STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	R-C 01/16/2020

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SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on January 16, 2020. The complaint was unsubstantiated Intake #NC00158185. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability	V 000		02/15/2020
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying,	V 108	DHSR - Mental Health FEB 11 2020 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maurice Whaley — TITLE: Executive Director — (X6) DATE: 2/7/2020

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V 108	Continued From page 1 reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 4 of 8 audited staff (#2, #4, #6 & #7) received training to meet the needs of the mh/dd clients. The findings are: Review on 11/18/19 of client #2's record revealed: - admitted to the facility 3/16/15 - Moderate Intellectual Developmental Disability (IDD); Autism; Schizoaffective Disorder & Intermittent Explosive Disorder (IED) - a psychological evaluation dated 10/14/19 defined IED as follows "...people with IED may attack others and their possessions, causing bodily injury and property damage...later they may feel remorse, regret or embarrassment..." Review on 11/18/19 of client #3's record revealed: - admitted 5/19/15 - diagnoses of Severe IDD; Seizure Disorder; Sleep Apnea; Schizoaffective Disorder and Diabetes II & IED Review on 1/16/20 of an incident report dated 1/6/20 for client #3: - "[client #2] reported to the home manager that staff (#7) threw a cup of water in [client #3's] face because [client #3] had a behavior and was yelling and cursing at staff" Review on 12/5/19 of the facility's inservice training signature sheets revealed the following	V 108	**V108** **The company Quality Assurance Department has been contacted and training on IED will be held with all staff. This training will be devised and taught by a PhD Psychologist. The training will be specialized to the interment explosive disorder. The training will be competency based. Staff will be required to pass a written exam after the training. The training class will be offered at three available dates and times to ensure all staff receives the training.** **Home manager will quiz staff at random times during the shifts while she conducts medication monitoring and supervisions daily on all shifts for 60 days.** **QP will quiz staff at random times during the shifts while he conducts shift monitoring and supervisions twice a week for 60 days.** **QP will complete client specifics form and test to ensure staff has retained the information learned during the training.**	

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V 108	Continued From page 2 trainings given by the Qualified Professional (QP#1) : - 8/14/19 - reviewed & discussed issues with staff about training needs: staff present - staff #1-#5 & #9 (duration 1 hour) - 9/19/19 - a brief history of IED; causes of IED; signs & symptoms of IED and supporting a person with IED: staff present - staff #1- #5, #7- #9 (duration 40 minutes) - 11/21/19 - a refresher on the factors and signs of IED and how to support a person diagnosed with IED: staff present - House Manager (HM), staff #1 & 2, #7 - #9 (no duration of time documented) During interview on 11/18/19 staff #1 reported: - she had worked at the facility since summer 2019 - worked from 8:30am - 2:30pm - will fill in on shifts at the facility if needed - she was 1:1 in the community for client #3 - QP#1 recently provided IED training - IED was an outburst when a client does not get something they wanted - the outburst could consist of curse words, will bang on something or physical aggression During interview on 11/18/19 staff #2 reported: - she has worked with the facility for 5 years - worked from 8:30am - 2:30pm - she was the 1:1 in the community for client #2 - will fill in on shifts if needed - she was not trained on IED - IED was when a client got out of hand...may hit themselves or others During interview on 11/18/19 staff #6 reported: - he had worked at the facility for 2 years - he worked from 4pm - 7pm	V 108		

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V 108	Continued From page 3 - from 4:30pm - 5:30pm he worked alone - he didn't know what IED was - client #3 will hit him on the arm sometimes...he will playfully say, "why did you hit me"...client #3 will apologize During interview on 11/18/19 staff #7 reported: - she had worked at the facility for the last 4 - 5 months - she worked 3rd shift - IED was discussed in the last staff meetings - not sure when the meetings were held - she could not recall what IED was - QP#1 did reference a shook up soda can to client #2 (both waiting to explode) - she passed the IED test During interview on 11/18/19 staff #8 reported: - he had worked at the facility since 2009 - he worked from 5:30pm - 1am - had recent training in IED - the training was how to diffuse clients with IED - clients with IED "can go off at anytime" - they may stomp or curse During interview on 11/18/19 staff #9 reported: - she had worked for the facility 8 years - she currently worked the 5am - 8am shift - the last HM provided IED training in the past - IED training was done this week by QP#1 and the Program Manager (PM) - IED was when a client had an outburst without reason, outburst could come from nowhere & happen suddenly - QP#1 gave the example: a person with IED was like a soda, if you keep shaking it, eventually it will explode During interview on 12/5/19 staff #4 reported:	V 108		

