NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

December 23, 2019

Nick Hobbs, Director
Resources for Human Development, Inc.
10224 Durant Road, Ste 205
Raleigh, NC 27614

Re: Annual and Follow Up Survey completed 12/4/19
Varsity Crest #3, 1503 Crest Road Apt 103, Raleigh, NC 27606
MHL #092-582
E-mail Address: Nicholas.hobbs@rhd.org

Dear Mr. Hobbs:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 12/4/19.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Tag cited is a standard level deficiency.
- Type A1 rule violation is for 10A NCAC 27G. 0205 Assessment and Treatment/Habilitation or Service Plan (Tag 112).

Time Frame for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is 2/4/20.
- Type A1 violation must be ***corrected*** within 23 days from the exit date of the survey, which is 12/27/19. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against Resources for Human Development, Inc. for each day the deficiency remains out of compliance.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Renee Kowalski, Team Leader at 919-552-6847.

Sincerely,

Kimberly Thigpen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSRreports@dhhs.nc.gov, DMH/DD/SAS
DHSR@Alliancebhc.org
Pam Pridgen, Administrative Assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-582	A. BUILDING: ______ B. WING ______	R 12/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VARSITY CREST #3	**1503 CREST ROAD APT. 103 RALEIGH, NC 27606**

(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 000	INITIAL COMMENTS An annual and follow up survey was completed on December 4, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	DHSR - Mental Health JAN 9 2020 Lic. & Cert. Section	

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure goals and strategies were developed and to implement to address one of two (#1) client's behaviors. The findings are:

Cross Reference 10A NCAC 27G .5602 STAFF
Based on record review and interviews the facility failed to ensure one of two (#1) clients were capable of remaining in the home or in the community for unsupervised times.

Review on 11/26/19 of Plan of Protection dated 11/26/19 completed by the QP and Director revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care. Consumer will be provided a discharge notice, a discharge plan. Unsupervised time will be re-assessed and updated today 11/26/19. Care coordinator and ACT team will be notified of above actions on this date 11/26/19. Consumer will be provided with at least three referrals and every attempt to coordinate a transition to a higher level of care will be made. Discharge policy will be updated to more quickly respond to behavioral changes. Unsupervised time will be completed with more frequency at least every 90 days. Staff will receive more training in Treatment planning and goal setting in 14 days."
-Describe your plans to make sure the above happens.
Qualified Professional will complete the above and notify state Director today 11/26/19"

Client #1 with diagnoses of Schizoaffective Disorder- Depression Type, Alcohol and Cannabis use Disorder was admitted to the

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V 112	Continued From page 2 facility in August of 2018. The facility is licensed for a 5600A Supervised Living home for Mentally Ill Adults, but received a waiver to reduce staffing and supervision requirements due to being an independent living apartment. Client #1 was initially assessed upon admission for eight hours of unsupervised time in the community. In the last few months, client #1 had multiple incidents of consuming alcohol, smoking marijuana and leaving at all times of the night calling 911 with suicidal ideations. Client #1 was seen in local hospital emergency department twice within a 24 hour period. Client #1 often missed evening medications due to being out of the apartment. The facility failed to implement any new strategies or goals to address the increased behaviors. This constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty in the amount of $1000.00 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 112		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure	V 290		

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V 290	Continued From page 3 the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure one of two (#1) clients were capable of remaining in the home or in the community for unsupervised times. The findings	V 290		

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V 290	Continued From page 4 are: Review on 11/25/19 of client #1's record revealed: -Admission date of 8/29/19. -Diagnoses of Schizoaffective Disorder-Depression Type, Alcohol and Cannabis use Disorder. -Treatment Plan dated 9/4/19. Review on 11/25/19 of Incident reports regarding client #1, -"9/6/19-...called 911 right before midnight on 9/5/19 and stated he was doing too much drinking and smoking marijuana. Police transported [client #1] to [local hospital]. [Client #1] reported to [local hospital] feeling stressed and noted paranoia but denied SI (suicidal ideation). Testing results positive for alcohol and cannabis. [Client #1] reported drinking alcohol and smoking marijuana at home. Resources for Human Development (RHD-Licensee) staff checked Varsity Crest premises for health and safety and removed cannabis debris, cigarette debris and empty beer can. [Client #1] was discharged from [local hospital] later that morning." -"9/8/19- [Client #1] reported calling 911 for suicidal ideation while he was out in the community. [Client #1] reportedly called Varsity Crest and informed staff that he was at [local hospital] trying to be committed for SI at approximately 12:19 am on 9/8/19. He was discharged that morning." -"9/8/19- [Client #1] called 911 again at approximately 9:40PM on 9/8/19 expressing SI and police came to transport him to [local hospital]. Staff reported that he was discharged from [local hospital] later that evening. [Local hospital] reported that [client #1] presented to emergency department two times within 24 hour period."	V 290		

