STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

(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) COMPLETION DATE
W 000	INITIAL COMMENTS An on-site complaint investigation was completed on 12/20/19 for complaint Intake: NC00159281. The complaint was not substantiated. The Condition of Participation in Client Protections was determined to be out of compliance.	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 all allegations of neglect were reported to the administrator immediately (W153) and ensure that all allegations of neglect were thoroughly investigated (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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure guardianship was secured for 1	W 125		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 125	Continued From page 1	W 125		

of 1 newly admitted client. The finding is:

The facility did not assist client #2 in obtaining a Guardian of the Person.

Review on 12/20/19 of client #2's behavior support program (BSP) dated 11/15/19 revealed he was prescribed Seroquel and Quetiapine as a component of his behavior support program (BSP) for the target behaviors of aggression, vocal agitation and self-injury. Review of his behavior consent revealed he signed the written consent for this program.

Review on 12/20/19 of client #2's individual program plan (IPP) dated 11/13/19 revealed client #2 was admitted on 10/16/19. Further review confirmed client #2 was his own legal guardian but that a family member had indicated they would be pursuing guardianship for him.

Review on 12/20/19 of a Psychological evaluation dated 10/26/19 using the Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV) indicated client #2 functioned in the Moderate Range of Intellectual Disabilities with a full scale intelligence quotient (IQ) of 44.

Interview on 12/20/19 by phone with a family member indicated they had intended to pursue filing a petition for guardianship since client #2's placement in October 2019, however this had not been done.

Interview on 12/20/19 with the Director revealed pursuing guardianship had been discussed with client #2 and family members at his IPP meeting on 11/13/19, as there was concern by his interdisciplinary team that client #2 needed

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	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

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W 125	Continued From page 2 assistance in making decisions of a legal, medical and financial nature, however a guardianship petition had not been filed.	W 125		
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 record review and interview the facility neglected to promptly address the behavioral and medical needs of 1 of 5 sampled clients (#2) . The findings include: Direct care staff failed to address the behavioral and medical needs of client #2 when his behaviors escalated on 12/6/19. Review on 12/20/19 of a direct care note dated 12/6/19 on second shift and interview with the Director revealed client #2 became upset in his bedroom, threw his body on the floor telling staff, "Don't touch me! Stay away from me!" Direct care staff #C and staff E were working. According to the Director, staff C and staff E left around 11pm. Staff A and staff B worked third shift in the facility (11pm-8am). Further review of the note indicated client #2 refused to get in bed and sat in the doorway to his bedroom blocking the bedroom door. After some time, client #2 refused to get up and then urinated on himself on the floor. When staff A prompted him to get up, he told staff A to hold his groin because staff A was his maid. Client #2 told direct care staff A that he couldn't walk. Direct care staff A and B	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

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W 149	Continued From page 3	W 149		

were able to get him up and take him to the bathroom. He went back to his bedroom and then again threw himself on the floor lying on his side on his arm.

Interview on 12/20/19 with direct staff A revealed she was working with direct care staff B on 12/6/19 from 11pm-8am. She observed client #2 sitting in the floor of his bedroom. She spoke with departing 2nd shift staff C and staff E. Staff C explained client #2 had been very non-compliant all evening not wanting to take a bath and then had a tantrum sitting on the floor of his bedroom and telling staff not to touch him. Staff A went back to his bedroom to check on client #2 when she came into work and he was sitting on the floor of his bedroom. After staff C left, staff A asked client #2 to get up and he refused. Staff A explained she observed client #2 several times between 11pm-4am as he stood up, got in bed or went to the bathroom (across the hallway from his bedroom) and then came back and threw himself on the floor. Staff A called the home manager (not certain of the time) and reported to her that client #2 was having non-compliance and she told staff #1 to monitor him and call her back if his behavior escalated. Staff A and staff B took turns checking on client #2 trying to convince him to get in bed and making certain he was okay. Further interview revealed throughout the early morning hours client #2 refused to get up. Client #2 sat on the floor, stood up, got into bed and then threw himself repeatedly onto the floor. Subsequent interview revealed staff D came into work around 7:55am and he called the home manager to tell her client #2 had not slept all night, continued to throw himself on the floor and client #2 complained he could not get up. Staff A stated she was concerned about client #2 and left work

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	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

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W 149	Continued From page 4	W 149		

about 8:30am after writing a note in the staff communication log. Subsequent interview revealed she did not contact the qualified intellectual disabilities professional (QIDP)/Nurse. Direct care staff A stated she was not aware of a behavior support plan (BSP) for client #2.

