Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-109	A. BUILDING: ______ B. WING ______	C 11/22/2019

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ALPHA RESIDENTIAL SERVICES-OAKLAND	2103 OAKLAND AVENUE HENDERSON, NC 27537

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V 000	INITIAL COMMENTS A complaint survey was completed on November 22, 2019. The complaint #NC00157830 was substantiated. 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 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111	DHSR-Mental Health DEC 2 3 2019 Lic. & Cert. Section	

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

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V 111	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to document strategies to address the client's presenting problems within the first thirty days effecting 1 of 1 clients (#3) admitted in the last 30 days. The findings are: Review on 11/6/19 and 11/18/19 of client #3's record revealed: - admission date 10/16/19 - diagnoses of Schizoaffective - Bipolar Type, Depression, Cocaine Use Disorder (DO) - Severe, Marijuana Use DO - Severe, Seizure DO, Gastro Esophageal Reflux Disease, Myocardial Infarction, History (Hx) of Traumatic Brain Injury and Hx of Diastolic Dysfunction. - a behavioral health and substance assessment dated 9/16/19 from a local hospital with: - "Pt (patient) brought himself to the ED (Emergency Department) today after relapsing and using cocaine and marijuana...Pt has not been in tx (treatment) since last year...and has not been on any medication since last month...Pt has been homeless for the past year...Pt ...has been having transient SI/HI (Suicidal Ideation/Homicidal Ideation) with plans to shoot himself and other people...Pt said he has a gun buried in the backyard of [local homeless shelter]...The patient is at severe elevated risk of suicide/dangerousness to others and further worsening of psychiatric conditions..." - an group home admissions assessment dated 10/16/19 with:	V 111	I QP training was held in order to ensure compliance with deficiencies found in completion of facility admission assessments as pertaining to 10ANCAC 27G 0205 II QP will ensure compliance weekly through chart reviews III QAQI team will ensure rule compliance through quarterly monitoring of files: rule 10ANCAC 27G.0205	11/25/19 weekly/ on-going quarterly

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V 111	Continued From page 2 - Presenting Problems: "Schizoaffective DO bipolar type" and "substance abuse/cocaine abuse" - Relevant Substance Use/Abuse: "Hx substance abuse/Not active at this time" - Relevant Medical Information: "N/A" - Suicide/Homicide Risk Potential: (Current and Past options available to check off) Nothing checked off. - History of Impulsive behavior danger to self/others: "N/A None" - No strategies to address client's presenting problems (There was no treatment plan present in the record on either 11/6/19 or 11/18/19). During an interview on 11/6/19, client #3 reported: - he had not discussed goals with anyone at the group home - he did not work on any goals - he thought his guardian decided and wrote the goals - had not seen or heard about any treatment plan - he wanted to become more independent and be safe During an interview on 11/18/19, the Qualified Professional (QP)'s supervisor reported there should have been strategies listed on the assessment. He was not sure why the QP had not included them. Review on 11/22/19 of a treatment plan dated 10/16/19 and submitted by an Administrator at their administrative offices revealed no strategies related to substance use, suicidal or homicidal ideation. The Administrator stated this treatment plan and goal grid sheets were located at the facility. This treatment plan was not available to	V 111	1) Person-centered planning training was conducted with staff to ensure compliance with rule 10A NCAC 27G.0205	12/17/19 and on-going monitoring

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V 111	Continued From page 3 this surveyor while at the facility.	V 111	II. QP will monitor person-centered process weekly to ensure rule compliance III. QAQI will monitor person-centered process quarterly to ensure compliance	weekly quarterly
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; (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.	V 118		

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V 118	Continued From page 4 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, staff #1 failed to ensure medications (meds) were administered correctly effecting 3 of 5 audited clients (#2, #3 and #4). The findings are: a. Observation on 11/6/19 at approximately 1:30pm revealed client #2's meds included: - Famotidine 3mg - Trazadone 50mg - Lithium 450mg - Haldol 5mg - Diphenhydramine 25mg - nicotine gum 2mg Review on 11/6/19 of client #2's record revealed: - admission date unclear - diagnosis of Schizoaffective Disorder - Bipolar Type During an interview on 11/5/19, client #2 reported: - staff #1 gave out meds one at a time in a cup with the clients name on it - a couple of times he gave the wrong meds in the wrong cup - clients knew what meds they took and knew to check the cup before taking any b. Observation on 11/6/19 at approximately 3:00pm revealed client #3's meds included: - Duloxetine 60mg - Depakote 500mg - Trazadone 50mg - Acetaminophen 325mg - prn (as needed) Review on 11/6/19 and 11/18/19 of client #3's record revealed: - admission date 10/16/19 - diagnoses of Schizoaffective - Bipolar Type,	V 118	I. Staff reviewed on 12/17/19 [illegible] medication management training to address deficiencies in Rule is 10A NCAC 27G.0209 and 10A NCAC 27D.0304, as cross-referenced II. RN training scheduled on 1/8/20 for staff including: medication administration, proper documentation, consultation with residents, etc.	12/17/19; 1/8/20 on-going monitoring

