's elopement behavior did not sound like him. Interview on 10/25/19 with FC #2's legal guardian revealed: -FC #2 was seen walking around town and he was picked up by his aunt in town during the middle of the day when he was supposed to have been at the facility; -She was uncertain how many times he eloped from the facility because she was never contacted by staff; -About 1 week prior to his removal from the facility by her, on 10/11/19, she called a meeting with staff, FC #2, his mental health therapist, and a Care Coordinator with the Local Management Entity (LME) about FC #2 having walked off from the program and him not being engaged in PSR services; -She was told at this meeting by the two female facility staff who were "in charge" that the facility was not a "lock-down" facility and they did not have the "manpower" to supervise every client who attended their program; -The guardian made the decision whether the individual continued in the program if an individual walked away from the facility; -If she had been notified by staff that FC #2 had left the facility, she could have "put someone on	V 115		

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V 115	Continued From page 40 him to locate him;" -She believed he might have relapsed during the program by using alcohol or illicit substances because 2 weeks after his admission, he had behaviors (cigarette cravings) which were like what she had seen in the past; -When she questioned him about suspected substance use, he told her he walked to the store with a female client (Client #9) who bought beer and she brought a beer back to the facility; -He had no smell of alcohol or marijuana on his body when he came home so she had no evidence of his substance use to get him help before his behaviors became "out of control," and he was hospitalized on 10/13/19. Interview on 10/24/19 with the Program Coordinator/QP #3 revealed: -She had been the Program Coordinator since 4/15/18; -The facility was a "volunteer" program, which meant when a client walked into the program every morning, they made their own choice as to what work activities (meal preparation, cleaning, answering the telephone, counting money) they wanted to participate in and how much of a work activity they wanted to do; -Each client was expected to sign in each morning they came to the program and if a client decided to leave, they were expected to sign out; -Clients were aware of this expectation during their orientation; -It was the client's choice if a client decided to walk away from the program; -If a client had a guardian and the client needed more one-on-one supervision, the facility was not the place for the client; -They did not keep a list of what clients were allowed to leave the program; -The facility averaged 44 clients a day who came	V 115		

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and went from the program;
-Staff could not watch every client every day;
-Some guardians were okay for their clients "to come and go" from the facility.

Interviews on 10/24/19 and 10/31/19 with the Associate Director/QP #2 revealed:
-Facility staff (not identified) told her about a car that kept entering the facility parking lot the wrong way (the exit), with FC #2 having ran outside to meet the car and 30 seconds later, the car would leave;
-One day (she did not recall an approximate date), she stood in the facility kitchen and saw 4 clients (FC #1, FC #2, Client #3 and Client #4) gathered outside around the car with their hands in their pockets;
  -Client #4 pointed the incident out to her;
  -QP #4 told her the car did this a lot;
-When FC #1 said at a house meeting about 2 months ago in front of his peers and staff that he smoked marijuana for his Bipolar, she and the staff were suspicious there may be a drug problem at the facility;
-She confirmed that on or about 10/17/19, the Residential Specialist received a verbal warning from her family member who dealt drugs that FC #1 needed to be kept away from his place or he would be robbed and beaten up;
-FC #1 had taken FC #2 and Clients #3 and #9 who had legal guardians with him when he went to the drug dealer's home as the drug dealer described these clients to the Residential Coordinator;
10/31/19, a couple of weeks ago, she saw Client #9 and FC #2 walking to a local convenience store that was located below her office;
-Client #9 bought 2 beers and brought 1 beer back to the facility and put it in her locker until time to return home on the public transportation

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V 115	Continued From page 42 van; -The facility established with client guardians at their admission that clients might leave the facility, and the guardian would be notified by staff if a client walked away from the facility; -There had been discussions in the past between her and the clients' local mental health providers about client substance issues, but she felt the mental health providers did not want to discuss the issue because marijuana was a "cultural thing" in the local community; -The facility's clubhouse model did not address client substance abuse except to refer clients back to their local mental health provider; -She did not consult with FC #1's mental health provider about the substance abuse referral. Interview on 10/31/19 with the ED/QP #1 revealed: -Client #3's guardian called him this morning after Surveyor #1 had spoken with her; -He and the Program Coordinator/QP #3 "attempted to call her" when Client #3 left the facility property with FC #1 and FC #2; -If a client needed one-on-one supervision, there were community support teams such as ACTT (Assertive Community Treatment Team) to provide a higher level of service and staff would have referred a client to such a service if needed; -"If a member has a guardian and needs around the clock supervision, this is not the program for them;" -He confirmed he made the client admission decision; -"Most of the folks we are able to handle with our staffing ratio of 1:8;" -Staff were at the facility to keep clients engaged in work activities and if clients walked away from the facility, this was a client choice; -"We can't stop them from leaving the property	V 115		

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V 115	Continued From page 43 because we don't have a fence around the property or a guard to keep them here;" -Guardians were informed at admission that staff had no control over whether clients left the facility; -Guardians chose whether to let their client continue coming to the program if a client continued to walk away from the facility; -Staff started in the last 2 months contacting client guardians if a client with a guardian walked off the facility property. This deficiency is cross-referenced into 10A NCAC 27G .1201 Scope (V174) for a Type A1 rule violation and must be corrected within 23 days.	V 115		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service,	V 116		

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V 116	Continued From page 44 pursuant to the requirements of 10 NCAC 45G .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were dispensed on the written order of a physician or other practitioner licensed to prescribe medications affecting 8 of 8 clients who had medications managed by the facility (Clients #8, #10, #11, #12, #13, #14, #15 and #16). The findings are: Review on 11-12-19 of the Case Manager/Qualified Professional's (QP#5's) record revealed: -Date of Hire: 6-18-18; -She received a master's degree in 2002 for rehabilitation counseling; -There was no documentation which indicated she had medication administration training. Review on 10-31-19 and 11-6-19 of Client #8's record revealed: -Date of admission: 4-24-01; -Diagnoses: Major Depressive Disorder recurrent	V 116		

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with Psychotic Behavior, Cocaine Dependence in remission, Migraines, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Fluid Retention, and Menopausal Disorder;
-A printed form titled "Medication Monitoring" which was dated 9-30-19 and completed by the Case Manager/QP#5 listed the following medications:
-glipizide extended release 5 milligram (mg) 1 tablet once per day for diabetes;
-fluoxetine hydrochloride 20mg 3 capsules every morning for mood disorder;
-atorvastatin 40 mg 1 tablet once per day for cholesterol;
-omeprazole delayed release 20 mg 2 capsules twice per day for acid reflux;
-quetiapine fumarate extended release 300 mg 2 tablets at bedtime for bipolar disorder;
-Advair (fluticasone/salmeterol) 250/50 microgram (mcg) inhaler use as directed for COPD, kept at home by the client;
-metformin hydrochloride 1000 mg 1 tablet twice per day for diabetes;
-divalproex sodium extended release 500 mg 1 tablet twice per day for bipolar disorder;
-benztropine mesylate 1 mg 1 tablet twice per day for side effects discontinued 6-14-19;
-montelukast sodium 10mg "take 1 tab his" for allergies;
-lisinopril 10 mg 1 tablet daily for high blood pressure;
-doxepin 100 mg 1 capsule at bedtime for insomnia;
-clonazepam 0.5 mg 2 tablets per day as needed for anxiety weaned and then discontinued on 7-5-19;
-aripiprazole 5 mg 1 tablet daily for depression and discontinued on 6-27-19;
-Toviaz (fesoterodine fumarate) 4 mg 1 tablet per day for bladder issues, kept at home by the

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client;
-Belsomra (suvorexant) 10 mg 1 tablet at bedtime for insomnia, do not take with doxepin and discontinued on 9-3-19;
-There were no signed physician orders on file in her record for these current and discontinued medications.

Review on 11-12-19 of Client #10's record revealed:
-Date of admission: 1-11-16
-Diagnoses: Major Depressive Disorder Recurrent Moderate and Unspecified Intellectual Disorder;
-A printed Medication Monitoring form which was dated 9-12-19 and completed by the Case Manager/QP#5 listed the following medications:
-sertraline hydrochloride 100 mg 1.5 tablets daily for depression;
-atorvastatin 10 mg 1 tablet at bedtime for cholesterol;
-doxepin hydrochloride 50 mg 1-2 tablets at bedtime for insomnia;
-She had no signed physician orders in her record for these current medications.

Review on 11-12-19 of Client #11's record revealed:
-Date of admission: 9-6-11
-Diagnoses: Schizophrenia, Major Depression, Borderline Personality Disorder, Hyperlipidemia, and Asthma;
-A printed Medication Monitoring form which was dated 8-2-19 and completed by the Case Manager/QP#5 listed the following medications:
-Aristada (aripiprazole lauroxil) 882 mg injection every month for mental or mood disorders, "last shot 7-24-19 left hip";
-tamoxifen 20 mg 1 tablet daily for cancer, "on 7-31-19 Client #11 reported that the doctor said

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V 116	Continued From page 47 [she didn't have to take these any longer]"; -lovastatin 40 mg 1 tablet with evening meal for cholesterol; -metformin hydrochloride 500 mg 1 tablet with evening meal for diabetes; -vitamin D3 2000 units with no written instructions of when and how to administer; -sertraline hydrochloride 100 mg 1 tablet daily for mood; -Symbicort (budesonide/formoterol) 160-4.5 mcg inhaler 2 puffs two times per day morning and evening for asthma, eat after use; - "A new rescue inhaler," which had the inhaler was prescribed by a physician on 7-24-19, to use every 4-6 hours as needed (PRN) but there was no written indication of the name of the medication or dosage amount; -She had no signed physician orders in her record for these current medications. Review on 11-12-19 of Client #13's record revealed: -Date of admission: 6-16-10 -Diagnoses: Bipolar Affective Disorder Mixed Unspecified, Attention Deficit Hyperactivity Disorder and Hypertension; -A printed Medication Monitoring form which was dated 11-7-19 and completed by the Case Manager/QP#5 listed the following medications: -aripiprazole 20 mg 1 tablet at bedtime for mood; -diazepam 5 mg 1 tablet per week as needed for anxiety; -doxepin hydrochloride 75 mg 1-2 capsules at bedtime for sleep; -fenofibrate 145 mg 1 tablet every morning for cholesterol; -lisinopril 20 mg 1 tablet twice daily for high blood pressure; -metformin 500 mg 1 table twice daily for	V 116		

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V 116	Continued From page 48 diabetes; -pantoprazole sodium 40 mg 1 tablet daily for acid reflux; -pravastatin 40 mg 1 table at bedtime for cholesterol; -ranitidine 150 mg 1 tablet twice daily for ulcers, which was discontinued on 10-31-19 and replaced by famotidine; -multivitamin 1 tablet daily in the morning for dietary supplement; -Vimpat (lacosamide) 100 mg 1 tablet twice daily for seizures; -vitamin D3 5000 units 1 capsule in morning with multivitamin for dietary supplement; -bupropion hydrochloride extended release 150 mg 3 tablets every morning for depression; -aspirin 81 mg 1 tablet at bedtime for prevention of blood clots; -Symbicort (budesonide/formoterol) inhaler (no instructions or dose) used to treat asthma and COPD (Chronic Obstructive Pulmonary Disease); - "sumabuptan succenate" (sumatriptan succinate) 50 mg (no instructions) for migraines; -famotidine 40 mg 1 tablet at bedtime, used to treat ulcers; -He had no signed physician orders in his record for these current medications. Reviews on 11-7-19 of printed Medication Monitoring forms for additional clients (Clients #12, #14, #15, #16) completed by the Case Manager/QP#5 revealed: -The medication monitoring forms did not indicate each client's admission date or their diagnoses; -The forms were maintained in an electronic format and printed for review; -There were no signed physician orders in each of their medications that were listed on their individual medication monitoring form; -Client #12's printed Medication Monitoring form	V 116		