Interview on 12/20/19 with staff D revealed on 12/7/19 when he arrived for work about 7:55am he was told by direct care staff A and B that client #2 had been very non-compliant all night on third shift, throwing his body on the floor and refusing to get up. Further interview revealed staff D walked back to client #2's room and client #2 told him to go away and not to touch him. Direct care staff D stated he was very concerned when client #2 stated he did not want to eat breakfast and remained on the floor of his bedroom. Further interview revealed staff D contacted the house manager before 9am to explain client #2 to would not get up from the floor of his bedroom. Subsequent interview revealed the home manager told him to attempt to get client #2 to stand up and go into the living area and that she would come over to the home and check on him. When asked if client #2 was complaining of pain, staff D stated client #2 did not complain of any pain but stated several times that he could not get up. Staff D stated that later in the morning the home manager arrived (not certain of time) and contacted the QIDP/Nurse.

Interview on 12/20/19 with client #3 revealed client #2 became upset when staff C asked him to take a bath. Client #3 stated client #2 told staff C he was not going to take a bath and he started screaming and went into his bedroom and sat on the floor. Client #3 stated client #2 was upset all night long, screaming and throwing himself on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

(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) COMPLETION DATE
W 149	Continued From page 5	W 149		

floor. Client #3 stated staff A and staff B tried to prompt client #2 to get up from the floor and that she (client #3) finally went to sleep. Additional interview revealed later in the morning, the home manager and the QIDP/Nurse arrived. She stated she did not know what time they arrived at the facility.

Interview on 12/20/19 with client #4 revealed client #2 became upset when staff C asked him to get a bath. She stated client #2 does not like to take a bath. She stated he took his clothes off and sat on the floor of his bedroom with the door open. She stated when staff A or staff B went into client #2's bedroom, he began to scream and try to hit at staff. She stated staff A and staff B worked all night and that she went to sleep. She stated later the next morning the home manager arrived. She said client #2 went to the hospital.

Interview on 12/20/19 with client #2 in the hospital revealed "he fell down and got hurt". When asked where he was when he fell, he stated "yes."

Interview on 12/20/19 with the home manager revealed she was contacted on 12/6/19 sometime on second shift that client #2 was being very non-compliant. She told staff A to monitor him and call her if his behaviors escalated. She stated she was not certain if staff A called her again early in the morning on 12/7/19. She stated staff D called her when he arrived at work around 8am on 12/7/19 and told her client #2 was being very non-compliant and refusing to get off the floor of of his bedroom. The Home manager told staff D to try to get client #2 to get up and go into the living room. The home manager told staff D she was coming to the facility later in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

(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) COMPLETION DATE
W 149	Continued From page 6	W 149		

morning. Further interview revealed she arrived at the facility around lunch time and that she contacted the QIDP/Nurse. She stated client #2's left arm appeared swollen and bruised and the Nurse advised her to transport client #2 to the hospital. Continued interview revealed she and staff C transported client #2 to the hospital (not certain of the time).

Review on 12/20/19 of client #2's individual program plan (IPP) dated 11/13/19 revealed he was admitted on 10/16/19 and has diagnoses of moderate intellectual disability, Gout, Acid reflux and Pre-Diabetes. Further review of the IPP revealed client #2 ingests Quetiapine and Seroquel to help address target behaviors of self injury, aggression, and vocal agitation.

Review on 12/20/19 of client #2's behavior support program (BSP) dated 11/15/19 which includes the use of Quetiapine and Seroquel for the target behaviors of self injury, aggression, and vocal agitation revealed staff are to redirect client. Further review of the BSP revealed, "Allow for choices and decision-making whenever possible: Before a problem develops provide clear opportunities rather than required participation whenever possible. Give choices as often as possible eve with choices such as outings, restaurants."