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V 290	Continued From page 5	V 290		

-"10/5/19- Myself and another staff came outside to discover a strong odor believed to be marijuana. After walking around the complex to find where the smell was coming from, I noticed [client #1] and another clients standing under the back stairway. [Client #1] looked to have something in his hand smoking it when I approached him. I asked [client #1] why was he smoking marijuana on the premises. [Client #1] denied smoking or smelling marijuana. I prompted him and the other resident to leave the area..."
-"11/2/19- Consumer left offside during the afternoon around 3:30 PM and did not return back to site for the remainder of the shift and did not receive his evening medications."
-"11/6/19-Consumer was offsite and did not return for evening medication."
-"11/13/19-....[Client #1] came into the office and told staff he was leaving would not be back to take his 8 pm medication because he would not get off of work until 4:00 am."

Review on 11/25/19 of client #1's treatment plan dated 9/4/19 revealed the following goals:
-"I want to get back in school' as evidenced by developing vocational skills in order to pick program in school and maintain his current employment."
-"I need help shopping' as evidenced by developed independent living skill and maintaining his housing through RHD."

During interview on 11/25/19 the Qualified Professional (QP) stated:
-Client #1 was admitted over a year ago from a provider who stated he was ready for independent living in their supervised apartments.
-Client #1 was referred to them from another group home and his Assertive Community

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V 290	Continued From page 6 Treatment (ACT) team. -Client #1's ACT team completed the treatment plan for clients they serve in their apartments. -He had a history of alcohol and marijuana use. -Did not have issues with him being non compliant until a few months after admission. -Assessed him upon admission for unsupervised time in the home and community based on the way their program is set up and the clients going to work. -Staff had observed him in the courtyard with a beer in the past and smelled marijuana coming from the area he was smoking from. -They had found beer cans and marijuana residue in his apartment. -He was attending a day program but quit and went out and got his own job. Did not know client #1's work hours. -Had requested client #1 to provide them with a schedule but he never did. -Staff started noticing he was not signing in and out when he was leaving. -They would go looking for him and could not find him. -Had spoke with his ACT team about this and they scheduled meetings with him at which he would leave before the meeting and not show. -He refused psychiatric appointments and therapy. -Client #1 is his own guardian. -Had recommended him for a higher level of care. -Not given him a discharge notice as she was giving his ACT team time to look for something else. -Had issues with making contact with ACT team as they may not return her call for days or up to a week. -Had met with him lots of times, almost weekly to discuss rules and expectations. -"He keeps telling us he is not going to follow the	V 290		

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V 290	Continued From page 7 rules." -Met with client #1 last week and told him they were planning to discharge him. -Client #1 had a "blank face" and stated he would just go to the homeless shelter. -Had not had a meeting to update his goals to address his ongoing behaviors with alcohol and drugs. -Had spoken to their director about moving forward with discharge within the last few days. -Had not assessed him again or taken his unsupervised time away due to the independent living apartments do not have staff in them. During interview on 11/26/19 The Director stated: -He was aware of ongoing issues with client #1's non compliance and behaviors. -They had reached out to his ACT team to discuss issues and let them know he needed a higher level of care. -They had attempted to meet with client #1 to address the rules and expectations but he refused to follow them. -Had discussed discharging client #1 but wanted to give the ACT team time to find him placement. -Not aware if any goals or strategies had been put in place for client #1 since his behaviors had increased. Attempted to contact client #1's ACT team with no return calls on 11/26/19 and 12/4/19. This deficiency is cross referenced into: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN for a Type A1 rule violation.	V 290		
V 736	27G .0303(c) Facility and Grounds Maintenance	V 736		

