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	34G298	A. BUILDING _____ B. WING _____	C 12/17/2019

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W 000	INITIAL COMMENTS An on site complaint survey was completed on 12/17/19. The Condition of Participation for Client Protections was determined to be out of compliance. This survey was as a result of complaint Intake #NC00158842.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibit neglect of clients (W149), ensure that direct care staff immediately reported all allegations of neglect to the administrator and other officials as required by policy (W153), and ensure that all allegations of neglect were thoroughly investigated by management staff (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, record review and	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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interview the facility failed to assure it's policies and procedures that prohibit neglect were implemented to prevent the neglect of 1 of 3 sampled clients (#4) with behaviors. The findings include:

Staff failed to ensure client #4 was adequately supervised to prevent him from eloping from the facility. Review on 12/17/19 of an internal investigation dated 11/30/19 revealed client #4 left the facility unsupervised on 11/30/19 while the qualified intellectual disabilities professional (QIDP) and direct care staff C were working in the facility.

Review on 12/17/19 of the facility's internal investigation revealed the QIDP was giving medications to one client in the medication room with the door shut while direct care staff C stepped out of the facility into the back yard to smoke a cigarette at 7:48pm leaving 5 clients unsupervised. Review of videotape from a camera mounted in the facility revealed client #4 left the facility through the front door at 7:51:47pm unaccompanied by staff. Additional review of the tape revealed staff C coming back into the living area looking at the front door open and then walking to the back of the facility, while the QIDP was still giving medications. The QIDP indicated staff C did not notify him that the front door was open or that any of the clients may have left the facility. Subsequent review of the investigation revealed direct care staff A was at home when he received a phone call from the facility next door that they had seen client #4 leave the facility in his pajamas walking down the street. Direct care staff A immediately contacted the QIDP, who was still in the medication room at the facility, to let him know client #4 was gone. Subsequently, the

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QIDP started searching for client #4 and told direct care staff C to stay with the clients in the facility. While the QIDP was searching for client #4, he received a call from the police department, that client #4 was in a local department store about a half mile from the facility. The QIDP drove to the department store, talked with Police and took client #4 back to the facility.

Interview on 12/17/19 with the qualified intellectual disabilities professional II (QIDP II) revealed following the elopement on 11/30/19, staff C did not work while the investigation was ongoing. She stated she did substantiate neglect to supervise and that staff C received a formal written warning as a result of the facility's internal investigation.

Further interview with the QIDP II revealed client #4's team met and revised his behavior support program originally dated 12/15/18. The BSP revision dated 12/2/19 included the target behavior of elopement and activating continuous door alarms on all doors and client #4's window when the window or any door to the facility was open. Continued interview revealed client #4's level of supervision was not changed. Additional interview confirmed many years ago client #4 had the target behavior of elopement but had not exhibited this target behavior for several years, so it was removed from his BSP.

Observation on 12/17/19 of all doors to the facility at 10:45am indicated all alarms were activated on all of the exits to the facility.

Observation on 12/17/19 of the videotape provided by the facility of footage on 11/30/19 from 7:52pm until 8:16pm confirmed statements

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given by the QIDP and staff C. The QIDP II attempted to roll back the footage to 7:47pm (when client #4 walked outside), but she was unsuccessful. The QIDP provided a typed timeline with times viewed on the videotape to confirm his location, staff C's location and when client #4 left the facility.

Review on 12/17/19 of client #4's record revealed he has diagnoses of Profound Intellectual Disabilities, Autism, Aggression and Impulse Control Disorder. His individual program plan (IPP) dated 2/28/19 indicates he has a behavior support program dated 12/15/18 for the target behaviors of self injurious behavior, aggression and agitation. This program incorporates the use of Risperdal, Catapres and Valium (which is used for dental appointments). Further review indicated client #4's BSP had been revised on 12/2/19 to include the target behavior of elopement and continuous alarms had been activated when the doors to the facility or client #4's window is opened. Additional review confirmed there were no changes in client #4's level of supervision.

Review on 12/17/19 of the facility's policy 1204:13(a) revealed Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Specific examples are given such as staff failure to implement procedures to prevent falls; staff not discovering injuries until 2-3 days later, failure to prevent peer to peer aggression, staff failure to report rights violations, staff not providing privacy to consumers during personal hygiene, not providing the appropriate diet consistency.