Continued review on 12/20/9 of client #2's BSP revealed for non-compliance staff give him instruction. Subsequent review revealed if he does not comply within (1) minute, staff will repeat the instruction. If he does not comply after one additional prompt, staff may remind him of reinforcers he may earn if compliant. For the target behavior of self-injury: Staff will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

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W 149	Continued From page 7 immediately try to redirect him at least three times. If he does not stop, continue with the activity. If he does not stop staff may intervene by using approved restraint to keep him from injury. Interview on 12/20/19 with the Director revealed the QIDP/Nurse was not contacted until the morning of 12/7/19 and QIDP/Nurse arrived at facility about lunchtime to assess client #2. She stated the QIDP/Nurse made the decision to send client #2 to the hospital. When asked how quickly the QIDP/Nurse should have been contacted she stated the evening of 12/6/19. She further stated, "Right away." When asked if not following client #2's BSP and not contacting the QIDP/Nurse on 12/6/19 constituted neglect, she stated, "I had considered that." She confirmed however her investigation of this incident did not substantiate neglect by the staff. Further interview with the Director confirmed facility policy is for direct care staff to contact the QIDP/Nurse or Director immediately if clients have escalating behaviors that are not addressed by their BSP or have injuries that require immediate medical treatment. Additional interview revealed client #2 was being treated for a broken hip and a broken arm in the hospital. In that staff did not immediately contact the facility nurse/QIDP for further instructions how to intervene with client #2's inappropriate behavior and staff did not obtain medical treatment for client #2 to assess him for pain and injury, their neglect subsequently resulted in client #2's delayed medical treatment.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

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W 153	Continued From page 8	W 153		

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, 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 5 sampled clients (#2) with behaviors. The findings are:

Direct care staff failed to report allegations of neglect to the administrator after client #2 was injured during a behavioral incident on 12/6/19.

Review on 12/20/19 of a direct care note dated 12/6/19 on second shift an interview with the Director revealed client #2 became upset in his bedroom, threw his body on the floor telling staff, "Don't touch me! Stay away from me!" Direct care staff #C and staff E were working. According to the Director, staff C and staff E left around 11pm. Staff A and staff B worked third shift in the facility (11pm-8am). Further review of the note indicated client #2 refused to get in bed and sat in the doorway to his bedroom blocking the bedroom door. After some time, client #2 refused to get up and then urinated on himself on the floor. When staff A prompted him to get up, he told staff A to hold his groin because staff A was his maid. Client #2 told direct care staff A that he couldn't walk. Direct care staff A and B were able to get him up and take him to the bathroom. He went back to his bedroom and then again threw himself on the floor lying on his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

(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) COMPLETION DATE
W 153	Continued From page 9	W 153		

side on his arm.

Interview on 12/20/19 with direct staff A revealed she was working with direct care staff B on 12/6/19 from 11pm-8am. She observed client #2 sitting in the floor of his bedroom. She spoke with departing 2nd shift staff C and staff E . Staff C explained client #2 had been very non-compliant all evening not wanting to take a bath and then had a tantrum sitting on the floor of his bedroom and telling staff not to touch him. Staff A went back to his bedroom to check on client #2 when she came into work and he was sitting on the floor of his bedroom. After staff C left, staff A asked client #2 to get up and he refused. Staff A explained she observed client #2 several times between 11pm-4am as he stood up, got in bed or went to the bathroom (across the hallway from his bedroom) and then came back and threw himself on the floor. Staff A called the home manager (not certain of the time) and reported to her that client #2 was having non-compliance. The home manager told staff #A to monitor him and call her back if his behavior escalated. Staff A and staff B took turns checking on client #2 trying to convince him to get in bed and making certain he was okay. Further interview revealed throughout the early morning hours client #2 refused to get up. Client #2 sat on the floor, stood up, got into bed and then threw himself repeatedly onto the floor. Subsequent interview revealed staff D came into work around 7:55am and he called the home manager to tell her client #2 had not slept all night, continued to throw himself on the floor and client #2 complained he could not get up. Staff A stated she was concerned about client #2 and left work about 8:30am after writing a note in the staff communication log. Subsequent interview revealed she did not contact the qualified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