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V 116	Continued From page 49 dated 9-16-19 listed the following medications: -Dupixent (dupilumab) 300 mg Injection administered every other week for eczema -lamotrigine 25 mg with no instructions for administration and frequency for mood; -trazodone 50 mg 1 tablet at bedtime for mood/sleep; -hydroxyzine hydrochloride 25 mg as needed for eczema, kept at home by the client; -mycophenolate 500 mg 3 tablets in the morning and 2 tablets at night for eczema, kept at home by the client; -hydrocortisone 2.5% ointment apply topically twice daily for skin condition; -doxycycline hyclate 100 mg 1 tablet twice daily with food for prevention of skin infection, kept at home by the client; -triamcinolone 0.1% ointment apply to affected area daily for skin condition, kept at home by the client; -Client #14's printed Medication Monitoring form dated 10-28-19 listed the following medications: -Aristada (aripiprazole lauroxil) 882 mg injection every 3 weeks, last injection 10-24-19 right hip; -benztropine mesylate 1 mg 1 tablet twice per day for tremors; -dicyclomine 10 mg 1 capsule three times per day for Irritable Bowel Syndrome (IBS); -Latuda (lurasidone) 120 mg 1 tablet with evening meal for mood; -omeprazole delayed release 20 mg 1 capsule every morning for acid reflux with an instruction to hold per Nurse Practitioner on 8-21-19; -potassium chloride extended release 20 milliequivalents (mEq) 2 tablets daily in the morning for potassium deficiency; -topiramate 25 mg 1 tablet at bedtime for headaches; -Ventolin (albuterol) 90 mcg Inhaler 2 puffs	V 116		

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every 6 hours as needed for asthma;
-Viibryd (vilazodone) 40 mg take one tablet with food (frequency not documented) for mood;
-Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol) 110-62.5-25 mcg Inhaler 1 puff daily for COPD;
-naproxen 400 mg 1 tablet twice per day for knee pain;
-hydrocortisone 2.5% cream with a written dispense date of 10-31-19, to be applied to face twice daily for 2 weeks and then applied once daily for two weeks for skin rash;
-ketoconazole 2% shampoo apply to scalp daily and leave on 2-3 minutes then wash out for dermatitis;
-Client #15's printed Medication Monitoring form dated 10-14-19 listed the following medications:
-amlodipine besylate 5 mg 1 tablet each morning for hypertension;
-atorvastatin 40 mg 1 tablet daily at bedtime for cholesterol;
-Belsomra (suvorexant) 20 mg 1 tablet at bedtime for insomnia;
-carvedilol 25 mg 1 tablet twice daily for hypertension;
-clonazepam 1 mg 1 tablet twice daily for mood stabilization;
-haloperidol 5 mg 1 tablet twice daily for mood stabilization;
-haloperidol 10 mg 1 tablet at bedtime for mood stabilization;
-Latuda (lurasidone) 80 mg 2 tablets daily with evening meal for schizophrenia;
-lisinopril hydrochlorothiazide 20-12.5 mg 1 tablet twice daily for hypertension;
-Linzess (linaclotide) 290 mcg 1 capsule each morning before breakfast for IBS;
-metformin hydrochloride 1000 mg 1 tablet twice daily with meals for diabetes;
-tamsulosin hydrochloride 0.4 mg 1 tablet twice

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daily for benign prostatic hyperplasia (BPH);
-timolol 0.5% eye drops 1 drop in the left eye every morning for glaucoma;
-zinc 50 mg 1 tablet daily for dietary supplement;
-omeprazole 20 mg 1 capsule by mouth daily for acid reflux;
-Client #16's printed Medication Monitoring form dated 11-4-19 listed the following medications:
-carbidopa/levodopa 25-100 mg 2 tablets at 6AM, 10AM, 2PM, and 6PM daily for Parkinson's disease;
-clozapine 25 mg 6 tablets daily at bedtime for bipolar disorder;
-ramipril 5 mg 1 capsule daily for hypertension;
-pramipexole 1 mg 1 tablet three times per day for Parkinson's disease;
-aspirin 81 mg 1 tablet daily at bedtime for prevention of blood clots;
-multi vitamin take one tablet daily for dietary supplement;
-metformin hydrochloride 500 mg 1 tablet daily with food for diabetes;
-ezetimibe 10 mg 1 tablet daily for cholesterol;
-rasagiline mesylate 1 mg 1 tablet daily for Parkinson's disease.

Reviews on 11-7-19 of printed client case notes for Clients #8, #10, #11, #13, #14 and #16 revealed:
-The case notes were electronically signed by the Case Manager/QP#5 which indicated the purpose of each client contact, a brief written description of each client contact, along with the effectiveness or outcome of each client contact;
-There were client contacts between these clients at the facility for the purpose of managing each client's medications;
-The contacts occurred when a client handed their prior week's medication planner to the Case

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(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 116	Continued From page 52 Manager/QP#5 at the facility to be refilled and received a week's filled medication planner in return; -Client #8 was met at the clubhouse and received another week's supply of medications per notes dated 2-19-19, 3-6-19 and 3-19-19; -Client #10 was met at the clubhouse and received another week's supply of medications per notes dated 3-27-19, 10-16-19 and 10-30-19; -Client #11 was at met the clubhouse and received another week's supply of medications per a note dated 9-11-19; -Client #13 was met at the clubhouse and received another week's supply of medication per notes dated 4-24-19, 9-6-19, 9-26-19 and 10-17-19, -Client #14 was met at the clubhouse and received another week's supply of medication per a note dated 10-9-19; -Client #16 was met at the clubhouse and received another week's supply of medication per a note dated 10-1-19. Interview on 10-24-19 with Client #8 revealed: -She received most of her prescription medications from the Case Manager/QP#5 at the psychosocial rehabilitation (PSR) facility; -The medications she received from the Case Manager/QP#5 were always in weekly planners and not in the original prescription bottles; -The Case Manager/QP#5 would inform her if the color, size or shape of the medication changed. Interviews on 11-6-19 and 11-7-19 with the Case Manager/QP#5 revealed: -She had not received any formal medication training by a Registered Nurse, pharmacist, or other person licensed or qualified to train in medication administration; -The facility did not have a license to dispense	V 116		

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V 116	Continued From page 53 prescribed medications to clients; -The facility did not have written physician orders on file for any of the clients' medications; -None of the clients she assisted with medication management had a doctor's order to self-administer their medications; -The physician orders were electronically sent to the local pharmacy after each client was seen by their doctor; -She received the clients' medications from a local pharmacy; -She removed the clients' medications from the original prescription bottles and placed them into the weekly pill reminder boxes or "planners;" - "Most of the time" the clients she helped with medication management met her at the facility to exchange their weekly pill planners from their prior week's medication to their current week's medication supply; -She brought a week's supply of medication to Client #8 at the facility earlier this morning on 11-6-19; -If a client returned a pill planner with any remaining medications, she re-dispensed them back into the original prescription bottles that had the client's dispensing label from the pharmacy; -The facility had been dispensing weekly pill planners to clients since her hire date in June 2018; -The Executive Director/QP #1 and the Associate Director/QP #2 assigned her the job responsibility of medication management for facility clients who lived in the apartments managed by the facility and needed help with their medications; -The Associate Director/QP#2 filled the weekly pill planners if the Case Manager/QP#5 was absent; -Neither she nor the Associate Director/QP#2 was a licensed Pharmacist or registered with the Pharmacy board to dispense client medication.	V 116		

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V 116	Continued From page 54 This deficiency is cross-referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 116		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.	V 117		

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V 117	Continued From page 55 This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure each prescription drug dispensed included a label with the prescriber's name, the current dispensing date, expiration date, clear directions for self-administration, the address of the pharmacy and the name of the dispensing practitioner for 8 of 8 clients who had medications managed by the facility (Clients #8, #10, #11, #12, #13, #14, #15 and #16). The findings are: Observation on 11-6-19 at 11:52 AM in the Case Manager's/Qualified Professional's (QP#5) office revealed: -There was a weekly pill planner for each client with individual sections for morning, noon, evening and night Sunday through Saturday; -There were pills present in each individual section of each pill planner; -The pill planner did not have pharmacy labels, or the required information about the medications each planner contained; -A label, which was typed and taped to each client pill planner, had the medication name, strength, and description along with the name and phone number of the local pharmacy, and last name of the prescriber; -Each label on the pill planner for each client had the same layout with columns categorized for morning, noon, evening and night with the number of pills to be taken at each timeframe. -The label did not have information that indicated a dispensing date, expiration date, clear directions for administration of the medication, the address of the pharmacy and/or the name of the dispensing practitioner. Interview on 11/7/19 with the Case	V 117		

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V 117	Continued From page 56 Manager/QP#5 revealed: -She removed the clients' medications from the original prescription bottles and placed them into the weekly pill reminder boxes according to the medication bottle dispense labels; -She typed a label for each client's pill planner and secured it to the planner with tape; -The same format was used to label every client's planner. This deficiency is cross-referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug;	V 118		

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V 118	Continued From page 57 (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observations and interviews the facility staff failed to demonstrate compliance in medication administration requirements affecting 8 of 8 clients who had medications managed by the facility (Clients #8, #10, #11, #12, #13, #14, #15 and #16). The findings are: CROSS-REFERENCE: 10A NCAC 27G .0209 (a) Medication dispensing (V116) Based on record reviews and interviews, the facility failed to ensure medications were dispensed on the written order of a physician or other practitioner licensed to prescribe medications affecting 8 of 8 clients (Clients #8, #10, #11, #12, #13, #14, #15 and #16) who had medications managed by the facility. CROSS-REFERENCE: 10A NCAC 27G .0209 (b) Medication packaging and labeling (V117) Based on observation and interview the facility failed to ensure each prescription drug dispensed included a label with the prescriber's name, the current dispensing date, expiration date, clear directions for self-administration, the address of the pharmacy and the name of the dispensing	V 118		

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V 118	Continued From page 58 practitioner for 8 of 8 clients who had medications managed by the facility (Clients #8, #10, #11, #12, #13, #14, #15 and #16). CROSS-REFERENCE: 10A NCAC 27G .0209 (d) Medication disposal (V119) Based on record reviews, observation and interview the facility failed to maintain a record of medication disposal specifying the medication strength, disposal method, signature of the person disposing of the medication and the person witnessing the destruction for 4 of 8 clients who had medications managed by the facility (Clients #8, #11, #13 and #16). CROSS-REFERENCE: 10A NCAC 27G .0209 (e) Medication storage (V120) Based on record/policy review, observation and interview the facility failed to store all medications in a securely locked cabinet for 8 of 8 clients who had medications managed by the facility (Clients #8, #10, #11, #12, #13, #14, #15 and #16). CROSS-REFERENCE: 10A NCAC 27G .0209 (f) Medication review (V121) Based on record reviews and interview the facility failed to obtain psychotropic drug reviews by a pharmacist or physician at least every 6 months affecting 8 of 8 clients who had medications managed by the facility (Clients #8, #10, #11, #12, #13, #14, #15 and #16). CROSS-REFERENCE: 10A NCAC 27G .0209 (h) Medication errors (V123) Based on record/policy reviews and interview the facility failed to ensure medication errors were immediately reported to a physician or pharmacist for 3 of 8 clients who had medications managed by the facility (Clients #8, #11 and #14).	V 118		

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V 118	Continued From page 59 Review on 11/13/19 of a Plan of Protection dated 11-12-19 and 11-13-19 completed by the Executive Director/Qualified Professional (QP#1) revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? - "10A NCAC 27G.209 Medication Dispensing: -11/13/2019 According to our Reviewers, the documentation below, stating that we are discontinuing help with our Members medication minders. However, they wanted us to be clear in this plan of correction that we are not abandoning any Member who requires help during the transition. Staff will insure Members are properly managing their medications as we discontinue help. Those who are not proficient at managing their own medications will be referred to another service for help in this area. We have already talked to the MCO [Managed Care Organization] regarding three such Members and are working to get the necessary referrals and authorizations for another Provider to assume responsibility. In the interim, we will closely supervise and monitor the Member doing their own pill planner. No Member will go without needed help in this area. -11/12/19 In August 2019, we received our annual review and were specifically reviewed regarding a complaint involving our assisting Members in managing their medication minders. The same Reviewers spent 6 hours interviewing our staff member that handles medication minders. A call was even made to a local pharmacist regarding whether what we did constituted the "dispensing of medication". It was determined that it was not. We received a letter from DHSR stating that the complaint was unfounded and that there were no deficiencies noted in our Annual Review. -With only a minor change, made at the	V 118		

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V 118	Continued From page 60	V 118		

recommendation of our Reviewers, we are doing the same procedures we were doing in August. It was my opinion that we should stop handling medications all together but allowed it to continue based on our DHSR Review. We are now cited for a Type A1 Serious Neglect and told that we may receive monetary penalties for this.
-Given the circumstances, we have no choice but to immediately discontinue helping our Members with Medication minders in order to protect our Consumers from further risk that they must have been in dating back to at least August. We will return all medications in their original containers and all medication minders to the perspective Consumer. If we believe that doing this places a Consumer at risk due to an inability to manage their medications on their own, we will contact [the local MCO] and ask for their help in making the necessary referrals to a program that can work with those clients regarding their medications, in compliance with all sections sited above".

