

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL034-267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/31/2020
NAME OF PROVIDER OR SUPPLIER INDEPENDENT LIVING AT THOMPSON DRIVE		STREET ADDRESS, CITY, STATE, ZIP CODE 1712 THOMPSON DRIVE WINSTON SALEM, NC 27127		
(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 A complaint survey was completed on 1/31/20. The complaint was substantiated (Intake ID #NC00159110). A deficiency was cited. This facility is licensed for the following service category: NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or	V 291		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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V 291	<p>Continued From page 1</p> <p>safety issues become a primary concern.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to coordinate with other professionals for 1 of 3 clients (Former Client #3(FC)). The findings are:</p> <p>Review on 1/27/20 of FC #3's record revealed:</p> <ul style="list-style-type: none"> - Date of Admission: 6/7/19 - Date of Discharge: 10/1/19 - Diagnoses: Major Depressive Disorder, Intellectual Disability, Autism Spectrum, and Disruptive Mood Dysregulation and Attention Deficient Disorder Combined type - Admission Assessment dated: 6/7/19 - Discharge summary dated: 10/1/19 - Person Centered Plan dated 6/7/19 with the following goals: increase independent skills by participating in household/residential chores, chose positive coping behaviors when agitated and receive day program services, comply with medications and all appointments. <p>Review on 1/30/20 of [City law enforcement] report dated 7/26/19 for FC #3 revealed:</p> <ul style="list-style-type: none"> - Date 7/26/19 at 6:38 pm - Victim: FC#3 has absconded from the group home residence as reported by Staff #2 - FC#3 resides at Independent Living @ Thompson Drive group home - Narrative in police report revealed: <ul style="list-style-type: none"> - "On 7/26/19 [officer] dispatched to contact [Home County for FC #3] at 11:20 pm regarding missing person (FC#3) - [Home County for FC#3] had been trying to make contact with the group home for at least two hours. 	V 291		

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V 291	<p>Continued From page 2</p> <ul style="list-style-type: none"> - [Officer] was advised that neighboring county law enforcement had located [FC#3] at a area gas station. - [Officer] attempted to contact Independent Living @ Thompson group home but was unable to get through with any of the phone numbers listed. - [Officer] then responded to the address for Independent Living @Thompson and spoke with the on-duty caretaker,[Staff #2]. - [Officer] provided [Staff#2] with the address where the officer had located [FC#3] and was there with him at that address (area gas station). - [Staff#2] advised he had just contacted on of his supervisors and further advised someone was going to go pick [FC#3] up from the [neighboring county]. - [Officer] asked who he (Staff#2) had contacted and [Staff#2] had said [the Qualified Professional(QP)]. - [Staff#2] provided [Officer] with [the QP's] telephone number. - However after calling the number several times, nobody answered the phone... - Ultimately [Officer] met me at the city limits after [FC#3] was willing to be voluntarily transported back to his group home. - [Officer] then transported [FC#3] back to the group home and left him in the care of [Staff#2]. - During the course of my follow-up investigation, the staff and personnel from the Independent Living at Thompson group home who have been charged with the care and well being of [FC#3] appeared to have made little to no effort in recovering [FC#3]. None of the numbers provided to me by [Staff#2] were answered when called, despite [Staff#2] having advised me that he had just spoken to his supervisor (the QP) via the numbers provided." 	V 291		

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V 291	<p>Continued From page 3</p> <p>Attempt to interview Staff #1 on 1/24/20 and 1/31/20. No return call or response to text message sent.</p> <p>Attempt to interview Staff #2 on 1/31/20. No return call or response to text message sent.</p> <p>Attempt to interview Staff #3 on 1/31/20. No return call or response to text message sent.</p> <p>Interview on 1/31/20 with the QP revealed:</p> <ul style="list-style-type: none"> - QP reported that all management is in charge of the group home. - Staff #2 never called the QP back with the location of FC#3 so he could go pick him up. - The QP reported that his phone doesn't show where the officer tried to telephone his mobile phone the evening of 7/26/19. - "I never got a phone call." <p>Interview on 1/30/20 with the Director revealed:</p> <ul style="list-style-type: none"> - "[Staff #1] contacted the QP that night. Then [the QP] contacted me the Director. <p>We all met at the house to look for the client (FC#3).</p> <ul style="list-style-type: none"> - [Staff #3] had seen [FC##] down the road and he went into the woods. At that point we all returned to the house. - The police took a report. It was third shift staff (Staff#2) that night. The police never gave the address to where [the QP] would pick up [FC#3]. - The police brought [FC#3] home that night." 	V 291		