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V 118	Continued From page 5 Depression, Cocaine Use Disorder (DO) - Severe, Seizure DO, Gastro Esophageal Reflux Disease, Myocardial Infarction, History (Hx) of Traumatic Brain Injury and Hx of Diastolic Dysfunction. During an interview on 11/6/19, client #3 reported: - staff #1 administered meds by putting them in small med cups with each clients name on it - staff #1 then put the cups on the table where they sat for breakfast - clients would have to check their cups to make sure they were given the right meds - he was never given the wrong meds but witnessed other clients getting the wrong cup or the wrong meds c. During an interview on 11/6/19, client #4 reported: - staff #1 administered meds by putting them in small med cups with each clients name on it and put the cups on the table where they sat for breakfast - he had seen the wrong medications in the cup During an interview on 11/14/19, staff #1 reported: - he had worked at the facility for approximately 5 months - he had been trained in medication administration when he was hired. He was trained to give meds out one at a time and to check the med packages against the MAR for each client before administration to ensure accuracy. - he first said he gave out medications one person at a time. He put the meds in a cup with the client's name on it. He also said he put the 5 cups of meds on the table after the meal and	V 118	III. QP to monitor weekly to ensure compliance with rules 10ANCAC 27G.0209 and 10ANCAC27D.0304, as cross referenced IV. QAQI team to monitor quarterly to ensure compliance with rules 10ANCAC 27G.0209 and 10A NCAC 27D.0304	12/17/19; 1/18/20 on-going on-going

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V 118	Continued From page 6 watched as the clients took their meds. He had never had any med errors. He followed the instructions on the MAR and signed the MAR immediately. During an interview on 11/6/19, the Qualified Professional reported he had never seen a problem with medication administration or the MARs. No client had ever reported staff #1 making mistakes with the meds. This deficiency is cross referenced into 10A NCAC 27D .0304 (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information;	V 367	I. Incident and quarterly report training conducted on 12/17/19 to address deficiency with rule 10A NCAC 27G.0604 II. QP to monitor for compliance at each incident to ensure appropriate completion and submission	12/17/19 ongoing

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V 367	Continued From page 7 (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the	V 367		

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V 367	Continued From page 8	V 367		

catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to submit all Level II incidents, to the LME (Local Management Entity) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:

Review on 11/6/19 of a "Police History Search" and attached reports revealed:
- 27 calls to the police between 10/12/18 and 11/1/19
- 15 of those calls were between 4/15/19 and 11/1/19
- 8 calls were about a missing/runaway client
- 11/1/19 - 2 calls 2 different clients at 2 different times;

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V 367	Continued From page 9 - 8/31, 8/26, 8/21, 6/30, 4/22 and 4/15/2019 - 3 calls were about assaults or accusation about staff mistreatment - 8/31/19 2 separate calls - 8/20/19 - 1 call for clients left unsupervised in house: 10/31/19 - 1 call was for client disorderly conduct: 7/29/19 - 1 call for a fire on the outside of the house: 10/8/19 - 1 call from a client saying he was in fear for his life because of staff; 6/15/19 Multiple reviews between 11/6/19 and 11/22/19 on the Incident Response Improvement System (IRIS) revealed no Level II incident reports were submitted for any of the above occurrences except for the runaways on 11/1/19. During interviews on 11/18/19, 11/20/19 and 11/22/19, the Qualified Professional (QP); the QP's Supervisor and an agency Administrator all reported: - if the facility called 911 only for an ambulance but the police also came out, they would not do a Level II Incident Report - if a client called the police and they came out, they would not do a Level II Incident Report - if they had not been informed by the staff that the police were at the facility, they would not know to do a Level II Incident Report - they did not routinely check with the police department to see if they (Police) had been to the facility - any other calls to the police should be reported to IRIS - they had not been made aware of any accusations from the clients until the one	V 367		