(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) COMPLETION DATE
W 153	Continued From page 10 intellectual disabilities professional (QIDP)/Nurse. Direct care staff A stated she was not aware of a behavior support plan (BSP) for client #2. Interview on 12/20/19 with the Director revealed the QIDP/Nurse was not contacted until the morning of 12/7/19 and QIDP/Nurse arrived at facility about lunchtime to assess client #2. She stated the QIDP/Nurse made the decision to send client #2 to the hospital. When asked how quickly the QIDP/Nurse should have been contacted she stated the evening of 12/6/19. She further stated, "Right away." When asked if not following client #2's BSP and not contacting the QIDP/Nurse on 12/6/19 constituted neglect, she stated, "I had considered that." She confirmed however her investigation of this incident did not substantiate neglect by the staff. Further interview with the Director confirmed facility policy is for direct care staff to contact the QIDP/Nurse or Director immediately if clients have escalating behaviors that are not addressed by their BSP or have injuries that require immediate medical treatment. Additional interview revealed client #2 was being treated for a broken hip and a broken arm in the hospital. In that staff did not immediately contact the facility nurse/QIDP for further instructions how to intervene with client #2's inappropriate behavior and staff did not obtain medical treatment for client #2 to assess him for pain and injury, their neglect subsequently resulted in client #2's delayed medical treatment.	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.	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

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W 154	Continued From page 11 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 an unknown injury involving 1 of 5 sampled clients (#2). The findings include: Management staff failed to thoroughly investigate an unknown injury to client #2 on 12/6/19. Review on 12/20/19 of a direct care note dated 12/6/19 on second shift and interview with the Director revealed client #2 became upset in his bedroom, threw his body on the floor telling staff , "Don't touch me! Stay away from me!" Direct care staff #C and staff E were working. According to the Director, staff C and staff E left around 11pm. Staff A and staff B worked third shift in the facility (11pm-8am). Further review of the note indicated client #2 refused to get in bed and sat in the doorway to his bedroom blocking the bedroom door. After some time, client #2 refused to get up and then urinated on himself on the floor. When staff A prompted him to get up, he told staff A to hold his groin because staff A was his maid. Client #2 told direct care staff A he couldn't walk. Direct care staff A and B were able to get him up and take him to the bathroom. He went back to his bedroom and then again threw himself on the floor lying on his side on his arm. Review on 12/20/19 of the facility's investigation of this incident revealed an IRIS report dated 12/10/19 and a statement from staff A. There was no statement from staff B who worked third shift with staff A on third shift on 12/6/19. There was no statement from staff C who worked second shift on 12/6/19 and accompanied client	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

(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) COMPLETION DATE
W 154	Continued From page 12 #2 to the hospital on 12/7/19. There were no statements from staff D who worked first shift on 12/7/19 and observed client #2 not wanting to get out of bed and not wanting to eat breakfast on 12/7/19. Staff D was still working in the facility when client #2 left for the hospital. In addition, there were no statements from two interviewable clients #3 and #4. There was no statement from the home manager who was contacted by direct care staff on 12/6/19. In addition, there was no statement from client #2 who was injured. Interview on 12/20/19 with the Director confirmed the only staff statement was from staff A. Further interview confirmed other sources of evidence such as statements from client #2, the home manager, QIDP/Nurse and other staff and clients were not considered in her investigation of this incident.	W 154		
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on record review and interview, staff were not sufficiently trained by management to intervene with 1 of 5 sampled clients' (#2) inappropriate behaviors. The finding is: Direct care staff were not trained in techniques to intervene with client #2's inappropriate behaviors. Review on 12/20/19 of a direct care note dated 12/6/19 on second shift and interview with the	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G103	A. BUILDING _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY PLACE	1050 HOGAN STREET FAYETTEVILLE, NC 28301

(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) COMPLETION DATE
W 193	Continued From page 13	W 193		

Director revealed client #2 became upset in his bedroom, threw his body on the floor telling staff, "Don't touch me! Stay away from me!" Direct care staff #C and staff E were working. According to the Director, staff C and staff E left around 11pm. Staff A and staff B worked third shift in the facility (11pm-8am). Further review of the note indicated client #2 refused to get in bed and sat in the doorway to his bedroom blocking the bedroom door. After some time, client #2 refused to get up and then urinated on himself on the floor. When staff A prompted him to get up, he told staff A to hold his groin because staff A was his maid. Client #2 told direct care staff A he couldn't walk. Direct care staff A and B were able to get him up and take him to the bathroom. He went back to his bedroom and then again threw himself on the floor lying on his side on his arm.