Clients #8, #10, #11, #12, #13, #14, #15 and #16 were admitted to the facility on various dates and each client had co-occurring medical diagnoses along with a diagnosis of a severe and persistent mental illness. These medical diagnoses included Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes, Hyperlipidemia, Asthma, and Parkinson's disease. The clients had medication regimens that incorporated a wide range of prescription medications to treat these conditions. Each of the 8 clients lived in one of the 3 apartment complexes managed by the facility and each had their medications managed by the Case Manager/QP #5 who was not licensed, or qualified to dispense prescribed client medications. The Case Manager/QP #5 had no training by a licensed, or qualified person in

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V 118	Continued From page 61 medication administration. Her job responsibility for managing client medications was assigned to her by the Executive Director/QP #1 and the Associate Director/QP #2 for clients who needed help with their medications. The clients' prescription medications were kept in the Case Manager's/QP#5's office, however they were not stored in a securely locked cabinet. She dispensed their medications from their prescribed medication bottles into their individual weekly pill reminder boxes with typed up information on each client's box about their medications. The weekly pill planners were not labeled with the required dispensing date, expiration date, directions for administration, the pharmacy address, or the name of the dispensing practitioner. The Case Manager/QP#5 met the clients at the facility to provide them with a week's filled medication planner and received from the client their prior week's planner. The were no written physician orders for the current and discontinued medications of these 8 clients at the facility and there was no evidence that a psychotropic drug regimen review was completed on the clients every six months. There was no evidence that these clients had their discontinued medications properly disposed of. The Case Manager/QP #5 acknowledged she returned client medications that were left over in their returned pill planners to the client's medication bottles. She failed to notify the pharmacist or provider of clients' missed medications. This constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,00.00 is imposed. If the violation is not corrected within 23 days and administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		

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V 119	Continued From page 62	V 119		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on record reviews, observation and interview the facility failed to maintain a record of medication disposal specifying the medication strength, disposal method, signature of the	V 119		

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V 119	Continued From page 63	V 119		

person disposing of the medication and the person witnessing the destruction for 4 of 8 clients who had medications managed by the facility (Clients #8, #11, #13 and #16). The findings are:

Review on 11-6-19 of Client #8's and Client #11's medication monitoring records revealed:
-Client #8 had the following medications discontinued:
  -benztropine mesylate 1 mg on 6-14-19:
  -aripiprazole 5 mg on 6-27-19;
  -clonazepam 0.5 mg on 7-5-19;
  -Belsomra (suvorexant) 10 mg on 9-3-19;
-Client #11 had the following medications discontinued:
  -tamoxifen 20 mg on 7-31-19 with a written notation from the Case Manager/Qualified Professional (QP#5);
-There were no written physician orders for the discontinued medications for these two clients;
-There was no written documentation which indicated when and how the discontinued medications for Clients #8 and #11 were disposed of.

Review on 11-6-19 of a written document attached to Case Manager/QP#5's office's file cabinet revealed:
-The document was a written record of medications which were "wasted" (taken to a local pharmacy for disposal);
-There were 4 entries dated from 8-16-19 through 10-30-19 on this document that had the date, the last name of the client, the medication and prescription number, the reason for the waste and the number of pills wasted as follows:
  -8-16-19 Client #8 "doxepin #635563 script change 50 milligrams (mg) to 100 mg #15";
  -8-21-19 Client #11 "lovastatin #1437615

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V 119	Continued From page 64 script change 20 mg to 40 mg #86"; -10-9-19 Client #16 "carbidopa-levo 50-200 #928275 script change to 15-100 #19"; -10-30-19 Client #13 "ranitidine #932775 change to famotidine 40 mg #41"; -There was no unit of measure documented for Client #16's medication; -The full name of the medication was not documented for Client #16; -The form did not contain a name or signature of the person who was responsible for or had disposed of the medications; -There was no documentation of a person having witnessed the disposal of the medications. Interview on 11-7-19 with the Case Manager/QP#5 revealed: -The facility had not maintained any record of medication disposal prior to 8-16-19; -The document with the 4 written entries from 8-16-19 through 10-30-19 was the only document on file for the disposal of medications; -She could not produce documentation for the disposal of Client #8's Belsomra; -She took clients' discontinued medications and placed them in a designated drop box for disposal at the local pharmacy or near the sheriff's office; -She was unaware of the requirement for a witness to be present during the disposal of client medications. This deficiency is cross-referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 119		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 120		

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(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 120	Continued From page 65 REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to store all medications in a securely locked cabinet for 8 of 8 clients who had their medications managed by the facility (Clients #8, #10, #11, #12, #13, #14, #15 and #16). The findings are: Review on 11-6-19 of the facility's written policy titled "Medication Services" established November 2003, revised 8-4-11 and reviewed 10-13-17 revealed: -No medications were to be stored or housed at the facility or Clinical Support offices; -All medications were to be stored in their original prescription containers by each client; -Clients who needed assistance in filling weekly	V 120		

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V 120	Continued From page 66	V 120		

pill planners were responsible for bringing their medication planners to the facility's Clinical Support office weekly;
-Consumers were responsible for assisting the clinical staff with filling their individual pill planners.

Observation on 11-6-19 at 11:52 AM revealed:
-8 medium sized plastic storage boxes were stored on top of a blue metal filing cabinet in the Case Manager's/Qualified Professional's (QP#5's) office;
-Weekly pill planners with medications contained in each were on top of multiple (at least 8) plastic storage boxes;
-Each storage box contained pharmacy-dispensed bottles of medications prescribed to clients;
-Medications stored included controlled and non-controlled medications used to treat psychiatric and medical conditions.

Interview on 11-7-19 with the Case Manager/QP#5 revealed:
-Client medications were stored in her office;
-The medications were kept in their bottles and in weekly pill planners and stored in the plastic storage boxes on top of the blue metal filing cabinet;
-The facility did not keep the medications secured in a locked cabinet;
-She locked the door to her office at the end of each work day.

This deficiency is cross-referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.

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V 121	Continued From page 67	V 121		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to obtain psychotropic drug reviews by a pharmacist or physician at least every 6 months affecting 8 of 8 clients who had medications managed by the facility (Clients #8, #10, #11, #12, #13, #14, #15 and #16). The findings are: Reviews on 11-6-19 and 11-7-19 of the medication management records for Clients #8, #10, #11, #12, #13, #14, #15 and #16 revealed: -An individual list for each client specifying their current and discontinued medications; -Client #8's medications were listed as follows: -glipizide extended release; -fluoxetine hydrochloride; -atorvastatin; -omeprazole delayed release; -quetiapine fumarate extended release; -Advair (fluticasone/salmeterol);	V 121		

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V 121	Continued From page 68 -metformin hydrochloride; -divalproex sodium extended release; -benztropine mesylate discontinued 6-14-19; -montelukast sodium; -lisinopril; -doxepin; -clonazepam discontinued 7-5-19; -aripiprazole discontinued 6-27-19; -Toviaz; -Belsomra (suvorexant) discontinued 9-3-19; -Client #10's medications were listed as follows: -sertraline hydrochloride; -atorvastatin; -doxepin hydrochloride; -Client #11's medications were listed as follows: -Aristada (aripiprazole lauroxil); -tamoxifen discontinued 7-31-19; -lovastatin; -metformin hydrochloride; -vitamin D3; -sertraline hydrochloride; -Symbicort (budesonide/formoterol); - "A new rescue inhaler"; -Client #12's medications were listed as follows: -Dupixent (dupilumab); -lamotrigine; -trazodone; -hydroxyzine hydrochloride; -mycophenolate; -hydrocortisone ointment; -doxycycline hyclate; -triamcinolone ointment; -Client #13's medications were listed as follows: -aripiprazole; -diazepam; -doxepin hydrochloride; -fenofibrate; -lisinopril; -metformin; -pantoprazole sodium;	V 121		

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V 121	Continued From page 69 -pravastatin; -ranitidine discontinued 10-31-19; -multivitamin; -Vimpat (lacosamide); -vitamin D3; -bupropion hydrochloride; -aspirin; -Symbicort (budesonide/formoterol); - "sumabuptan succenate" (sumatriptan succinate); -famotidine; -Client #14's medications were listed as follows: -Aristada (aripiprazole lauroxil); -benztropine mesylate; -dicyclomine; -Latuda (lurasidone); -omeprazole delayed release; -potassium chloride extended release; -topiramate; -Ventolin (albuterol); -Viibryd (vilazodone); -Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol); -naproxen; -hydrocortisone cream; -ketoconazole shampoo; -Client #15's medications were listed as follows: -amlodipine besylate; -atorvastatin; -Belsomra (suvorexant); -carvedilol; -clonazepam; -haloperidol; -Latuda (lurasidone); -lisinopril hydrochlorothiazide; -Linzess (linaclotide); -metformin hydrochloride; -tamsulosin hydrochloride; -timolol eye drops; -zinc;	V 121		

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V 121	Continued From page 70 -omeprazole; -Client #16's medications were listed as follows: -carbidopa/levodopa; -clozapine; -ramipril; -pramipexole; -aspirin; -multivitamin; -metformin hydrochloride; -ezetimibe; -rasagiline mesylate; -A binder that maintained printed and electronically signed individual client case contact notes by the Case Manager/Qualified Professional (QP#5) for each of these clients; -There was no documentation in each of the client's medication management records that indicated a psychotropic drug regimen review by a pharmacist or physician. Interview on 11-7-19 with the Case Manager/QP#5 revealed: -She did not know if the clients she managed medications for had drug regimen reviews for their psychotropic medications; -There was no record of drug regimen reviews maintained by the facility for any of the clients; -Coordination of drug regimen reviews for clients was not her responsibility; -She stated "Each doctor should be aware of what the other prescriber is giving. It's not for the Clubhouse to keep up with." This deficiency is cross-referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 121		

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V 123	Continued From page 71	V 123		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication errors were immediately reported to a physician or pharmacist for 3 of 8 clients who had medications managed by the facility (Clients #8, #11 and #14). The findings are: Review on 11-6-19 of the facility's written policy titled "Medication Services" established November 2003, revised 8-4-11 and reviewed 10-13-17 revealed: -In the event that a client refused medication, clinical support staff should: -review with the client the reasons why the medication was prescribed; -discuss with the client their reason for refusing the medication; -document the medication refusal/noncompliance; -notify the prescriber of the medication refusal and the reasons for the refusal. Review on 11-7-19 of printed client notes	V 123		

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V 123	Continued From page 72 documented by the Case Manager/Qualified Professional (QP#5) revealed: -Client #8 returned a total of 14 doses of Belsomra (suvorexant) and one morning dose of an unknown medication per a note dated 9-4-19; -Client #11 returned 2 evening doses of an unknown medication and 2 vitamin D3 pills per a note dated 9-11-19; -Client #11 returned 3 morning doses and 4 nightly doses of an unknown medication and "was not taking her medication half of the time" per a note dated 9-18-19; -Client #11 was "non-compliant with her mediations" and returned 3 morning doses of an unknown medication and 4 evening doses of an unknown medication per a note dated 10-30-19; -Client #14 "had missed Latuda on Monday and Tuesday and four noon Dicyclomine" per note dated 9-25-19; - None of the above medication errors/refusals included documentation that the errors were reported immediately to a physician or a pharmacist. Interview on 11-7-19 with the Case Manager/QP#5 revealed: -She determined if clients were compliant with their medications when she received their pill planners from the previous week; -It was possible for clients to throw their medications away without taking them; -Most of the clients would inform her if they weren't taking their medications; -Clients would decompensate and could need hospitalization if they didn't take their medications; -She was not consistent with notifying the physician or pharmacist about client medication errors/refusals; -She stated "I only call the doctor or pharmacy	V 123		

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V 123	Continued From page 73 depending on how many times pills are missed. If it's just a few days it's okay, but if it's a lot of days I call the doctor"; -She did not call the physician or pharmacist when Client #8 returned 14 doses of Belsomra (suvorexant). This deficiency is cross-referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 123		
V 174	27G .1201 Psychosocial Rehab - Scope 10A NCAC 27G .1201 SCOPE A psychosocial rehabilitation facility is a day/night facility which provides skill development activities, educational services, and pre-vocational training and transitional and supported employment services to individuals with severe and persistent mental illness. Services are designed primarily to serve individuals who have impaired role functioning that adversely affects at least two of the following: employment, management of financial affairs, ability to procure needed public support services, appropriateness of social behavior, or activities of daily living. Assistance is also provided to clients in organizing and developing their strengths and in establishing peer groups and community relationships. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to operate within the	V 174		