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V 108	Continued From page 4 - IED was clients with behaviors - his (staff #4)'s memory was not what it used to be - a white lady at the office did the IED training During interview on 12/4/19 the HM reported: - she started October 2019 - the PM provided the training on IED - a client can be fine one minute and then anything can trigger the client to cause an outburst - staff had to take a test on IED after the training During interview on 12/12/19 QP#1 reported: - he started February 2019 - IED trainings for staff were completed on two separate dates: September 2019 & November 2019 - he "tag teamed" the November 2019 training with the PM - clients with IED have no warning signs - he tried to use examples like: clients with IED can be like a closed soda can when its shook up - there job was to slow the shook up can down - there were no white females that worked in management - he was not sure how staff could become more knowledgeable about IED During interview on 12/16/19 & 1/16/20 the PM reported: - QP#1 provided IED training on two separate occasions - she was present during the second training - staff #6 called out during the second training - she would schedule IED training for staff #6 - no test was given after the IED training - only verbal discussion about IED - she may have to get someone from the	V 108		

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V 108	Continued From page 5 corporate office to provide the IED training - staff #7 had been suspended until investigation was completed & they hear from Health Care Personnel Registry [This deficiency constitutes a re-cited deficiency.]	V 108		
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	**V112** **The facility will continue to maintain a positive relationship with the families and guardians of each consumer served. Staff will ensure guardians are given every opportunity to be a part of all treatment/medical plans of the consumers. The House Manager will ensure guardians are notified of scheduled treatment/medical plans. Guardians will be updated accordingly by the House Manager as well as by the Qualified Professional of changes to treatment/medical plans. The House Manager will in-service staff of the importance of maintaining communication with guardians in relations to treatment/medical plans of consumers.**	03/01/2020

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V 112	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop & implement strategies to address aggressive behaviors between 2 of 3 clients (#2 & #3). The findings are: A. Cross reference tag (V108). 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS. Based on record review and interview the facility failed to ensure 4 of 8 audited staff received training to meet the needs of the mental health/developmental disabled clients. B. Review on 11/18/19 of client #2's record revealed: - a treatment plan dated 4/12/19 with no goals or strategies to address physical aggression between client #2 & #3 - a psychological evaluation dated 10/14/19 revealed "...[client #2] has been increasingly aggressive including physical assaults and destroying property. Two weeks ago he fought a peer and both were injured, bruised. He is triggered by seeing his peers at the group home go on visits with their family. Just recently the group home made an agreement for his parents to commit to a regularly scheduled visit...total IQ = 51 (extremely low)..." Review on 11/18/19 of client #3's record revealed: - a treatment plan dated 7/1/19 with no goals or strategies to address physical aggression between client #2 & #3 - a psychological dated 4/30/19..."recently all aggressive behaviors have been a problem. He displays verbal aggression, communicating threats with cursing, physical aggression...total IQ = 33 (very low)..."	V 112	**V 112 Continued** **QP will coordinate with treatment team, care coordinators, guardians & natural supports to ensure ISP & BSP update revisions are completed.** **QP will suggest to Care Coordinators that Members risk assessments and crisis plans are updated and revised to outline behaviors associated with the members diagnosed with IED.** **All staff will be retrained in restrictive intervention training (YSIS) on 2/3/20. This is a competency-based training.** **Client specific forms and test will be completed** **The team will discuss on a monthly basis to determine frequency of monitoring.**	