Interview on 12/20/19 with direct staff A revealed she was working with direct care staff B on 12/6/19 from 11pm-8am. She observed client #2 sitting in the floor of his bedroom. She spoke with departing 2nd shift staff C and staff E. Staff C explained client #2 had been very non-compliant all evening not wanting to take a bath and then had a tantrum sitting on the floor of his bedroom and telling staff not to touch him. Staff A went back to his bedroom to check on client #2 when she came into work and he was sitting on the floor of his bedroom. After staff C left, staff A asked client #2 to get up and he refused. Staff A explained she observed client #2 several times between 11pm-4am as he stood up, got in bed or went to the bathroom (across the hallway from his bedroom) and then came back and threw himself on the floor. Staff A called the home manager (not certain of the time) and reported to her that client #2 was having

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W 193	Continued From page 14	W 193		

non-compliance and she told staff #1 to monitor him and call her back if his behavior escalated. Staff A and staff B took turns checking on client #2 trying to convince him to get in bed and making certain he was okay. Further interview revealed throughout the early morning hours client #2 refused to get up. Client #2 sat on the floor, stood up, got into bed and then threw himself repeatedly onto the floor. Subsequent interview revealed staff D came into work around 7:55am and he called the home manager to tell her client #2 had not slept all night, continued to throw himself on the floor and client #2 complained he could not get up. Staff A stated she was concerned about client #2 and left work about 8:30am after writing a note in the staff communication log. Subsequent interview revealed she did not contact the qualified intellectual disabilities professional (QIDP)/Nurse. Direct care staff A stated she was not aware of a behavior support plan (BSP) for client #2.

Interview on 12/20/19 with staff D revealed on 12/7/19 when he arrived for work about 7:55am he was told by direct care staff A and B that client #2 had been very non-compliant all night on third shift, throwing his body on the floor and refusing to get up. Further interview revealed staff D walked back to client #2's room and client #2 told him to go away and not to touch him. Staff D stated he was very concerned when client #2 stated he did not want to eat breakfast and remained on the floor of his bedroom. Further interview revealed staff D contacted the house manager before 9am to explain client #2 to would not get up from the floor of his bedroom. Subsequent interview revealed the home manager told him to attempt to get client #2 to stand up and go into the living area and that she

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W 193	Continued From page 15	W 193		

would come over to the home and check on him. When asked if client #2 was complaining of pain, staff D stated client #2 did not complain of any pain but stated several times that he could not get up. Staff D stated that later in the morning the home manager arrived (not certain of time) and contacted the QIDP/Nurse.

Review on 12/20/19 of client #2's BSP dated 11/15/19 which includes the use of Quetiapine and Seroquel for the target behaviors of self injury, aggression, and vocal agitation revealed staff are to redirect client. Further review of the BSP revealed, "Allow for choices and decision-making whenever possible: Before a problem develops provide clear opportunities rather than required participation whenever possible. Give choices as often as possible eve with choices such as outings, restaurants."

Continued review on 12/20/9 of client #2's BSP revealed for non-compliance staff give him instruction. Subsequent review revealed if he does not comply within (1) minute, staff will repeat the instruction. If he does not comply after one additional prompt, staff may remind him of reinforcers he may earn if compliant. For the target behavior of self-injury: Staff will immediately try to redirect him at least three times. If he does not stop, continue with the activity. If he does not stop staff may intervene by using approved restraint to keep him from injury.

Interview on 12/20/19 with the Director confirmed that she had no documentation to show that direct care staff working with client #2 were inserviced on this BSP for client #2. Further interview revealed they had discussed this in a

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W 193	Continued From page 16 house meeting but there was no documentation of this meeting.	W 193		