Although changes were made to client #4's BSP

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after this elopement on 11/30/19 there was no written documentation that additional incidents had occurred. For example: Interviews on 12/17/19 with direct support staff and the QIDP, and others outside of the group home revealed:

a) Direct care staff A had located a videotape in client #4's bedroom about a month ago and did not recognize it. He stated he remembered several years ago, when client #4 was much younger, that he would elope from the facility looking for videotapes. He stated he took the videotape to the facility adjacent to their facility (next door) and the staff at the adjacent facility indicated client #4 had come over and taken it several weeks before. Staff A stated he did not report this to management staff.

b) Direct care staff B stated she had overheard direct care staff talking that client #4 had been seen in the community at a department store more than once but she did not provide dates or times. Additional information was reviewed however there was no written documentation to support any other incidents had occurred.

c) The QIDP stated he was working on 11/22/19 when he heard a door open. He went outside at 10pm and client #4 was in the front yard walking towards the facility next door. He redirected client #4 and took him back into the facility. He recorded the incident on his behavioral data but did not report this to other team members or his supervisor. The QIDP stated he was the only staff working in the facility until third shift arrived with 6 clients.

d) Interview with clients #3, #2 and #6 revealed: The QIDP was giving medication and client #4 left

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the facility at night. The front door was open. Staff C was supposed to supervising them while the QIDP was giving medications. They did not see staff C in the living room when they noticed the front door was open. The QIDP left the home and staff C stayed with them until the QIDP brought client #4 back to the facility.

e) Interview on 12/17/19 by phone with the manager for the adjacent facility revealed:
She had been told by at least two of her staff that client #4 comes over to their facility unaccompanied by staff and takes videotapes underneath the television in the living room. She had been told that one of the facility staff had come over to her facility to return a videotape that client #4 had taken. She had been told by one of her staff that client #4 had come over to their facility, unaccompanied by staff, within the last month.

Review on 12/17/19 of the facility's policy 1204:13(a) revealed Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Specific examples are given such as staff failure to implement procedures to prevent falls; staff not discovering injuries until 2-3 days later, failure to prevent peer to peer aggression, staff failure to report rights violations, staff not providing privacy to consumers during personal hygiene, not providing the appropriate diet consistency.

Interview on 12/17/19 with the QIDP II confirmed the team did not consider increasing client #4's level of supervision to ensure all direct care staff were aware of his location at all times, especially in the evenings when clients take medications

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W 149	Continued From page 6 and are assisted with bathing. Additional interview revealed she was unaware that client #4 had left the facility multiple times, unaccompanied by staff, to go next door to the adjacent facility to get videos. In that, client #4 was having multiple incidents of elopement that were not reported prior to the incident on 11/30/19. The facility failed to report, assess and develop a plan to address client #4's behavioral needs. This resulted in the neglect of client #4.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on review of investigations, client records and interviews, facility direct care staff failed to report allegations of neglect immediately to the administrator or to other officials as required by policy. This affected 1 of 3 sampled clients (#4) with behaviors. The findings are: Direct care staff failed to report allegations of neglect to supervise client #4 to management as required by facility policy. Review of an internal investigation dated 11/30/19 revealed client #4 left the facility unsupervised on 11/30/19 while the qualified intellectual disabilities professional (QIDP) and direct care staff C were working in the facility. Further review of the	W 153		

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facility's internal investigation revealed the QIDP was giving medications in the medication room with the door shut to one client while direct care staff C stepped out of the facility into the back yard to smoke a cigarette at 7:48pm leaving 5 clients unsupervised. Review of videotape from a camera mounted in the facility revealed client #4 left the facility through the front door at 7:51:47 unaccompanied by staff. Further review of the tape revealed staff C coming back into the living area looking at the front door open and then walking to the back of the facility, while the QIDP is still giving medications. The QIDP indicated staff C did not notify him that the front door was open or that any of the clients may have left the facility. Additional review of the investigation revealed direct care staff A was at home when he received a phone call from the facility next door that they had seen client #4 leave the facility in his pajamas walking down the street. Direct care staff A immediately contacted the QIDP, who was still in the medication room at the facility, to let him know client #4 was gone. Subsequently, the QIDP started searching for client #4 and told direct care staff C to stay with the clients in the facility. While the QIDP was searching for client #4, he received a call from the police department, that client #4 was in a local department store about a half mile from the facility. The QIDP drove to the department store, talked with Police and took client #4 back to the facility.