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V 736	Continued From page 8 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a clean, safe and attractive manner. The findings are: Observation on 11/26/19 at 11:45 AM revealed: -Bed frame in client #1's room was broken and leaning on the wall. -Blinds in client #1's room was broke in several spots. -Smoke detector chirping in the living area. -Bath tub knob in client #1's bathroom was broken off. -Floor throughout the home was dirty. During interview on 11/26/19 Staff #1 stated: -Client #1 was extremely paranoid and looks out the window all the time which is why the blinds are broken. -Not aware of client #1's bed being broken. -Not aware of the bathtub know being broken. -The vacuum from the home had been broken for a few weeks. -Will make a list for maintenance to get repairs.	V 736		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
MHL092-582		12/4/2019

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VARSITY CREST #3	1503 CREST ROAD APT. 103 RALEIGH, NC 27606

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0108 Reg. # 27G .0202 (F-I) LSC	Correction Completed 12/04/2019	ID Prefix V0111 Reg. # 27G .0205 (A-B) LSC	Correction Completed 12/04/2019	ID Prefix V0289 Reg. # 27G .5601 LSC	Correction Completed 12/04/2019
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Kimberly Thigpen 12/19/19	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 10/19/2018

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Date: 01/08/2020

With respect to: *"Varsity Crest #3" ID #: MHL092-582*

State Form Printed: *12/20/19*, Received via certified Mail *12/30/2019.*

Thank you for the opportunity to develop a plan of correction to address each deficiency noted on the state form specified above. As you will find below, with respect to ID Prefix Tag V736, all deficiencies have been corrected and we have made several changes to prevent these problems from occurring again, noted who will monitor this situation, and how often the monitoring will take place.

However, with respect to ID Prefix Tags V112, and V290 we would strongly contest that a deficiency occurred that met the threshold for a Type A1 rule violation. We would also strongly contest that 'neglect' occurred. It is possible the disputed violation may be a result of NC DHHS not having reviewed all documentation pertinent to the situation, and increased access and or transparency to supporting documentation can be made available. Nevertheless, RHD strives to provide a culture of continuous learning and we are always open to ways to improve and provide the highest quality of service to our consumers. Thus, we have identified and implemented several measures and improvements in response to the alleged rule violation that may make our compliance more transparent in the future.

Page 2: ID prefix tag: V112 paragraph 2:

Response: The consumer, "Client #1," has moved and is no longer active in the Varsity Crest Program. However, we disagree that 'facility failed to ensure client was capable of remaining in the home or in the community for unsupervised times.' We have documentation signed from a physician as recent as 36 days prior to this survey stating, "Recommended Level of Care" as "Other" and "Supportive Apartment." The doctor also noted the "Discharge Plan" selection as "Other" and "Supportive Apartment." We also have similar documentation signed by a different physician on 09/24/19 stating, "Recommended Level of Care" as "Other" and "Supervised Living." Doctor also noted "Discharge Plan" selection as "Other" and "Supervised Living." Both of these recommendations, signed by different non-RHD physicians, were provided after "client #1" completed inpatient stays. Additionally, there is supporting documentation from the QP addressing additional steps during and after hospitalization to address "Client #1's" needs.

Page 2: ID prefix tag: V112 paragraph 3:

Response: A Plan of Protection was completed as stated. As noted above, RHD strives to provide a culture of continuous learning and we are always open to ways to improve and provide the highest quality of service to our consumers. To increase transparency on the capability of consumers to remain in the Varsity Crest Program, the following changes were implemented:

1. Program Policy was updated to include the necessity for the QP or Program Manager to complete the "Unsupervised Time Assessment" every 90 days in addition to the initial screening process. The policy also addresses steps to take should consumers no longer qualify for unsupervised time.
2. A significantly improved "Unsupervised Time Assessment" was created and is now being used to better assess and demonstrate a consumer's ability to safely remain in an apartment with unsupervised time.
3. Due to the treatment plan not being as strong and clear as best practices might dictate (The Treatment Plan is completed by consumer's ACT Team, NOT RHD) a 2-hour treatment plan training was conducted on 12/19/19 by the Clinical Director for RHD's Northeast Division for the Varsity Crest QP.

Page 3: ID prefix tag: V112 paragraph 1:

Response: The consumer, "Client #1," has moved and is no longer active in the Varsity Crest Program. Additionally, "Client was initially assessed upon admission for eight hours of unsupervised time in the community." (This is correct.) However, we would disagree that 'the facility failed to implement any new strategies or goals to address the increased behaviors.' Documentation from the case notes demonstrates interventions and strategies to address the increased behaviors. Additionally, more than one non-RHD physician recommended the "Level of Care" as "Other" and "Supervised Living" or supportive apartment as well as the "Discharge Plan" as "Other" and "Supervised Living" or supportive apartment.