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V 367	Continued From page 10 accusation made on 11/1/19 at which time the accused staff (#1) was immediately suspended and an investigation was initiated - a 24 hour report and a new investigation was begun as soon as they became aware of the new accusations on 11/18/19. The staff accused had already been suspended and would remain so until the end of the investigation.	V 367		
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, 1 of 1	V 512	I Staff was immediately terminated upon report of incident II Staff was called in for review of clients rights as applicable to rule 10A NCAC 27D.0304 regarding protection of residents from harm, abuse, neglect or exploitation. III Staff training was conducted 12/17/19 on harm, abuse, neglect, and exploitation to	11/1/19 11/1/19 12/17/19

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V 512	Continued From page 11 Paraprofessional Staff (#1) subjected 2 of 5 current clients (#1, #2) and 1 of 3 former clients (#7) to physical abuse; 1 of 6 clients (#1) to exploitation; 5 of 5 current clients (#1- #4 and #6) and 3 of 3 former clients (FC) (#5, #7 and #8.) to verbal abuse and neglect. The findings are Cross Reference: 10A NCAC 27G .0209 Medication Administration (Tag V118). Based on observations, record reviews and interviews, staff #1 failed to ensure medications (meds) were administered correctly effecting 3 of 5 audited clients (#2, #3 and #4). Review on 11/6/19, 11/7/19 and 11/18/19 of client records revealed: - client #1: - admission date December, 2018 - diagnosis of Dementia, Parkinson's Disease, Seizure Disorder (DO), Diabetes, Bipolar DO, Chronic Obstructive Pulmonary Disease - no unsupervised time allowed in the home or community - client #2: - admission date unclear - diagnosis of Schizoaffective Disorder - Bipolar Type - no unsupervised time allowed in the home or community - client #3: - admission date 10/16/19 - diagnoses of Schizoaffective - Bipolar Type, Depression, Cocaine Use DO - Severe, Marijuana Use DO - Severe, Seizure DO, Gastro Esophageal Reflux Disease, Myocardial Infarction, History (Hx) of Traumatic Brain Injury and Hx of Diastolic Dysfunction. - a behavioral health and substance assessment dated 9/16/19 from a local hospital	V 512	III (contd.) ensure compliance with rules 10A NCAC 27D. 10A NCAC 27G.0209 0304 and. IV QP to monitor weekly to ensure client rights aren't violated V QAQI to monitor quarterly to ensure compliance with both 10A NCAC 27D.0304 and 10A NCAC 27G.0209, as cross-referenced. VI A Staff reviewed medication management training; VI b RN training sceduled for 1/8/20 to ensure 10A NCAC.27G.0209 to ensure compliance and resident safety	12/17/19 weekly quarterly 12/17/19 1/8/20

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with: "Pt (patient) brought himself to the ED (Emergency Department) today after relapsing and using cocaine and marijuana...Pt has not been in tx (treatment) since last year...and has not been on any medication since last month...Pt has been homeless for the past year...Pt ...has been having transient SI/HI (Suicidal Ideation/Homicidal Ideation) with plans to shoot himself and other people...Pt said he has a gun buried in the backyard of [local homeless shelter]...The patient is at severe elevated risk of suicide/dangerousness to others and further worsening of psychiatric conditions..."

- no unsupervised time allowed in the home or community
- client #4:
  - a chart review was not done. Client #4 reported he had been at the facility for 2 months.
- client #6:
  - admission date November, 2018
  - diagnoses of Schizoaffective DO, Alcohol Use DO and Cocaine Use DO
  - allowed 2 hours unsupervised time in the community
- former client #5 (FC #5)
  - admission date August, 2019
  - diagnoses of Schizoaffective DO, Bipolar DO and Hx of Attention Deficit Hyperactivity DO
- former client #7 (FC #7):
  - admission date August, 2019
  - diagnoses of Schizoaffective DO, Bipolar DO and Hx of Attention Deficit Hyperactivity
- former client #8 (FC #8)
  - a chart review was not done. Review of a police report of a 911 call made by FC #8 dated 6/15/19 revealed FC #8 reported he was in fear for his life from staff.