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V 174	Continued From page 74 scope of the program for which it is licensed, affecting 14 of 16 audited clients (#3, #4, #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16, FC #1 and FC #2) and 4 of 6 Qualified Professionals (Executive Director (ED/QP#1), Associate Director/QP #2, Program Coordinator/QP #3 and Case Manager/QP #5). The findings are: CROSS-REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) Based on record review and interview, the facility failed to ensure 4 of the 6 Qualified Professionals (Executive Director (ED)/QP#1, Associate Director/QP #2, Program Coordinator/QP #3 and Case Manager/QP #5) demonstrated the knowledge, skills and abilities required by the population served. CROSS-REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review, observation and interview, the facility failed to develop individualized treatment plans for 5 of 8 audited clients (Clients #3, #4, #6, Former Client (FC#1) and FC#2, and failed to implement strategies to meet the needs of 7 of 8 audited clients (Clients # 3, #4, #6, #7, #9, FC #1 and FC #2). CROSS-REFERENCE: 10A NCAC 27G .0208 Client Services (V115) Based on record review and interview, the facility failed to ensure the safety and welfare of 5 of 8 audited clients (Clients #3, #4 and #9, Former Client (FC #1) and FC #2). CROSS-REFERENCE: 10A NCAC 27G .1203 Operations (V176) Based on record review and interview, the facility	V 174		

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V 174	Continued From page 75 failed to provide skill development activities for 12 of 16 current clients (Clients #3, #4, #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16) and 1 of 2 former clients (FC #2) in the areas of medication management, use of leisure time, securing needed educational services. Review on 10/31/19 of an initial Plan of Protection dated and signed on 10/31/19 by the ED/QP #1 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -"I [the Executive Director/QP #1] was given 30 minutes to complete a plan. Since developing any meaningful plan to stated statutes I do not have access to in that time frame, I will close the Adventure House to all Consumers on 11/1/19 and develop a meaningful plan to reopen on 11/4/19." Describe your plans to make sure the above happens. -"Called [the local public transportation service] and cancelled all transportation for tomorrow. Staff will be at the program tomorrow to re-direct and other Consumers until we can complete a meaningful plan. Will notify [the Local Management Entity (LME)] of our closure." Review on 11/1/19 of a 2nd Plan of Protection dated and completed on 11/1/19 by the ED/QP #1 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -"We contest that anyone was at risk or endangered or neglected; -In regards to 10A NCCAC 27G.1201 Scope: -The Adventure House has been Accredited by Clubhouse International as an Evidence Based Model accepted by the NC Division of Mental	V 174		

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V 174	Continued From page 76 Health as a preferred form of PSR (Psychosocial Rehabilitation); -In fact we have been reviewed by [the LME (Local Management Entity)]/MCO (Managed Care Organization) and receive a higher rate of reimbursement for using this Model; -In addition, we received an annual survey by DHSR on August 13, 2019 that resulted in no deficiencies cited; -Members of the Adventure House are unable to engage in 6 to 8 hours of working on goals and we meet them at a level where they can be successful; -We began today working with staff in an all day staff training to refresh staff on the Model and in meeting the Scope of PSR as defined in statute; -Emphases was placed on Documentation of services, which is new to all staff due to our recent conversion to an electronic record. We understand that the HER (health electronic record) does not adequately prompt staff to complete necessary actions to protect the Health and Safety of our Members, and will perform followup training so that actions such as contacting a legal guardian is adequately documented; -In regards to 10A NCAC 27G.0205 Assessment and PCP (Person-Centered Plan): -We have received nothing from our reviewers (Surveyors #1 and #2) in writing so it is difficult to know what corrective action is needed. When asked, [Surveyor #1] stated that she could not tell me that; -Therefore, We are going to work to improve the timeliness of our PCPs, though we are dependent on Physicians to sign them in a timely manner; -We will review our plans to insure they are relevant to the Consumer, reflecting the goals actually being worked on through the program;	V 174		

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V 174	Continued From page 77 -Our Documentation was reviewed by both [the LME]/MCO and CARF (Commission on Accreditation of Rehabilitation Facilities) and found to be in compliance with state requirements. However, the implementation of the EHR may have adversely affected the quality of our Documentation; -We plan to provide additional training to staff, which began today, and review documentation as a part of ongoing staff supervision; -In regards to 10A NCAC 27G.0208 Client Services is again difficult to respond to in the absence of any documentation for our Reviewers; -We believe this may refer to how we deal with Members who have been adjudicated Incompetent; -We plan to review our policies regarding these individuals, ensuring that Legal Guardians are thoroughly informed of our Program and services, and any limitations regarding direct supervision and monitoring of these individuals; -We will discharge Consumers immediately if their behavior in our program poses a threat to their safety or the safety of others. We will keep the Guardians fully informed of problems as well as successes achieved through our work with these individuals. As always, we encourage family and guardians to visit the Clubhouse and Tours are available at any time; -We will also be more responsive in removing threats from other Consumers as we did with the events leading to the complaint that prompted this review; -Persons threatening other Consumers or instigating the use of illegal drugs will be immediately suspended and/or expelled; -Meals served through the program are heavily subsidized to reduce cost to Consumers and there has been a system in place for 33 years of operation, that no one will go without a nutritious	V 174		

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V 174	Continued From page 78 lunch." Describe your plans to make sure the above happens. -"We have contacted [the LME]/ MCO, and have requested technical assistance and support to assure our Clubhouse Model Program remains in compliance with all rules and regulations regarding our services and the documentation of our services; -We will begin a new weekly staff meeting each Wednesday to review our Policies, develop plans for dealing with more difficult Consumers and appropriate documentation; -We will invite [our EHR provider], to provide staff with additional training. Monthly House meetings involving all Members will occur on a regular basis so that Members understand their rights, review drug and alcohol policies, and other agenda items requested by the Members; -We will also encourage Members to use our Grievance Policy and to report any Heath and Safety issues immediately to staff; -[The LME]/MCO will also be invited to attend staff meetings to assist us in meeting all rule, regulations, guidelines or best practices as they deem appropriate; -Staff of the MCO in charge of the Provider Network have been copied on this report." Review on 11/4/19 of a 3rd Plan of Protection dated and completed on 11/4/19 by the Executive Director revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -"10A NCAC 27G .1201 Scope Psychosocial Rehabilitation Facilities for Individuals with Severe and Persistent Mental Illness: - The Adventure House currently meets all of the requirements identified in the Scope of	V 174		

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Service;
-We attempted to share with our Reviewers (Surveyors #1 and #2) the International Clubhouse Standards, which expands upon the requirements noted in this statute, but [Surveyor #1] stated that 'They did not care about the Clubhouse Model;'
-Our Plan of Protection dated 11/1/19 documented our compliance, not just by our own report, but the Accreditation process of Clubhouse International;
-Further evidence of our compliance with the scope of service and the requirements of NC Clinical Coverage Policy number 8A can be found by our participation in the Provider Monitoring Process conducted by [the LME/MCO] on August 15, 2018, where we were found to be COMPLIANT. This can be verified by contacting (the LME/MCO) Provider Network Director;
-The Management team of [the LME/MCO] recently received a tour of our Program and participated in a meeting with us on September 4, 2019. All present reported being impressed with our Program and services;
-Finally, we received a Annual Review from DHSR on August 13, 2019, where no deficiencies were sited;
-Our reviewers (Surveyors #1 and #2) failed to share with us their concerns regarding any specific issue of concern regarding scope of service;
-Both Reviewers were given two tours of our Clubhouse over the past several months, which specifically addresses the scope of our services;
-I was questioned about our Supported Education services and answered all questions;
-These supports are also covered in our tour and program materials, as well as the Standards we met regarding Edicational Supports documented in International Clubhouse

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V 174	Continued From page 80 Standards; -Scope also refers to 'individual served;' -All individuals Served are reviewed by [the LME/MCO] and we are given their Authorization to serve all the participants in our program; -Authorizations are based on adequate Assessments and Person Centered Plans, that are submitted to [the LME/MCO] as part of the Authorization Process; -We would have to be in compliance in order to receive Authorizations for services; -Our Reviewers were given access to the Documentation of these assessments, Person Centered Plans, and Authorization for Psychosocial Rehabilitation services ...; -It appears that our Reviewers are unfamiliar with Mental Health Services, and apparently are unaware of the population we serve; -We remain one of the top PSR programs in the state of NC and have been providing services for 33 years. In all those years have never encountered such a negative response to our Program. -Our plan is to continue to meet all the requirements under scope of service; -Without specific written concerns, we do not know how we can provide further information; -Responsibility for ensuring the program requirements are being met: -Our reviewers met with our Executive Director, Associate Director and Program Coordinator; -There should be no question regarding who is responsible; -Specifically, our Executive Director and our Associate Director are responsible for ensuring our program continues to meet program requirements of the NC Division of Mental Health, Medicaid, Clubhouse International, CARF and [the LME]/MCO; -10A NCAC 27G .0205 Assessment and	V 174		

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V 174	Continued From page 81 Treatment/Habilitation or Service Plan: -[The Associate Director] reviews all treatment plans, with Consumer input; -New Consumers may have current treatment plans from their referring Provider. Those needing treatment plans will be completed by a QP (Qualified Professional) and reviewed by [the Associate Director]; -[The LME/MCO]also reviews all treatment plans before as a part of their Authorization Process; -This is in place; -The PCP is based on a Clinical Assessment and these documents require the participation of Consumers; -We are aware that we have not always met the 30 day time table, and we do not receive payment for services until completion; -We have identified additional QP staff to assist with the timeliness of PCPs and [the Associate Director]and [the Case Manager/QP] to complete Clinical Assessments; -We should all new plans up to date within two weeks; -All strategies documented in our PCPs involve participation of the Consumer in Our Program; -Members choose how they utilize the Clubhouse, per the Clubhouse Model accepted by the Division of Mental Health; -All staff are responsible, with a specific staff designated to document the strategies; -Records will be reviewed by a QP to ensure compliance; -Training has already begun to train staff to better document services on our Electronic Record System. Further training will occur weekly in staff meetings, and upon the review of weekly documentation by [the Associate Director]and [the Executive Director]; -10A NCAC 27G .0208 Client Services:	V 174		

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V 174	Continued From page 82 -As was explained repeatedly to our Reviewer (Surveyor #1), there is nothing short of a fence and a guard that will ensure staff will know if a Consumer leaves the facility; -The Adventure House is not a locked facility and we are working with [the LME/ MCO] to develop a Consent to be signed by the guardian of any participant adjudicated incompetent of our limitations, so that their informed understanding is well documented; -The above mentioned Consent will include the name and telephone number of the legal guardian who will be called by the first staff Member to learn of a Participant leaving the facility; -Any specific instructions by the guardian shall be documented on this signed consent; -The time frame in which the legal guardian will be notified-Immediately upon a staff Member becoming aware of the problem, or as directed in writing by the legal guardian; -Those adjudicated incompetent, who have walked away from the program, will be the priority so that a plan acceptable in writing to the guardian can be put in place, or the person will be discharged from the program; -At no time shall staff assure a guardian that their ward is under constant staff control or that staff will be immediately aware of a Member leaving the program; -No individual will be physically detained by [the facility] staff; -[The LME/MCO] Provider Specialist, her supervisor, and [The LME/MCO] Provider Network Director have been made aware of the issues we have encountered with the two reviewers from DHSR; -They have offered any support we may need to address the problems; -[The Executive Director] is responsible for all	V 174		

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V 174	Continued From page 83 timelines and corrections." Review on 11/13/19 of a 4th Plan of Protection dated and completed on 11/13/19 by the ED/QP #1 and with a written letter dated 11/11/19 from a separate mental health provider revealed: -"We contest that anyone was at risk or endangered or neglected; -In regards to 10A NCCAC 27G.1201 Scope: -The Adventure House has been Accredited by Clubhouse International as an Evidence Based Model accepted by the NC Division of Mental Health as a preferred form of PSR; -In fact we have been reviewed by [the Local Management Entity (LME)/MCO and receive a higher rate of reimbursement for using this Model; -In addition, we received an annual survey by DHSR on August 13, 2019 that resulted in no deficiencies cited; -Members of the Adventure House are unable to engage in 6 to 8 hours of working on goals and we meet them at a level where they can be successful; -We began today working with staff in an all-day staff training to refresh staff on the Model and in meeting the Scope of PSR as defined in statute; -Emphases was placed on Documentation of services, which is new to all staff due to our recent conversion to an electronic record; -We understand that the EHR does not adequately prompt staff to complete necessary actions to protect the Health and Safety of our Members, and will perform follow up training so that actions such as contacting a legal guardian is adequately documented. -10A NCAC 27G.1203 Skill Development: -Our Reviewers (Surveyors #1 and #2) seem to have a narrow view of skill development activities which makes it very difficult to explain how these	V 174		