It is also noted on "Page 3" that the consumer was "calling 911 with suicidal ideations." This is also accurate, but not an indication of his inability to safely remain in his apartment. "Client #1's" Act Team completed/updated his Crisis Plan on 09/06/19 and the "Safety Planning Section" stated they completed a crisis plan, "which included calling 911…" The consumer calling 911 with increased frequency appears to be an attempt to follow his own crisis plan, which is positive progress towards safety, not a demonstration of his inability to remain safe in his apartment.

DHSR has imposed a Type A1 Violation: "A violation by a facility, which results in death or serious physical harm, abuse, neglect, or exploitation." We believe the above demonstrates this threshold has not been crossed, and additional supporting documentation can be provided as well. Further, DHSR defines "Neglect" as "the failure to provide care or services necessary to maintain the mental or physical health and well-being of the client." Again, we do not believe this threshold was crossed as the above notes care and services were implemented to maintain "Client #1's" well-being in coordination with his

ACT team and doctor, different physicians from different inpatient units, and collaboration with the MCO to begin the transition/discharge process.

Page 3,4,5,6,7,8: ID prefix tag: V290:

Response: The consumer, "Client #1," has moved and is no longer active in the Varsity Crest Program. However, we would disagree that the facility failed to ensure client was capable of remaining in the home or community for unsupervised times as evidenced in the responses to ID Prefix V112. Again, the repeated citation of the "Client #1" contacting 911 is a very positive demonstration of his following his "Crisis Plan," completed/updated by his ACT team on 09/6/19 to ensure his safety. Each time the consumer, "Client #1," was hospitalized, his transition back to Varsity Crest appears to have been supported by the discharging physician as well as his ACT Team.

RHD does not contest that the consumer reached a point to where it became evident that a higher level of care may better benefit him, however, we would strongly contest that allowing him to stay within the RHD Varsity Crest program while we coordinated with his ACT team and the MCO to ensure continuity of care and a transition to a suitable placement placed the consumer at risk, or constituted neglect in any way. Proper discharge planning with the consumer's participation and respect to his choices in the discharge planning process are of great importance to RHD.

Page 9: ID prefix tag: V736:

Response:

- Bed Frame was broken and leaning on wall
- Blinds in room broken in several spots
- Smoke detector chirping in living area
- Bath Tub knob was 'broken off.'
- Floor throughout home was dirty.

All issues have been addressed and remedied by the Landlord and the Operations Manager, thus all deficiencies resolved.

The bed frame was removed, as this room is currently vacant and will be replaced prior to another resident moving in. The blinds were repaired. The smoke detector had the battery replaced and was tested. The Bath Tub knob was repaired/replaced. The floors were cleaned. The on-site staff will check the apartment daily, the team leader will review and personally assess a minimum of one time weekly, and the QP will review and personally assess every two-weeks to ensure compliance and the quickest reaction to any possible items or locations that become or are not safe, clean attractive and/or free from offensive odor.

Summation: All location and exterior requirement rules have been remedied and all deficiencies resolved. With respect to all other rules, the consumer referred to as "Client #1" has moved and is no longer active in the Varsity Crest Program. Furthermore, while the consumer referred to as 'Client #1' is no longer involved in the program, RHD is formally requesting DHSR to arrange for an informal meeting to resolve disputed statements noted above, specifically any and all allegations of "neglect" and the "Type 1" rule violation. RHD can demonstrate that as the consumer began to demonstrate lack of progress or regression, actions were taken to intervene and assist the consumer in an effort to maintain his placement. As it became evident the consumer would be better benefited by a higher level of care than Varsity Crest is designed to provide, RHD began to make arrangements to transition/discharge the consumer. RHD strongly contends that respecting the consumer's choices and working with his other care team members to provide continuity of care and to ensure a smooth transition to another level of care was the best and safest course of action. RHD can demonstrate this was in progress prior to DHSR's survey on 11/25 and 11/26/2019. Finally, the collaboration and documentation from multiple inpatient doctors, as well as "Client #1's" Act team demonstrate a collaborative agreement that "Client #1" was safe at Varsity Crest. We look forward to making the improvements we noted above, as well as demonstrating that a "Type A1" rule violation did not occur.

Sincerely,

Nick Hobbs, MBA
State Director
Resources for Human Development, Inc.