Review on 12/17/19 of a facility policy 1204:13(b) When to complete a report. Reports should be completed as soon as possible following the occurrence of a consumer accident or discovery of a consumer injury.

Although changes were made to client #4's BSP

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after this elopement on 11/30/19, there was no written documentation that additional incidents had occurred. For example: Interviews on 12/17/19 with direct support staff, the QIDP, and others outside of the group home revealed:

a) Direct care staff A had located a videotape in client #4's bedroom about a month ago and did not recognize it. He stated he remembered several years ago, when client #4 was much younger, that he would elope from the facility looking for videotapes. He stated he took the videotape to the facility adjacent to their facility (next door) and the staff at the adjacent facility indicated client #4 had come over and taken it several weeks before. Staff A stated he did not report this to management staff.
b) Direct care staff B stated she had overheard direct care staff talking that client #4 had been seen in the community at a department store more than once but she did not provide dates or times. Additional information was reviewed however there was no written documentation to support any other incidents had occurred.
c) The QIDP stated he was working on 11/22/19 when he heard a door open. He went outside at 10pm and client #4 was in the front yard walking towards the facility next door. He redirected client #4 and took him back into the facility. He recorded the incident on his behavioral data but did not report this to other team members or his supervisor. The QIDP stated he was the only staff working in the facility until third shift arrived with 6 clients.

Interview on 12/17/19 with the qualified intellectual disabilities professional II (QIDP II) revealed she had been not told that a videotape was located in client #4's room that belonged next

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W 153	Continued From page 9 door at an adjacent residential facility. She stated she was unaware of any allegations of client #4 leaving the facility going to any department store other than the incident on 11/30/19. She stated she had not been told about the incident on 11/22/19 when client #4 walked out of the facility at 10pm and was located by the QIDP, although it was recorded on Therap in his behavioral data. When asked if elopement from the facility should be reported to her as the QIDP II, she stated, "Yes."	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of facility records and interview, the facility failed to consider all sources of evidence to thoroughly investigate allegations of neglect involving 1 of 3 sampled clients (#4). The findings include: Management staff failed to thoroughly investigate allegations of neglect involving client #4 leaving the facility unsupervised. Review of an internal investigation dated 11/30/19 revealed client #4 left the facility unsupervised on 11/30/19 while the qualified intellectual disabilities professional (QIDP) and direct care staff C were working in the facility. Further review of the facility's internal investigation revealed the QIDP was giving medications in the medication room with the door shut to one client while direct care staff C stepped out of the facility into the back	W 154		

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yard to smoke a cigarette at 7:48pm leaving 5 clients unsupervised. Review of videotape from a camera mounted in the facility revealed client #4 left the facility through the front door at 7:51:47 unaccompanied by staff. Further review of the tape revealed staff C coming back into the living area looking at the front door open and then walking to the back of the facility, while the QIDP is still giving medications. The QIDP indicated staff C did not notify him that the front door was open or that any of the clients may have left the facility. Additional review of the investigation revealed direct care staff A was at home when he received a phone call from the facility next door that they had seen client #4 leave the facility in his pajamas walking down the street. Direct care staff A immediately contacted the QIDP, who was still in the medication room at the facility, to let him know client #4 was gone. Subsequently, the QIDP started searching for client #4 and told direct care staff C to stay with the clients in the facility. While the QIDP was searching for client #4, he received a call from the police department, that client #4 was in a local department store about a half mile from the facility. The QIDP drove to the department store, talked with Police and took client #4 back to the facility.

Further review on 12/17/19 of the facility's internal investigation revealed there were no statements from 3 interviewable clients in the facility. There were also no statements from staff A, the staff from the adjacent facility, the police department or the department store.

Interview on 12/17/19 with the qualified intellectual disabilities professional II (QIDP II) revealed she did not consider all of the above sources of evidence when she completed this

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W 154	Continued From page 11 internal investigation involving client #4 eloping from the facility. Additional interview confirmed that she completed the investigation, since the QIDP was involved, when client #4 eloped from the facility on 11/30/19.	W 154		