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activities are accomplished within a Clubhouse Model Program;
-Rather than asking 'help me understand how [the facility] accomplishes skill development', they ask rapid fire questions that throws staff into a defensive posture and results in getting off subject;
-The question remains unanswered;
-Skill development is accomplished through participation in the work ordered day of the Clubhouse and through the work mediated relationships developed with both staff and Members;
-Such skills as listed in this section cannot be taught in a vacuum;
-The skills only assume importance in their relatedness to the whole of a person's life ... through participation in the activities of daily living in the Clubhouse;
-Members cannot be forced into classes and may not be able to be fully involved for 6 to 7 hours per day when they first come to the Clubhouse;
-Community Living skills is not some kind of prescribed formula, which should be administered in calibrated dosages by qualified professionals to their ill patients;
-Many programs expect professionals to be actively engaged in daily life, and the Consumers are expected to sit in groups and classes and learn about the living from a safe and separate place.
-The Adventure House is a rehabilitation program in which the Clubhouse structure and relationships foster the development of Members' confidence and ability to function, their interest in caring for themselves, in socializing with others and in participating in activities of the work ordered day;
-The Clubhouse is not preparing people to live

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in the community, but rather, we are the community. Members and staff are living daily, side by side, learning and sharing as we go;

-The central ingredient is that it is a "normalized" environment. It is a place people come to live their lives. Members learn by doing and being a part of the work ordered day of the Clubhouse;

-We cannot teach budgeting, if there is nothing in the world that our consumers can envision as worth budgeting for. Why save to buy new clothes when there is no place to go in them, or for vacation, when there is no one with whom to go and nothing from which to take a vacation?

-Activities of daily living, personal care, grooming, social relationships, etc cannot be taught in the vacuum of skill classes. It is unlikely that any reader of this document learned their personal hygiene skills in a class room setting;

-Likewise, skills such as interpersonal and social skills cannot be taught in a vacuum. One must have contact with others in order to develop such skills;

-Teaching the use of leisure time does little good if people are isolated in a rural community without public transportation;

-We have found that poor personal hygiene is not due to adults with mental illness lacking skills, but rather is due to isolation with no reason to regularly take a bath or wear deodorant;

-Rather than conducting personal hygiene classes, simply pulling the person aside to address a hygiene issue usually takes care of the problem, giving them a reason to clean up;

-The Clubhouse has personal hygiene products we give to members who lack such items and assistance to help them obtain those items on their own;

-The Clubhouse provides the opportunity to develop real relationships with others that helps

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Members to use their existing social skills;
-In essence, the Clubhouse is where Members have the opportunity to use and further develop such skills by doing, rather than some abstract concept taught in classes. Through the work of the Clubhouse, and interacting with other Members and staff, Members learn other skills such as housekeeping, cooking, etc.;
-Members are made aware of the limited transportation opportunities in [the local] County;
-When [the local public transportation service] first developed a van (bus) route (CCT) around [the local town], the Clubhouse bought tickets and strongly encouraged that all Members and staff ride the loop to see firsthand where it goes and how to use it;
-Members have also been provided information on a free van route (REACH) that goes by the Community College and Social Services, and showed where to catch this van, within a block of the Clubhouse;
-Supported Education has always been a part of our Clubhouse;
-We had on site classes for ABE (Adult Basic Education) and High School Diploma classes until the Community College had to withdraw the teacher due to funding cuts;
-We now offer to take Members to placement testing at the Community College and assist all who are interested in taking these classes at the community college or help them to take courses on line;
-Both Members and staff serve as tutors for those having difficulty with a subject like math;
-In fact, a need for basic math tutoring arose during this Review, when four Members, enrolled in [a free online school], encountered a math problem for which they needed help and staff and members worked on the problem together;
-We have had two Members Graduate from

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V 174	Continued From page 87 local colleges with a four year degree, and have one active member with several associate degrees and certificates in retail marketing and business through the ongoing supports she receives through [the facility]; -Many have earned their high school diploma through [the facility], with Members and staff there to applaud them at graduation. (Our Executive Director arranged to sign one Member out of the locked unit at Broughton Hospital so she could participate in her graduation, returning her to the hospital following the ceremony); -We keep materials on a variety of educational opportunities, having difficulty keeping current offerings from the community college available because Members take them home. (These elements of our Supported Education Program are documented here because several attempts to tell our Reviewers were interrupted with rapid fire questions which made it difficult to explain our Supported Education); -We intend to increase our focus on Supported Education, through regular announcements in our daily morning meeting, our daily in-house newsletter and new Member meetings that we plan to start again in December; -We will again start monthly Employment dinners for all Members participating in, or interested in Supported Employment and Transitional Employment; -It is our plan to include Supported Education opportunities to these after hour monthly meetings, where we will offer dinner. All members are welcome. The meetings will be in the evenings so that our employed Members can attend. -This regular part of our program, was suspended due to a change in staff. Our current staff that takes the lead in Supported Education has been out with knee surgery.	V 174		

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V 174	Continued From page 88 -Our Education Corner will be restocked next week and we will follow up to be certain Supported Education is still included in our tour of the Clubhouse, where each Program component is reviewed along with each of our three prevocational work units. -(Our Reviewers received two such tours in the last three months, each lasting over an hour. How they missed important components like Supported Education will be reviewed and any needed corrections made.); -Certainly, all Members are not always at their best, and some are not able to perform more than a few tasks each day; -As I tried to explain to our Reviewers, rather than complaining about Members sitting on the sofa (there are a total of 5 such seats available) we celebrate the fact that the Member got to the sofa, which may have taken more effort than those involved all day; -Many, like our Reviewers tour guide started out on that sofa. Now she is giving tours to DHSR Reviewers, and participated in a two week comprehensive Clubhouse Training at a Clubhouse International Certified Training Base. Members of the Adventure House have attended 14 of the 16 International Seminars, including the ones in Sweden, Finland and Canada) since 1987. Several Members conducting workshops on various components of the Clubhouse Model alongside staff. Adventure House Members have attended all USA Clubhouse Conferences, and numerous meeting of the NC Clubhouse Coalition. Members have accompanied staff to all comprehensive Clubhouse trainings, including the original Clubhouse in NYC. One Member of the Adventure House now serves on the International Clubhouse Advisory Board, attending yearly meetings in New York with our Executive Director;	V 174		

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V 174	Continued From page 89 -In regards to 10A NCAC 27G.0205 Assessment and PCP: -We have received nothing from our reviewers in writing so it is difficult to know what corrective action is needed; -When asked, [Surveyor #1] stated that she could not tell me that; -Therefore, We are going to work to improve the timeliness of our PCPs, though we are dependent on Physicians to sign them in a timely manner; -We will review our plans to insure they are relevant to the Consumer, reflecting the goals actually being worked on through the program; -Our Documentation was reviewed by both [LME]/MCO and CARF, and found to be in compliance with state requirements; -However, the implementation of the EHR may have adversely affected the quality of our Documentation; -We plan to provide additional training to staff, which began today, and review documentation as a part of ongoing staff supervision. -11/12/19 At admission: -We will document strategies to address client presenting problems/needs from the referral form and any assessment we have access to; -This will be documented as an initial treatment plan on the first day of admission; - Any revisions will be documented as revisions and all will be incorporated into the initial PCP within 30 days of admission; -(The) Plan will address problems/needs documented by referral source and/or stated by Consumer and will document staff responsible for implementing the strategies during the first 30 days, or until a full PCP including PSR services is put in place; -A Member of [the facility] once stated on his first day at the Clubhouse that he 'likes Adventure	V 174		

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House'. When asked why, he stated that he had been here all day and nobody asked him what is wrong with him. Sadly, this will no longer be the experience of future Members;
-In regards to 10A NCAC 27G.0208 Client Services:
-(This) is again difficult to respond to in the absence of any documentation for our Reviewers;
-We believe this may refer to how we deal with Members who have been adjudicated Incompetent;
-We plan to review our policies regarding these individuals, ensuring that Legal Guardians are thoroughly informed of our Program and services, and any limitations regarding direct supervision and monitoring of these individuals;
-We will discharge Consumers immediately if their behavior in our program poses a threat to their safety or the safety of others;
-We will keep the Guardians fully informed of problems as well as successes achieved through our work with these individuals;
-As always, we encourage family and guardians to visit the Clubhouse and Tours are available at any time;
-We will also be more responsive in removing threats from other Consumers as we did with the events leading to the complaint that prompted this review;
-Persons threatening other Consumers or instigating the use of illegal drugs will be immediately suspended and/or expelled;
-Meals served through the program are heavily subsidized to reduce cost to Consumers and there has been a system in place for 33 years of operation, that no one will go without a nutritious lunch;
-11/12/19 A notation was added to this section regarding client supervision at PSR program:
-Our Reviewer, [Surveyor #1], reported that she

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witnessed a Consumer get in an argument with another Member on the patio and that this escalated to a level she felt was unsafe;
-She stated no staff were present to intervene;
-I was not aware of this incident;
-Later that day, I received documentation regarding this incident from one of my staff, who alerted the Program Coordinator who dealt with the upset Consumer regarding his inappropriate behavior and took him home to cool off;
-A Level 1 incident report was completed;
-So, it appears staff were present, the incident was documented and the issue was addressed with the Consumer.
-[Surveyor #1] also reported an incident that occurred while she was present regarding a Consumer adjudicated incompetent leaving the property;
-[Surveyor #1] was given documentation of this incident and the steps we took;
-[Surveyor #1] pointed out that the group home was called about the incident, and not the legal guardian as evidence that we are not taking the steps we said we would;
-We first called the group home, so that they would be alerted that we would be bringing this Member home;
-It was not necessary to call the guardian because the group home told us the guardian was in [the local town] and they would call the guardian to come to [the facility]and talk with the Consumer;
-One of my staff, and I both spoke with the guardian, who ask us not to discontinue services and give this Consumer one more chance to not leave the Program. I spoke briefly with the Consumer, making it clear that she could not continue coming to [the facility] if she left the property again;
-The Guardian then met with the Consumer,

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V 174	Continued From page 92 who remained in the program for the remainder of the day. Our calling the Group Home was totally appropriate in this case, because we were sending the Consumer home. A call would have been made to the Guardian next to explain that we could no longer provide services. That call was not needed. -Those are two incidents sited by our Reviewer (Surveyor #1) that we had failed to provide proper supervision to the best of my knowledge. In both cases I believe we responded appropriately. This is not to say we will not make mistakes, but we are committed to taking continued corrective actions to safeguard the Members of the Adventure House." PLANS TO MAKE SURE THE ABOVE HAPPENS: -"We have contacted [LME]/MCO and have requested technical assistance and support to assure our Clubhouse Model Program remains in compliance with all rules and regulations regarding our services and the documentation of our services; -We will begin a new weekly staff meeting each Wednesday to review our Policies, develop plans for dealing with more difficult Consumers and appropriate documentation; -We will invite [our EHR provider], to provide staff with additional training; -Monthly House meetings involving all Members will occur on a regular basis so that Members understand their rights, review drug and alcohol policies, and other agenda items requested by the Members; -We will also encourage Members to use our Grievance Policy and to report any Health and Safety issues immediately to staff; [LME]/ MCO will also be invited to attend staff meetings to assist us in meeting all rule,	V 174		

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regulations, guidelines or best practices as they deem appropriate. Staff of the (LME)/MCO in charge of the Provider Network have been copied on this report;
- (On) 11/12/19 I was told that our Executive Director, Associate Director, Program Coordinator, and Case Manager assisting with medication minders were declared 'incompetent' by our Reviewers;
-[Surveyor #1] clarified with me (the ED/QP #1) that I was competent to write the plan of protection, but I (ED/QP #1) was not competent to see that it is implemented;
-As I understand it, I must find someone from outside our Organization to implement our Plan of Protection and that no one from [the LME]/MCO can be designated to do that;
-Therefore, we have contacted [Chief Executive Officer (CEO)] of a [local mental health organization];
-He has agreed to do whatever is required by DHRS to ensure our plan and any addendums added by DHSR are implemented;
-They request that DHSR provide in writing, what is expected of them, and what reporting they need to provide back to DHSR;
-I met with [the CEO]and his staff on 11/11/19 to review this plan, and he or his designee shall come to [the facility]during our Reviewer's "Exit" if possible. Hopefully, they will be able to conduct the Exit Interview with us and [the CEO]'s staff on the morning of 11/12/19. This is important for them to be present during the exit and be able to ask any questions they may have. A representative of [the LME]/MCO will also be invited to attend this meeting."