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V 112	Continued From page 7 Review on 11/18/19 of medical summaries from primary physician's office for client #3 revealed the following: - 7/11/19 - "...laceration of left ear...2 sutures...was pushed by another resident..." - 9/10/19 - "...right hand bruised, hand and fingers hurt...his caretaker reports that at the group home another resident (client #2) stepped on his hand prior to the onset of symptoms...pain and swelling of the fingers..." - 9/20/19 - "...was in a fight with another of the residents (#2) of his group home...he kicked a door barefoot with great toe or right side and now the toenail is gone..." - 9/23/19 - "...caregiver reports that patient was bitten on his left forearm by another resident (client #2) of the group home during an altercation this morning..." - 9/26/19 - "...patient has bruise under left eye this morning...caregiver believes it happened when he was in a different altercation at the beginning of this week...he was also seen because of a bite injury..." Review on 11/18/19 of the facility's plan of protection dated 10/16/19 & revised 11/5/19 revealed the following: - requested by Department of Social Services (DSS) - no documentation of who completed the plan of protection - "[client #2] treatment team will coordinate to have current behavior support plan revised" - "[client #3]" treatment team will coordinate to put a behavior support plan in place..." - "all staff will be retrained on IED (Intermittent Explosive Disorder)..." - "ensure both members are involved within their communities to have time away from each other..."	V 112	**V 112 Continued** **The facility will administer and provide the necessary supervision to ensure the safety and welfare of all consumers. The facility will continue to monitor consumers during all activities and interactions with house mates. The House manager will daily oversee reports of incidents and will inform qualified professional, guardians, care coordinators, and etc. of any changes and/or issues. Qualified Professional will facilitate a treatment team meeting that will address the need of identifying additional behavior issues and supportive strategies into each consumer's Individualize Service Plan and Behavior Support Plan.** **Protocol is being put in place, and staff trained, on protecting [redacted] and responding when he responds to the actions of [redacted] and [redacted]**	

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V 112	Continued From page 8 - "additional staff in home during the hours of 5am - 8am..." - (revision 11/5/19) "Home Manager (HM) & Qualified Professional (QP#1) will monitor the home during each shift at least twice a week for 60 days or unless aggressive behaviors continue..." During interview on 11/18/19 staff #1 reported: - client #2 & #3 have IED - both have the same triggers - no money or something does not go their way they will have an outburst...cursing - after client #3 cursed at her...he later apologized - she would just laugh it off or ignore the behaviors During interview on 11/18/19 staff #2 reported: - client #2 hit her one time last year - he will get loud and demanding - she has witnessed client #2 push client #3 down...client #3 ended up with stitches on his head - client #3 always ended up with injuries - since she was 1:1 for client #2, she didn't know much about client #3 - she was aware client #3 had a diagnosis of IED - she was not sure what caused client #3 to get upset - client #2 gets upset when he can't get something or something doesn't go his way - there needed to be at least 2 staff on shift, since 2 clients in the facility had a diagnosis of IED - it could be dangerous working a shift alone with 2 IED clients During interview on 12/4/19 staff #7 reported:	V 112		

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V 112	Continued From page 9 - client #2 got upset because the other clients received visitors - client #3 talked about his visits with his mom which caused client #2 to get upset - client #3 knew this caused client #2 to get upset & have an outburst - client #2 will hit client #3 with a shoe, kick at him or push him - several incidents happened on her shift - she worked alone prior to the 5am - 8am staff being hired - there was no HM (until 10/1/19), she had to cook breakfast in the morning, get them ready and try to keep eyes on client #2 & #3 - there needed to be 2 staff prior to 10/1/19 - client #2's father picked him up on the weekends now - this has helped with client #2's behaviors - when client #2 & #3 started to bicker...she would have client #3 to calm down in his room - client #2 liked to draw, write or listen to his radio - she redirected them to do something positive During interview on 11/18/19 staff #8 reported: - if a person showed client #2 & #3 respect, they would have no problems with the two - his size also intimidated client #2 & #3 - he did not have any problems on his shift During interview on 11/18/19 staff #9 reported: - client #2 & #3 have ongoing incidents - she started working the 5am - 8am in October 2019 - she does not have any incidents on her shift - she has worked for the facility for years - the clients are different with each staff - it helps with 2 staff on shift due to the bickering & behaviors of client #2 & #3	V 112		

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V 112	Continued From page 10 During interview on 1/16/20 the HM reported: - no major incidents like September 2019 - a week ago client #2 punched client #3 on the arm - no injuries were reported During interview on 12/12/19 QP#1 reported: - goals & strategies to address client #2's & #3's aggressive behaviors between the two had not been discussed - both require a lot of attention - he would speak with management & care coordinators to identify ways to address their behaviors During interview on 12/16/19 the Program Manager reported: - majority of the incidents between client #2 & #3 happened on third shift - staff #9 was requested to come in from 5am - 8am to assist staff #7 - a revision to the plan of protection was done 11/5/19...due to DSS arrival an the 5am - 8am staff was not present - extra monitoring weekly by management was also implemented at that time (11/5/19) - it has been found client #2 gets upset when client #1 and #3 was picked up for weekend visits - client #3 will tease client #2 if he does not get a weekend visit - management implemented for staff to take client #2 in the community on a weekend outing if he doesn't have a family visit - there was less incidents since the HM was hired and the plan of protection was implemented	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 118		