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a. The following is evidence of physical/verbal abuse:

Review on 11/6/19 of a police report dated 8/31/19 revealed:
- Police responded to call on 8/31/19 at 4:39pm from a client (FC #7) who reported an employee (staff #1) "hitting him and mean talking him."
- the officer reported: "ALL OK ARGUMENT OVER TV BOTH SUBJECT SAID BOTH OF THEM ASSAULTED EACH OTHER/NO VIABLE INJURIES TO REPORT."

Review on 11/5/19 of an Incident Report filed 11/5/19 about client #2 eloping from the home on 11/1/19 revealed: "...Police found [client #2] down the street from the group home. Upon [client #2] way back to the group home he reported to the police that he was being abuse by the staff. He reported that staff was being mean, smoking weed and drinking alcohol while at work...After speaking with his guardian (mother) [client #2] apologizes to staff about his behaviors and admitted taking money out of staff's room and a cell phone last week. [Client #2] also admitted he told police false allegations about staff."

Review on 11/6/19 of police reports revealed:
- on 6/15/19, at 10:18am FC #8 called police and stated he was in fear of his life because of staff #1. No other information was available.

During an interview on 11/6/19, client #2 reported:
- he lied when he admitted stealing money and only wrote the note saying he stole the money and lied to police to get them (staff) off his back
- on 10/29/19 staff #1 came into his room at approximately 5:00am and told him and his

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roommate to "get your a*ses up" Staff #1 accused client #2 of stealing $3.00 from his wallet. Staff #1 also said he gave client #3 $42.00 and he lost $3.00. Staff #1 then said client #2 stole $42.00 from him. Staff #1 patted him all over without asking and checked his pockets without finding anything

- he and other clients saw staff #1 hit client #1 on the head with an open hand. "He (staff #1) didn't want to hear him (client #1) keep repeating things. He did it almost every day."
- he told the Qualified Professional (QP) but the QP did not believe him. He said 2 other clients (#4 and #5) also told the QP. The QP told staff #1 to "just give him (client #1) a Mountain Dew and he'll be okay."
- staff #1 also slapped him on the a*s once and told him to pull up his pants

During an interview on 11/6/19, client #3 reported:

- staff #1 and another client (#2) argue all the time and staff #1 called client #2 "dumb and things like that"
- staff #1 had an "attitude problem" with clients #2 and #4. And "he can't stand [client #1]"
- he and 2 other clients saw staff #1 slap client #1 in the back of the head. The other two clients would know more details.
- saw staff #1 unplug the phone when client #1 asked to call his brother. He then gave the phone to client #1. When client #1 did not get any answer staff took the phone and told client #1 "No more calls for you."

During an interview on 11/6/19, client #4 reported he had lived at the facility for 2 months and said staff #1 was rude to everyone.

During an interview on 11/7/19, FC #5 reported:

- he had lived at the facility for 3 months and

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was transferred to another facility the previous day (11/6/19) to be closer to his family
- he saw staff #1 slap client #1 more than once.
- client #2 tried to stick up for client #1
- he didn't think staff #1 should be able to work at the facility

b. The following is evidence staff #1 exploited client #1:

During an interview on 11/7/19, client #1's brother reported:
- when client #1 was admitted to this facility (December, 2018) his family bought him all brand new clothes; "hundreds of dollars" worth of clothes so he didn't need anything
- he and client #1's mother visited with client #1 on October 23, 2019
- they went out and bought client #1 more new clothes and daily supplies
- they had recently also bought client #1 a new television and a new set of hair clippers
- he then gave a $100.00 bill to staff #1 for any future supplies or spending money needed for client #1
- in the past he had seen the financial book which documented the clients spending money and had not had any concerns

Review on 11/6/19 and 11/18/19 of client #1's "Personal Funds" sheet and folder revealed:
- no documentation of $100.00 being logged into his account anytime in the last 6 weeks
- documentation of monthly deposits for the previous 6 months ranging from $24.00 to $30.00
- documentation of a withdrawal on 10/14/19 of $30.00 with a balance of $1.00
- documentation of a monthly deposit made on 11/7/19 of $30.71 with a balance of $30.71

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- no receipts for any purchases in October or November, 2019