Review on 11/ /19 of a printed and signed letter dated 11/11/19 from the CEO of a local mental health organization revealed:

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V 174	Continued From page 94 -The printed letter was addressed to the ED/QP #1 of the facility; -The letter had statements that: -the ED/QP #1 was to identify a community mental health agency, as requested by the NC Division of Health Service Regulation (DHSR), to provide QP consultation in implementation of his Plan of Protection; -a meeting with held on 11/11/19 between the ED/QP #1 and the Associate Director (Program Manager)/QP #2 and the CEO and his staff regarding the cited rule violations; -The CEO of the mental health organization believed he and his staff had the ability to assist the ED/QP #1 as requested with his Plan of Protection. Clients #3, #4, #5, #6, #7, #9 and Former Clients (FC #1 and FC #2) were each admitted to the facility on various dates and each client had a diagnosis of a severe and persistent mental illness. Clients #3, #7, #9 and FC #2 were each diagnosed with Schizophrenia while Client #4 and FC #1 were diagnosed with Bipolar Disorder. They did not have individualized treatment plans developed. The treatment plans of Client #3, #4, #6, FC #1 and FC #2 were worded the same and ranged from each client's preferences and strengths to their needs and goals. They had the same strategies for one-on-one assistance, direction and supervision by staff to support their daily work tasks which were not implemented by staff to keep each these clients engaged and appropriately supervised in their work units and how to use their leisure time appropriately to ensure their individual safety. Clients #3, FC #1, #2 with Client #9 for example, had walked away from the facility without staff supervision. These clients engaged in substance abuse behaviors to the extent that they were threatened to be robbed	V 174		

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V 174	Continued From page 95 by a local drug dealer if they tried to buy drugs from him. Client #9's treatment plan dated 9/9/19 did not include strategies that addressed her behaviors of elopement, personal care, and stealing. Client #7's treatment plan dated 8/14/19 included his desire to continue Adult Basic Education classes but there was indications staff were working with him to develop an educational goal or implement educational strategies such as focusing on options to access classes. The Executive Director/Qualified Professional (ED/QP #1) acknowledged he and the Associate Director/QP #2 were responsible for ensuring the facility met the requirements of the psychosocial rehabilitation (PSR) program. The ED/QP #1, who was ultimately responsible for managing the PSR facility, communicated to the staff and clients his perception that the clients, which included 14 of 16 audited clients (#3, #4, #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16, FC #1 and FC #2), did not need to be taught skills and were able to manage on their own with their existing strengths and abilities. As a result, Clients such as FC #1 and FC #2, who had substance abuse issues which interfered with their own rehabilitation needs, were involuntarily removed from the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3,000.00 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 174		
V 176	27G .1203(A) Psychosocial Rehab - Operations	V 176		

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V 176	Continued From page 96 10A NCAC 27G .1203 OPERATIONS (a) Skills development, educational and prevocational services. Each facility shall provide: (1) skills development activities which include: (A) community living, such as housekeeping, shopping, cooking, use of transportation facilities, money management; (B) personal care such as health care, medication management, grooming; (C) social relationships; (D) use of leisure time; (2) educational activities which include assisting the client in securing needed education services such as adult basic education and special interest courses; and (3) prevocational services which focus on the development of positive work habits and participation in work activities. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide skill development activities for 12 of 16 current clients (Clients #3, #4, #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16) and 1 of 2 former clients (FC #2) in the areas of medication management, use of leisure time, securing needed educational services. The findings are: Review on 10/24/19 of the facility's printed undated Client Handbook revealed: -Clients who were interested in Adult Basic Education (ABE) could take online classes through the facility; -The facility was working on ways to support	V 176		

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clients who wished to continue their education beyond high school.

Review on 11/12/19 of the facility's written policy titled "Clubhouse Educational Supports," which had an established date of 1986 and a reviewed date of 11/11/16 revealed:
-ABE and High School Diploma classes would be provided to clients through the local community college;
-Other educational supports would be provided on an individual basis to clients who wished to further their education;
-The ED/QP #1 was responsible for arranging for educational classes to be conducted twice a week at the facility;
-There was adequate space at the facility for these classes;
-Staff were responsible for keeping educational materials offered in the community up to date at the facility;
-The vocational work unit, "Member Services," would assist clients with financial aid applications, tutoring and problem-solving transportation issues.

Review on 11/4/19 of the local community college's website revealed:
-There were no offered online ABE and/or GED (high school equivalency) courses;
-These courses were offered onsite at the community college.

Reviews between 10/24/19 through 11/6/19 of Client #3's and FC #2's records revealed:
-Client #3's initial treatment plan dated 11/26/18 and FC #2's initial treatment plan dated 9/3/19 each had the staff responsible for:
-evaluating their educational status;
-assisting in the development of new or

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additional educational goals;
-helping them examine educational options;
-There was no documentation which indicated staff worked with either Client #3 or FC #2 on their educational needs, interests and/or options.

Review on 10/31/19 of Client #4's written progress notes for the period from 8/27/19 to 10/15/19 revealed:
-A note dated from 8/27/19-9/3/19 had her frustrated, loud and confrontational with staff during a social activity when staff attempted to redirect her;
-From 9/3/19-9/10/19, she engaged in taking breaks as needed during the week and speaking with her peers while she struggled with her decision-making skills by her having left the facility with peers and returned "after getting high;"
-From 10/15/19-10/22/19, she used her breaks to smoke and socialize with her peers;
-The break areas were to allow for "unstructured socialization skills each day;"
-She got into an argument with a peer that required staff to de-escalate to calm her;
-She tended to sit in the kitchen unit and nap.

Reviews from 10/24/19 to 11/6/19 of Client #7's record revealed:
-His 8/14/19 treatment plan included his educational interest in continued Adult Basic Education (ABE) courses;
-There was no documentation in his record that indicated staff had worked with him to access ABE classes online or at the local community college.

Review on 11/6/19 of Client #9's record revealed:
-Her 9/9/19 treatment plan included an additional diagnosis of nighttime enuresis (bedwetting) and

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had her with a tendency to "wear the same clothes for days;"
-Her plan included her "constant need" for staff prompting and re-checking of her personal hygiene;
-A written note dated 11/6/19 indicated she repeated her behavior of having walked off from the facility.

Reviews from 11/6/19 through 11/7/19 of the medication management records for Clients #8, #10, #11, #12, #13, #14, #15 and #16 revealed:
-The facility's Case Manager/Qualified Professional (QP #5) managed each of these client's prescribed medications.

Observation on 11/8/19 of Client #3 at 9:24 AM revealed:
-He was seated by himself in the same place he was observed on 10/24/19 at 11:10 AM;
-He was dressed in a pair of black denim jeans and a black-colored hooded sweatshirt which was the same clothing he wore the previous 2 days, on 11/6/19 and 11/7/19.

Observation on 11/8/19 at 9:31 AM of Client #7 revealed:
-He was seated at a table with a female client in a location that was considered an area for Client Transportation Services;
-His physical appearance was disheveled, in that, his hair was uncombed, he was unshaven and dressed in a wrinkled shirt.

Observation of and interview on 10/23/19 at 11:20 AM with Client #9 revealed:
-Her hair was uncombed, and her clothes were wrinkled and soiled;
-She stated she did not need assistance from her caretakers with bathing, dressing, grooming

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and/or laundering her clothes;
-She talked about her interests of drawing and listening to music on the computer;
-She stated she used her time at the facility by sitting around, eating and smoking cigarettes.

Observation on 11/8/19 at 9:40 AM of Client #9 revealed:
-She was dressed in the same clothing she wore on 10/23/19;
-Her clothing was a navy-blue sweatshirt with a large chalky white stain down the front side of her shirt;
-Her hair was unkempt and tangled.

Interview on 10/23/19 with Client #3 revealed:
-He was willing to let staff (the Program Coordinator/Qualified Professional (QP#3)) know that day, 10/23/19, he wanted to go to school.

Observation and an additional interview on 10/24/19 at 11:10 AM with Client #3 revealed:
-He was seated by himself next to a bookshelf in a corner of a room that was considered by the facility to be the "Education Center;"
-He stated he told the Program Coordinator/QP #3 yesterday he wanted to go back to school;
-He had not looked through any of the school information on the bookshelf because "it was old stuff;"
-Observation of the local community college course directory on the bookshelf was for the school year 2017-2018.
Interview on 10/23/19 with FC #1 revealed:
-The facility had "no real activities," to keep clients occupied throughout the day;
-Clients signed up when they came into the facility to volunteer to do work tasks for the facility (cooked and served the meals while the clients paid for the meals, swept and cleaned the

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V 176	Continued From page 101 building, counted the money the facility made from their snack bar, breakfast and lunch meals, and kept client attendance records) with no scheduled activities in between the work activities except a social event every Tuesday; -Staff did not know where each client was during the program hours because sometimes, they (clients) left and walked around the neighborhood and walked to the store without staff having noticed they were absent; -The Program Coordinator/QP #3 said they were not there to supervise everyone and the guardians could pull their clients out of the program if they (the guardians) did not want them there; -He was his own guardian; -There were only a "few" clients who were placed into jobs in the community. Interview on 10/25/19 with FC #2's legal guardian revealed: -Staff told her they would work with FC #2 on his high school equivalency courses while he was at the facility, but he provided her with no evidence of his efforts in pursuing his education. Interview on 11/6/19 with a staff of the Adult Learning Center at the local community college revealed: -The Adult Learning Center provided the ABE, Adult High School (AHS), and GED with High School equivalency programs; -These programs were provided onsite at the community college and were not available online; -A couple of ABE classes used to be provided at the facility but he believed the classes were discontinued because of low attendance; -He did not know if clients from the facility came to the Adult Learning Center currently unless he had their names.	V 176		

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V 176	Continued From page 102 Interviews on 11/6/19 and 11/8/19 with the Associate Director/Qualified Professional (QP #2) revealed: 11/6/19, the funding for the ABE classes was discontinued about 10 years ago due to local community college budget cuts; -Computers were in the TE (Transitional Employment) room if clients wanted to take online ABE or GED courses through a local community college; -Staff #6, who was out for knee surgery, helped clients work on school assignments on facility computers, gave them documents about community college courses and helped clients complete applications for financial aid programs (Pell grants); -Various staff from the rehabilitation specialists to the QPs filled in for Staff #6's job duties with clients while she was out; -They had 1 client who attended ABE classes at the local community college, 1 client who took high school equivalency courses at the local community college, 1 client who took math classes online and 1 client who took online educational classes through the Khan Academy; -The facility had an average of 40-50 active clients; 11/8/19, one of the problems with getting clients daily to the local community college was transportation; -The facility had a van but no budget funding for educational transportation although they were trying to work on this area; -Staff could show clients how to use the public transportation service to get to the school; -If a volunteer teacher came to the facility and taught ABE classes, this meant the facility would be responsible for the volunteer's training costs because volunteers had to be trained like paid	V 176		

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staff;
-They did not have additional funding to train volunteer staff.

Interviews on 10/31/19 and 11/6/19, with the Executive Director/QP #1 revealed:
-10/31/19, the facility had 80 active members (clients);
-Clients had already learned basic skills like personal hygiene to care for themselves and were not taught skills at the facility (refer to V 112 for additional information);
-11/6/19, he did not have additional client written progress notes to provide from the week of 10/31/19 because the facility's electronic client record system "wiped out" 100% of the progress notes that had been entered into the system by staff;
-4 members (clients) were in active supported education, which meant they took educational courses online and 1 client attended the local community college for her ABE courses;
-Clients had the right to use their break time between their work activities how they wanted;
-Clients should not be engaged 6-7 hours in work activities a day because they did not have the stamina;
-Clients needed to take breaks after a doing a task and it was a client's choice what how they used their time at the facility when they came;
-The facility's program was based on the "Fountain House" or "Clubhouse" model where clients' abilities were focused on and not their illnesses or what they were not able to do;
-He had no response regarding staff engagement with clients in areas of leisure time activities and group education with examples of coloring, drawing, medication education and dependent on client interests and needs;
-He had an average of 50 people a day at his

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V 176	Continued From page 104 program and everyone could not be watched. This deficiency is cross-referenced into 10A NCAC 27G .1201 Scope (V174) for a Type A1 rule violation and must be corrected within 23 days.	V 176		
V 502	27D .0102 Client Rights - Suspension and Expulsion 10A NCAC 27D .0102 SUSPENSION AND EXPULSION POLICY (a) Each client shall be free from threat or fear of unwarranted suspension or expulsion from the facility. (b) The governing body shall develop and implement policy for suspension or expelling a client from a service. The policy shall address the criteria to be used for an suspension, expulsion or other discharge not mutually agreed upon and shall establish documentation requirements that include: (1) the specific time and conditions for resuming services following suspension; (2) efforts by staff of the facility to identify an alternative service to meet the client's needs and designation of such service; and (3) the discharge plan, if any. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement its policy for expelling a client (Former Client (FC#1)) from a service. The findings are:	V 502		

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V 502	Continued From page 105 Review on 11/7/19 of a written facility policy titled "Suspension or Expulsion of Services" revealed: -The policy was a 2-page document which had the policy established on 12/3/03; -The policy was approved by the Board of the Licensee on 2/22/11 and had a date reviewed on 2/10/17; -The procedures contained in the written policy for client suspension or expulsion included: -Authorization was given to all staff to "immediately" suspend a client for behavior that interfered with another client in the program; -Staff needed to attempt to resolve issues as an issue arose to prevent suspension if possible; -If a client's behavior was an exacerbation of their mental illness, the client was to be referred "immediately" to their "clinical home" or an emergency service; -Suspensions were not to be used as punishment toward a client but to protect client safety; -Client suspensions or expulsions were to be documented in a written progress note and followed by the completion of a Level II incident report for submission to the Local Management Entity within 72 hours; -All client suspensions and expulsions would be reviewed by a Client's Right Committee at a scheduled meeting or at "special called meeting" if the suspension or expulsion occurred outside the regularly scheduled meeting. Review on 10/23/19 of a written North Carolina Incident Response Improvement System (IRIS) report dated 10/16/19 for FC #1 revealed: -10/16/19, FC #1 was asked to leave the facility by a staff (Staff #7) after Client #5 screamed he was not returning to the facility because FC #1, who had sent him threatening texts with profanity and threatened to harm him, had returned to the	V 502		

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program;
-On 10/18/19, the Executive Director/Qualified Professional #1 received a report from the facility's Residential Specialist who had a family member who dealt illegal drugs and this family member;
-The Residential Specialist warned that if FC #1, and two other clients (FC #2 and Client #3) tried to return to his home, which was within walking distance of the facility to buy more drugs, they were endangered of being robbed;
-The report indicated FC #1 was discharged from the facility on or about 10/18/19 based on his difficulties with his substance abuse disorder and anger issues;
-He was recommended to seek help for his substance use disorder and to be assessed for his "hostile" behavior.

Interview on 10/23/19 with FC #1 revealed:
-He acknowledged he made threats through a social media format toward Client #5 that contained profanity and a threat to harm him that would put Client #5 in the hospital;
-The threats were made outside the psychosocial rehabilitation (PSR) program's hours and related to the context of Client #5's relationship with his (FC #1)'s family member;
-He sent Client #5 a follow up message through a social media format prior to his 10/16/19 return to the program that told Client #5 he had no intentions of harming him and he wanted them to keep separated;
-When he walked into the facility on 10/16/19, Client #5 started screaming either he (FC #1) had to leave the program or he was going to leave;
-Staff #7 took him into the TE (transitional employment) room at the facility and told him that the Executive Director/Qualified Professional (ED/QP #1) told him he had to return home

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because of his threats toward Client #5;
-Staff #2 took him and his wife home;
-He called the facility to talk with ED/QP #1 and had to leave a message for his call to be returned;
-On 10/18/19, he received a voice mail message from the Associate Director/QP #2 that he could not return to the program and needed help for his substance use and anger issues;
-He had no meeting with the ED/QP #1 or other staff that explained his expulsion from the program.

Interview on 11/8/19 with the Associate Director/QP #2 revealed:
-She had left the voice mail on FC #1's cell phone on 10/18/19 which told him that he was not allowed back to the program and needed to return to his clinical home for more treatment of his anger and substance abuse;
-She was certain she had told him to go back to his local mental health provider;
-The ED/QP #1 made the decision that FC #1 was expelled from the PSR program;
-The Local Management Entity (LME) expected the facility to have a Clients Right Committee in place but the committee had not operated in over one year;
-The Coordinator of the Clients Right Committee was in the hospital and she was responsible for recording and maintaining meeting minutes;
-There was no backup for the Coordinator of this committee;
-The Associate Director/QP #2 did not know where the written meeting minutes of the Clients Right Committee were kept;
-There was no special-called meeting when FC #1 was expelled from the PSR program;
-The staff responsible for a called special meeting was her;

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V 502	Continued From page 108 -The ED/QP #1, her and the former Quality Assurance/Quality Improvement (QA/QI) staff person who retired the end of last year served as the QA/QI committee for the facility.	V 502		
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. (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 record review and interview, the facility failed to protect its clients from exploitation by making it contingent for clients who lived in the apartments managed by the Licensee that they participate in the psychosocial rehabilitation	V 512		

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V 512	Continued From page 109 (PSR) program operated by the Licensee. The findings are: Review on 11/6/19 of a written facility policy with an established policy date of 1989 and titled "Management of Adventure House Apartments" revealed: -The policy had a Board approval dated in 11/2002; -The policy had a date reviewed on 12/9/16; - The 4 apartment complexes listed under the facility's management responsibility were: -[Apartment Complex C] -[Apartment Complex D] -[Apartment Complex A] -[Apartment Complex B]; -A paragraph that pertained to the [Apartment Complex A] included a statement that the facility received a management fee equal to 13 % for the total rent collected; -All "prospective" residents of the apartments were required to have a "Supported Living Service" as part of their facility treatment plan; -An "unofficial waiting list" was maintained of facility clients who applied for an apartment; -A "selected member" (client) was placed on an "official waiting list," which triggered the required paperwork to be completed for a client to be moved into an apartment managed by the facility; -The facility was responsible for rent collection, which was accomplished through the facility's "Member Bank;" -All apartment residents were required to set up a bank account through the facility's Member Bank to pay their monthly rent; -The written requirement for apartment residents to use this one method with which to pay their monthly rent was reiterated in the facility's 1989 written policy titled "Supported Living."	V 512		

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V 512	Continued From page 110 Review on 10/24/19 of the facility's undated client handbook revealed: -Member Services was one of the 4 vocational work units of the facility; -One of the duties in Member Services was to assist members (clients) with apartment documentation and their annual recertification; -There were 3 of 4 supportive housing apartments that were included: [Apartment Complex C] with 11 single bedroom units, [Apartment Complex A] with 8 single bedroom units and [Apartment Complex B]; with 10 single bedroom units; -A statement that a member (client) had to be an active member of the facility to be "eligible" for an apartment." Reviews on 10/24/19 and 11/12/19 of the October 2019 and November 2019 resident apartment lists and a written list of the current facility clients provided on 10/23/19 revealed: -3 of 4 apartments were identified with the number and names of the occupants; -[Apartment Complex C] had 9 residents in 10/2019 and 8 residents in 11/2019; -[Apartment Complex A] had 8 residents in 10/2019 and 11/2019; -[Apartment Complex B] had 10 residents in 10/2019 and 11/2019; -Each resident in these 3 apartment complexes was a current facility client. Review on 11/8/19 of Client #8's apartment packet with a move-in date of 2/6/17 revealed: -Her apartment packet was in an individual paper record with her demographic data and was maintained at the facility; -She had 2 written and signed lease agreements; -The 1st lease agreement made on 2/6/17 was between her as "Tenant" and [the Facility] as	V 512		

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"Landlord;"
-This agreement added the name of the Licensee as the landlord and included Client #8's portion of her monthly rent;
-Her 2nd lease agreement made on 2/21/17 was with a regional government housing subsidy program which indicated [the Facility] as the "Owner" and included both the government rent subsidy amount and Client #8's rent amount per month;
-A 5-page document of written apartment rules and regulations for [Apartment Complex A] that:
-included a minimum of 42 rules made by the Licensee/facility for the apartment residents;
-the rules were acknowledged to be a part of each client's apartment lease;
-#40 rule stated "Tenants of the [Apartment Complex A] APARTMENTS MUST BE ACTIVE MEMBERS IN GOOD STANDING AT [THE FACILITY];"
#41 rule had that if, for any reason a client's requirement for supervision capability exceeded the capabilities of the facility's supervised living program, as determined by a physician, the client's lease could be terminated by the Licensee/facility.

Review on 11/12/19 of Client #17's apartment packet with a move-in date of 9/12/17 revealed:
-Her apartment packet was in an individual paper record with her demographic data and was maintained at the facility;
-Her record had the same types of documents as reviewed in Client #8's apartment packet regarding the 2 types of leases, and written apartment rules.

Review on 11/12/19 of 2-3 random lease agreements of clients who resided in [Apartment Complex B] and [Apartment Complex C]

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V 512	Continued From page 112 revealed: -Their lease agreements were between each tenant and the [Apartment Complex B and C Owner] as the owner; -Each lease agreement had the facility's Residential Coordinator's signature as "Manager." Review on 11/12/19 of a written payment invoice dated for 10/2019 to the apartment owner of [Apartment Complex A] revealed: -The owner was [Apartment Complex A Owner], Inc, which was a separate entity from the Licensee/facility; -The total amount of rent collected for this period was $4,000 and included both the tenants' portions and government subsidies; -Of this total amount, a check dated 10/29/19 in the amount of $2,586.53 was made payable to the owner while the Licensee/facility kept a total of $1,413.47 for a 13 % management fee for total rent collected or $520.00 in addition to a reimbursement cost of $893.47. Review on 11/12/19 of a written client financial accounting ledger for [Apartment Complex A] for the period 11/30/18 to 11/4/19 revealed: -The date and amount of each client's monthly rent deposited from the client's individual "Member" bank account; -The date and amount of the monthly lump sum deposited from the regional housing subsidy program; -The date, check number and amount of monthly rent made payable to the apartment owner; -The dates and check numbers of the 13% monthly management fee and reimbursement costs made payable to the facility; -For 8/2019, the facility paid itself $455.00 for the 13% management fee and $1,241.15 in reimbursed costs for a totaled amount of	V 512		

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$1,696.15;
-For 9/2019, the facility paid itself $584.09 for the 13 % management fee and $1,479.34 in reimbursed costs for a totaled amount of $2,063.43.

Interview on 11/12/19 with the Chief Operating Officer (COO) of Home Living Opportunities, Inc revealed:
-His organization owned [Apartment Complex A] and collected the monthly check for rent and utilities and was responsible for major costs such as hot water heaters;
-His organization had no tenant-landlord relationship with the individuals who lived in the apartments;
-The Licensee/facility was responsible for the management of [Apartment Complex A];
-The Licensee/facility created the apartment rules and his organization was not involved in the creation and/or enforcement of the apartment rules.

A review on 10/31/19 of Client #6's record revealed she was admitted on 5/15/19 and diagnosed with Panic Disorder, Asthma, and Hypertension.