During an interview on 11/6/19, client #2 reported:
- while outside on the deck, he was told by client #1 that his family gave $100.00 to staff #1 for his (client #1's) personal needs. Staff #1 then came out on the deck and said he had $100.00 in his pocket.
- client #2 wondered about that because client #1 had just told him his mother gave him $100.00
- client #4 told him staff #1 gave him (#4) a $100.00 bill and told him and 2 other clients to go to the store and buy snacks, cigarettes and soda

During an interview on 11/6/19, client #3 reported:
- he saw client #1's brother give staff #1 a $100.00 bill .
- after the family left, staff #1 came out on the deck where he and other clients were smoking and said he had $100.00 in his pocket.
- staff #1 sent him and 2 other clients to the store to buy snacks, cigarettes and soda. The staff gave the $100.00 bill to one of the other clients. The same clients went twice more to the store for snacks in the following 2 days.
- none of the clients sent to the store were allowed unsupervised time in the home or community

During an interview on 11/6/19, client #4 reported:
- staff #1 was a "hustler"
- staff #1 hustled them out of their money.
- staff #1 gave them money for cigarettes and then charged them. Staff #1 said "If we got something from him we had to give him something back."
- staff #1 would give them cigarettes then said they owed him

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- he did not know if the money staff #1 gave them was his (staff #1) or out of the client's own funds

Review on 11/22/19 of copies of receipts submitted by an agency Administrator as client #1's receipts revealed
- numerous receipts dated in June, 2019, September 2019.
- several of the receipts were dated on the same day at the same store at relatively the same time (within an hour)
- there were no names on any of the receipts nor were there any receipts after client #1's family visit on 10/23/19

c. The following is evidence staff #1 subjected clients to neglect:

1. Leaving clients unsupervised in the facility or sending clients into the community unsupervised:
During interviews on 11/6/19 and 11/7/19 clients reported:
- client #2:
- clients were left alone in the house. On 10/31/19, Staff #1 took the bike and left and came back with a bag in his hand. He did not know what was in the bag. The clients had called the police and complained they were left alone. When the police arrived (about the same time as staff #1 returned) staff #1 ran into the house
- staff #1 told him he had $100.00 in his pocket immediately after client #1 told him his mother had just given him (client #1) $100.00. Staff #1 sent 3 clients (#3, #4 and Former Client #5 (FC #5)) who did not have any unsupervised time to the store to buy snacks, cigarettes and soda with a hundred dollar bill. He sent the same three clients to the store unsupervised 2 more times

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- client #3
  - sometimes staff #1 left the clients alone at the house and went to the store to buy soda or something
  - last week 2 clients called the police to report they were left alone in the home.
  - staff #1 sent 3 clients (himself, #4 and FC #5) with no unsupervised time to the store on 3 different occasions to buy snacks, cigarettes and soda. Staff #1 gave them the $100.00 bill from client #1's family to buy stuff for everyone
- client #4
  - Staff #1 has left the clients alone in the house for 40 minutes. Once clients called the cops and he showed up just as the cops showed up

2. Failing to provide supervision to ensure safety.
- Review on 11/6/19 of police 911 calls to the facility revealed:
  - 27 calls between 10/12/18 and 11/1/19
  - 8 of the 15 calls between 4/15/19 and 11/1/19 were about a missing/runaway client
- on 11/1/19 there were 2 calls for 2 different clients at 2 different times;
- other calls about clients going AWOL (away without official leave) occurred on:
  - 8/31/19: report at 6:57pm FC #7 went AWOL
  - 8/26/19 : report at 2:02pm FC #7 went AWOL
  - 8/21/19 : report at 6:47 FC #7 went AWOL
  - 6/30/19: report at 7:15pm client AWOL (no name)
  - 4/22/19: report at 12:11pm former client (#9) went AWOL
  - 4/15/19: report at 7:11pm former client (#9) went AWOL

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Review of a police report dated 11/1/19 revealed:
- on 11/1/19 police received a call at 6:59am reporting "[Client #1] left the residence sometime during the night and hasn't returned....Supplement:...spoke with Caretaker (staff #1) who stated he put [Client #1] to bed around 10:00pm on 10/31/19. [Staff #1] stated [Client #1] left out of the front door of the residence sometime during the night. He was last seen wearing black boxers and a white shirt. It is unknown what [Client #1] is now wearing...At 9:05am [Client #1] was located at [local church...]."
- police transported him back to the facility

During an interview on 11/6/19 the detectives who responded to this and other calls at this facility reported:
- client #1 was located in a church parking lot 4 miles from the group home
- the weather on 10/31/19 - 11/1/19 was very cold and a strong thunderstorm had occurred during the night
- the roads between the group home and the church where the client was found included dark, hilly, wooded sections with creeks and deep ditches, some without sidewalks. One of the roads was a major thoroughfare with 55 mph speed limits.
- they would not feel safe walking on these roads.
- believed the clients were in danger because of lack of supervision
- the doors at the facility did not have alarms on them that they ever saw
- a 2nd call came in at 8:24am on 11/1/19 reporting a second client (#2) had eloped from the facility. This client was found approximately 30 minutes later down the road.