Interview on 10/24/19 with Client #6 revealed:
-She began at the facility 7 months ago;
-She moved into an apartment under the facility 2 ½ months ago;
-She was homeless prior to her move into an apartment;
-Although she had a job in the community, she understood she had to come to the facility at least 3 days a week to continue to live in her apartment;
-The Residential Specialist told her this when she applied for an apartment;

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V 512	Continued From page 114 -Her apartment contract was with the facility and she paid a $50.00 move-in deposit. A review on 10/31/19 of Client #7's record revealed he was admitted on 4/6/92 and diagnosed with Schizophrenia-paranoid type, Hearing loss, and psychosocial problems related to housing, medical/health, psychiatric, education, and primary support group. Interview on 10/24/19 with Client #7 revealed: -He had been coming to the facility almost 34 years and had a diagnosis of Schizophrenia; -He attended the facility 5 days a week; -He had been living in [Apartment Complex B] apartments for 15 years; -Prior to this living arrangement, he had been in 9 different assisted living homes; -His rent was going up by $9.00 in 11/2019 from $296.00 to $305.00 and was not sure of the reason why; -There were 3 apartments under the facility and were managed by the Residential Specialist and the Residential Assistant who conducted the monthly apartment inspections; -His apartment had written rules that were made and enforced by the Residential Specialist; -Examples of the rules included guests overnight stays of 1-2 times once a year, call the facility for any repairs needed and use the on-call service during the weekends in the case of an emergency, and come to the facility at least 3-4 days every week; -" You have to come here to live in an apartment;" -"If you don't come in, they (staff) will call you and check on you." A review on 10/31/19 of Client #8's record revealed she was admitted on 4/24/01 and diagnosed with Major Depressive Disorder,	V 512		

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V 512	Continued From page 115 Cocaine Dependence-remission, Hypertension, and Chronic Obstructive Pulmonary Disease (COPD). Interview on 10/24/19 with Client #8 revealed: -She began coming to the facility about 15 years ago for the psychosocial program due to her diagnosis of Schizophrenia and Bipolar; -She had lived at the [Apartment Complex A] apartment complex for almost 2 years; -She moved out from [Apartment Complex B] and lived on her own for about 1 year because she broke the apartment rules by having her boyfriend over as an overnight guest over 5 times a year; -[Apartment Complex A] and [Apartment Complex B] had apartment rules that included: -No drinking, no illegal drugs, and no overnight guests more than 5 times in a year; -Attendance at the facility at least 3 days a week; -"If you don't come in in 3 days, they (staff) will come out and tell you to come in;" -She came to the facility 3 days a week and the other 2 days, she stayed at home and watched her stories on television; -Staff rotated on-call for the apartments in case apartment residents had an emergency and needed immediate assistance because there had not been on-site apartment managers in about 5 years at either [Apartment Complex A] or [Apartment Complex B]. Interview on 10/24/19 with the Residential Specialist revealed: -She was the apartment manager for the 3 apartment complexes: [Apartment Complex C], [Apartment Complex A] and [Apartment Complex B]; -She managed 29 apartment units; -[Apartment Complex D] had been sold over a	V 512		

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year ago;
-The apartments were all furnished with furniture and appliances;
-Clients had to get permission to bring special pieces of furniture into the apartments;
-Monthly rent was based on 30% of an individual's monthly income;
-She confirmed that when a client was admitted to the facility for the psychosocial rehabilitation (PSR) program, the client had to be in the program at least 90 days to apply for an apartment unit managed by the facility;
-If a client in the PSR program is assessed by staff to be able to live in an apartment past a 90-day period, the client's name went on a waiting list;
-If an apartment unit came available, she reviewed the waiting list and clients who were homeless were "bumped up" (given higher priority) for apartment consideration in which she took the client's housing application, sent the application to the [Apartment Complex B and C Owner] and ran a criminal background check on the client;
-If the application and criminal check returned approved, she took the client shopping for linens, personal items and groceries as the apartments were already furnished with furniture;
-If the client's application and criminal check was not approved, the client did not get housing, but the client was allowed to continue the PSR program.

Interview on 11/6/19 with the facility's Finance Office/Human Resource Officer revealed:
-Members (Clients) who were apartment residents paid their rent through their individual "Member Account" which was located at the facility;
-The Member Account was a non-interest-bearing

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account held at a local bank;
-The account was set up as non-interest-bearing because there was no way to divide any small amount of interest among 56-57 client accounts;
-This account was a separate account from the facility's administrative accounts;
-There were 3 ledger formats the facility used to track client money transactions: an individual member paper ledger, a master member ledger and an electronic member ledger;
-She confirmed the owners of [Apartment Complex A], [Apartment Complex B] and [Apartment Complex C];
-The apartment owners did not want to receive and track payments of multiple rent checks and was the reason the facility sent one monthly rent check to the owners with an itemized list of the clients with their rent amounts and the subsidy amounts.

Interviews on 11/6/19, 11/8/19 and 11/12/19 with the Associate Director/Qualified Professional (QP #2) revealed:
-11/6/19, the [Apartment Complex D] was sold about 1 ½ years ago;
-The facility continued to manage the [Apartment Complex A], [Apartment Complex B] and the [Apartment Complex C] apartments;
-11/8/19, the facility collected a 13% management fee for the total amount of rent collected from each of the 3 apartments and for maintenance expenses;
-There was no requirement for a client to come to the facility but 1 day a month and this was to pay their rent;
-"We don't have a policy in writing that specifically says that to our members;"
-"Members have to be in 'good standing' (active) to get an apartment;"
-"There used to be a 30-day waiting period for a

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	MHL023004	A. BUILDING: _____ B. WING _____	C 11/14/2019

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ADVENTURE HOUSE	924 N. LAFAYETTE STREET SHELBY, NC 28150

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V 512	Continued From page 118	V 512		

member to get an apartment but now it's a 90-day waiting process;"
-11/12/19, there was no requirement that a client had to come and attend the facility
to live in an apartment;
-"We have members who don't come here and live in one of the 3 apartments."

Interviews on 11/6/19 and 11/12/19 with the Executive Director/QP #1 revealed:
-11/6/19, he confirmed the clients' non-interest-bearing bank accounts and each client's deposit and withdrawal of their funds was individually tracked in 3 formats;
-Clients chose if and how much of their money they deposited into their Member Account;
-"The only ones (clients) who were in housing put their money in the bank account in order to pay their rent;"
-"The other folks (clients) used their account however they wanted;"
-11/12/19, members who paid their rent through their Member Account at the facility was not part of the PSR program;
-The Member Account was a part of a system of how the facility accomplished its management responsibilities of the apartments;
-He did not agree that a client's residency at one of the apartments managed by the facility was contingent on the client attendance at the facility;
-He "hated" rule #40 was found and he would have that rule removed immediately from the written apartment rules;
-He was surprised the October 2019 reimbursement costs were high and would have to investigate the costs further;
-The reimbursement costs of [Apartment Complex A] usually included items such as door knobs.

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V 512	Continued From page 119 Review on 11/13/19 of a Plan of Protection dated 11/13/19 completed by the Executive Director/QP #1 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? "10A NCAC 27D.0304 -11/13/2019, The majority of issues related here is simply a misunderstanding of terminologies. The only valid concern is that our Reviewers (Surveyors #1 and #2) found some Apartment Rules regarding our [Apartment Complex A Owner] that were inaccurate hold overs from when the [Area Mental Health Center] first put the funding together for these apartments and used [Apartment Complex A Owner] and Adventure House to share the various aspects of managing the apartments. These old rules, mistakenly still in use stated that apartment residents had to be/remain Members of Adventure House in good standing. This was never the case and no Member has ever lost any Apartment managed by Adventure House for failure to participate at any level in the Adventure House Day Program. This is not only a mistake, but the two[Govermnment Houseing Subsidy Program] projects specifically forbids that [Govermnment Houseing Subsidy Program] 811 and 202 Apartments requires participation in any kind of mental health treatment or program. We apply this standard to the non-[Govermnment Houseing Subsidy Program] [Apartment Complex B] as well. -We will immediately review all signed leases and Apartment Rules to ensure that documentation is not present. Where it is present, it will be taken out and Residents will ask to sign the new lease, agreement, or rules that had contained such a requirement.	V 512		

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V 512	Continued From page 120 -The remainder of the issues are regarding what is loosely referred to as the "Member Bank" or "Member Services." Auditors (Surveyors #1 and #2) were confused by the statement that Apartment Residents must have an account in our Member Bank. In practice, this is simply a revenue/cost center with the Residents name, where their rent payments are posted as received and their rent payment is then combined with all rent received for each apartment complex and mailed to their prospective managing company (i.e. [Apartment Complex A Owner] or [Apartment Complex B and C Owner] for the two [Govermnment Houseing Subsidy Program] projects.) Residents receive full credit for having paid their rent each month and there are several checks and balances to insure this is accomplished. The actual bank account used is kept separate from our Organization's funds. We used Bankers serving on our Board and Accountants to ensure that the Member bank uses accepted accounting practices and that there was no co-mingling of funds and that Resident rent payments were handled properly. We apologize that our terminology turned into such a concern and welcome a full audit of that account at any time. Our Organization is audited by a CPA annually that includes all accounts of our Organization, including the Member Bank. You may contact [CPA] who completes an audit annually for our Board of Directors. -The same account through which rent is collected and paid, is also used, at their choosing, by both residents and non-residents to handle their "banking" needs without the penalties and service charges found at banks in the community. Again, there are checks and balances in place to ensure that every cent is accounted for. -We have a few Members who are required to have a payee. Adventure House never wanted to	V 512		

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V 512	Continued From page 121	V 512		

be a Member's or resident's payee, but Social Security would simply withhold their Disability check until a suitable and willing payee could be identified. In order to prevent a Member from becoming homeless, we entered the role of Representative Payee. We do this reluctantly, and only as a last resort for the Member. We do not charge for this service. Anyone wishing that Adventure House stop being their Payee are referred to a company in Charlotte, the only company was are aware of, to take over this role. As Payee, we meet all of the requirements for this by Social Security and have passed every audit from Social Security. We offer budgeting assistance and training to all involved with the Member bank and work particularly hard with those for whom we are their payee, to involve them in all choices regarding their money. We will only be the payee to Members who want us to perform this function. We will gladly notify Social Security for any Member who no longer wants Adventure House involved.
-Also, our Reviewer (Surveyor #1) was confused about the 13% Property Management fee we receive from [Apartment Complext A Owner] for the [Apartment Complex A]. This fee was established by the [Area Mental Health Center] when the apartments were built and has never changed. We provide all property manage activities for [Apartment Complext A Owner] who review our work periodically. Rather than sending them a check for the rent due on all units and then [Apartment Complext A Owner] turn around and pay the management fee. The Management fee is subtracted from the rent due when we pay [Apartment Complext A Owner] the rent due. They receive a bill from us totally 13% of the rent collected and the remainder of the rent collected. Adding the bill to the rent money submitted, equals the total rent paid. Our DHSR auditors

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V 512	Continued From page 122 spoke with [the Chief Operating Officer] of [Apartment Complext A Owner], who I assume explained the same thing. -It is not uncommon for Clubhouses in the USA to have a Housing component. There are Clubhouse Standards that address Housing. Adventure House was the winner of the [Corporation Award] for our Housing Program in 2008. We received a crystal trophy, presented by actress [Actress Name] that is proudly displayed at Adventure House." Clients #6, #7 and #8 had housing contingent upon participation in the licensee/facility's psychosocial rehabilitation (PSR) program and dependent on a physician's determination of a client's level of necessary level of supervision. Each of these clients lived in 1 of the 3 apartment complexes managed by Cleveland Psychosocial Services Incorporated (the Licensee)/Adventure House (the facility) and were required to pay rent to the owner of the apartment complexes. Additionally, clients were required to have a member back account at the facility in order to pay their rent. These accounts were non-interest bearing. While there were discrepancies between the Associate Director/Qualified Professional (QP #2) and the Executive Director/QP #1's verbal accounts of whether there was a requirement that existed of client facility participation and client apartment living, there was consistent information in the facility's written policies (facility management policy and supported living policy) and client information (client handbook and apartment rules) that made the client living condition contingent upon their facility participation. The Residential Specialist and the	V 512		

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V 512	Continued From page 123 Associate Director/ QP #2 added that a client had to attend the facility for 90 days before they could make application for an apartment managed by the facility and they were assessed for their ability to live in an apartment beyond a 90-day period. Although the 3 apartment complexes, [Apartment Complex C], [Apartment Complex A] and [Apartment Complex B] were owned by other entities that were separate from Cleveland Psychosocial Services Inc./Adventure House, this Licensee/facility financially benefited from their apartment management duties from the apartment residents they served as clients through their psychosocial rehabilitation program. Cleveland Psychosocial Services Inc./Adventure House received a monthly management fee of 13% the total amount of rent collected at least from Charles Road #1 apartments and was financially reimbursed for the maintenance costs of all 3 apartment complexes. These monetary charges were deducted from the monthly total amount of money paid to the apartment owners each month. For the month of October 2019, the Executive Director/QP#1 did not understand why the maintenance reimbursement amount was as high as $893.47 Additionally, the licensee/facility's October 2019 13% management fee equated to $520.00. Thus the total amount of money recevied by the licensee/facility for the month of October 2019 was $1413.47 for Charlees Road apartments. This deficiency constitutes a Type A1 rule violation for serious exploitation and must be corrected within 23 days. An administrative penalty of $3,000.00 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	V 512		

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V 512	Continued From page 124 compliance beyond the 23rd day.	V 512		