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3. Drinking on the premises: During interviews on 11/6/19 and 11/7/19 clients reported:
- client #2
  - "[Staff #1] is cool but when he drinks he's cussing and yelling for no reason"
  - all the clients knew he (staff #1) was drinking. He would stay in his room with the door locked for hours. If clients knocked on his door he'd say "what the f**k do you want?"
  - he saw a beer can in the staff bedroom once
- client #3
  - staff #1 told him he drank alcohol in the home and that he needed to go to the ABC (Liquor) store
  - staff #1 once sent another client (#6) to the liquor store to get alcohol for him
  - he had seen staff #1 drunk a lot - about 2 times per week. He drank when 2 clients went to their day programs
- FC #5
  - he thought staff #1 drank at the house but had never witnessed it

During interviews on 11/6/19 and 11/7/19 clients also reported:
- staff #1 "was a hustler, the devil"
- always rude to everyone
- staff #1 would "push issues" with him to try and get him to fight
- he had seen staff #1 slap client #1 on the head on more than 1 occasion
- the alarms were only put on the outside doors last week after 2 clients ran away

During an interview on 11/14/19, staff #1 reported:
- he had been working at this facility for approximately 5 months
- he was a live in staff and stayed at the

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facility providing coverage 24/7
- his responsibilities included doing hourly checks on clients throughout the night. "When needed" (if there was a change in behavior) he would check on client #1 every 30 minutes
- he had been trained in Abuse/Neglect/Exploitation several times (Note: Review of personnel record on 11/7/19 revealed training in this area on 3/1/19, 4/10/19 and 10/2/19).
-he had been trained in medication administration and only gave out meds one person at a time after checking the medication against the Medication Administration Record.
- he had never put his hands on any client. He had never hit or slapped anyone.
- he did not call clients any derogatory names
- some clients don't like to follow the rules and can get mad or aggressive when told to do so
- first said he had never seen any family member give clients money
- then said he saw it once when he first started (April or May, 2019). He said client #1's family sent a money order (in April or May) when they were told client #1 needed new clothes. He took client #1 to a local discount store and said all the receipts were in his folder. He repeated that was the only time client #1's family sent money.
- when asked about client #1's recent family visit (10/23/19), staff #1 said "hold on." The call was then disconnected.
- an attempt was made to call back staff #1 without success and a message was left.
- staff #1 then sent a text message at 12:19pm with: "Pls when I get home...Driving... [Staff #1]"
- in the next 3 hours, two more phone call attempts were made to contact staff #1 without success and a text message was also sent

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without any answer

- review 4 days later on 11/18/19 of a text message sent by staff #1 on 11/18/19 at 11:42am revealed: "Good Morning..I have not been around and have been very busy... You asked me question in regard to money brought to [Client #1] by her mother to shop for him.. Yes. Myself, qp and other residents took him to [3 local discount stores] and shop him clothes, shoe and foodstuff..Some of the items are kept in the staff room to avoid misuse, kitchen cabinet and the extra lock door close at the living room..All receipts are kept in the residential fund kept at the medication box..[Staff #1]"
- clients sometimes owed each other money for cigarettes
- he slept sometimes at about 12:00am or 1:00am. "During the day if all the clients go to program I can sleep during day." Only 2 of 6 clients attend a day program. If he only has one or two clients in the house he can sit in the living room and rest.
- there were chimes on the outside doors but they were not working before the incident on 10/31/19.
- On 10/31/19, he helped client #1 get into bed at 10:00pm
- he checked on client #1 at midnight (12:00am) and he was sleeping
- when he went back at 5:00am, client #1 was not in his room. He checked outside without finding him then called the QP who told him to call police. He called police sometime before 6:00am.
- the police brought client #1 back to the facility at approximately 10:00am
- client #1's health had been deteriorating in behavior, attitude and especially memory and he sometimes stumbled when he walked.
- he never drank alcohol at the facility. He did

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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 512	Continued From page 23	V 512		

not drink alcohol at all.
- he never left clients alone in the facility and never sent clients into the community unsupervised. Only one client (#6) was allowed unsupervised time in the community.

During interviews on 11/6/19 and 11/20/19, the QP reported:
- the House Manager (staff #1) position was live-in. The overnight time is considered both awake and "downtime." Staff #1 did hourly checks on all clients, however, he could use his discretion after 12:00am until 5:00am. This is considered "downtime". Staff could randomly check on clients if they (staff) got up to go to the bathroom during those hours.
- he had never gotten any complaints from clients about staff #1
- he had never had any concerns about staff #1's interactions with clients
- he never saw staff #1 acting inappropriately with clients
- staff #1 always kept the records up to date, had never reported any issues with medications, kept the facility in a clean and attractive manner, was well trained and a good team player
- staff #1 was an excellent employee who always had his work done and the house in shape
- had he heard any complaints he would have reported it immediately as the agency does not tolerate any mistreatment of clients
- never smelled alcohol on staff #1 or in the house
- one client (#2) had a history of lying and making false accusations
- some clients don't like to follow the rules and he thought their issue with staff #1 was he enforced the rules

During an interview on 11/18/19 the QP's

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	MHL091-109	A. BUILDING: ______ B. WING ______	C 11/22/2019

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V 512	Continued From page 24	V 512		

supervisor reported:
- he had never received any complaints from clients about staff #1
- he looked in client #1's financial pouch and envelopes and could not find any receipts
- there was approximately $30.00 in the pouch and the last withdrawal was on 10/13/19
- there was no deposit of $100.00

During an interview on 11/22/19, an Administrator reported:
- they had never received any complaints from clients about staff #1 until the most recent incident on 11/1/19
- staff #1 was immediately suspended and an investigation started
- a 24 hour and a 5 day report was submitted to the Health Care Personnel Registry

Review on 11/22/19 of a Plan of Protection written on 11/22/19 by the facility Administrator revealed:
- What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm? "The staff was removed from the facility immediately. The QP will monitor the resident by weekly report meeting."
- Describe the plans to make sure the above happens. "Monthly meetings with the QP for updates. Monthly training with the staffs and Qualified Professional."

Staff #1's failure to provide adequate supervision resulted in 8 calls to the police in a 6 1/2 month period for clients missing from the facility. On one recent occasion a 54 year old client with Dementia, Parkinson's Disease, Seizures, Diabetes and COPD (Chronic Obstructive Pulmonary Disease) left the facility sometime

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V 512	Continued From page 25 after 12:00am and was not discovered missing by the staff until 5:00am. The client left on a very cold, stormy night and was found 4 miles away from the facility at 9:00am by the police. Staff #1 was observed by numerous clients (both current and former) hitting the client with Dementia in the back of the head on numerous occasions. Clients reported Staff #1 did not like the client repeatedly asking the same questions. Staff #1 admitted to police on 8/31/19 that he hit a client during an argument about the television. Multiple current and former clients reported staff #1 drank alcohol while at the facility. Multiple current and former clients reported staff #1 left them alone in the facility and only one client was allowed unsupervised time. Clients called the police once to report being left alone. Staff #1 was seen returning to the home with a bag in his hand at the same time police arrived at the facility. Multiple clients reported staff #1 occasionally gave them the wrong medications or put all the medications in cups with their names on it on the dining room table for them to take with meals. A family member reported giving $100.00 to staff #1 on 10/23/19 for his family member's needs. This money was never logged in to the client's fund balance and three clients reported staff #1 gave them the $100.00 to go to the store and buy snacks, cigarettes and soda. None of these clients were allowed unsupervised time in the community. One of the clients sent to the store had recently (10/16/19) been discharged from a local psychiatric hospital where he had been admitted after relapsing on cocaine and marijuana and threatening to kill himself and others with a gun he had buried in the local homeless shelter. This deficiency constitutes a Type A1 rule violation for serious abuse, neglect and exploitation and must be corrected within 23 days. An administrative penalty of $1000.00 is	V 512		

Division of Health Service Regulation

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V 512	Continued From page 26 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 512		