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V 118	Continued From page 11 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure MARs were kept current for 2 of 3 clients (#1 & #2). The findings are: A. Review on 11/18/19 of client #1's record	V 118	**V118** **The overseeing QP will continue to complete regular monthly monitoring and supervisions at the facility; however additional medication reviews will be conducted twice weekly by the overseeing QP. Medication reviews will include the overseeing QP and home manager reviewing each member's physician order, MAR, and medication labels to ensure they correspond and match up.** **The Home manager will review the QMAR and backup MAR daily at the end of each shift to ensure that all medication passes have been accurately documented.** **Home Manager will complete monitoring sheets to support each MAR review per shift and submit to Program Manager for review for 30 days.**	02/15/2020

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V 118	Continued From page 12 revealed: - admitted to the facility on 6/2/15 - diagnoses of Mild Intellectual Development Disability (IDD); Seizures & Schizophrenia - a 6/21/19 physician's order dated 6/21/19: Fludrocortisone milligram daily (mg) (prevents the release of substances in the body that cause inflammation) & Montelukast 10mg in evening (pm) (can treat allergies); 6/3/19 order: Gabapentin 600mg daily (can treat seizures), Lamotrigine 200mg twice a day (can treat seizures) & Phenytoin 100mg 2 by mouth (PO) twice a day (BID) (can treat and prevent seizures) & a physician's order dated 6/26/19: Quetiapine 300mg 2 PO BID (can treat schizophrenia) Review on 12/4/19 of the client #1's October 2019 MAR revealed: - the above medications were not signed on 10/5/19 B. Review on 11/18/19 of client #2's record revealed: - admitted to the facility 3/16/15 - Moderate Intellectual Developmental Disability (IDD); Autism; Schizoaffective Disorder & Intermittent Explosive Disorder (IED) a physician's order dated 3/10/19: Atorvastatin 10mg daily (can treat high cholesterol); Benztropine 1mg twice day (can treat side effects of other drugs); Chlorpromazine 50mg morning (can treat mental illness); Chlorpromazine 50mg 2 bedtime; Docusate Sodium 100mg twice day (used to treat occasional constipation's); Lamotrigine 200mg twice day & Levetiracetam 750mg twice a day (can treat seizures) Review on 12/4/19 of client #2's October 2019 & November 2019 MAR revealed: - no staff initials for the above medications on	V 118	**V118 Continued** **QP will review QMAR daily for 30 days to ensure accurate documentation of medication passes.** **QP will complete monitoring review sheets of QMAR and Backup MAR twice weekly for 30days and submit to Program Manager.** **All staff will be retrained in Medication administration on 2/3/2020 by licensed Registered Nurse. Training will be competency based with in-depth focus on proper documentation.** **Client specifics forms and test will be completed.** **Equipment (QMAR Scanner) have been replaced in order to ensure accurate documentation of medication passes.**	

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V 118	Continued From page 13 10/31/19 & 11/27/19 During interview on 12/4/19 the House Manager (HM) reported: - staff documented medications in their QMAR computer system - if the computer system was down, staff documented on the paper MARs - she reviewed the MARs for blank spaces daily - she was not sure how she over looked the blank spaces on the MARs - the Qualified Professional (QP#1) reviewed the MARs also - she was not sure how often During interview on 12/4/19 QP#1 reported: - he has not reviewed the MARs since October 2019 when the HM began - he will ask the HM to review the MARs daily - he will start to review MARs weekly [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 118		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services	V 132		03/16/2020

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V 132	Continued From page 14 as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview the facility failed to notify Health Care Personnel Registry (HCPR) of an abuse allegation within 5 working days. The findings are: Review on 11/18/19 of client #3's record revealed: - admitted 5/19/15	V 132	**V132** **All allegations of abuse, neglect, and exploitation are to be investigated by trained staff. Any staff involved in the incident will be placed on Administrative Leave pending the outcome of the investigation. Staff may not return to work until investigation is concluded, recommendations are approved, and the individual in clear.** **When reporting incidents of bruising that may have been the result of abuse and neglect supervisor or Program Manager will complete the health care registry report within in 72 hours.**	

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V 132	Continued From page 15 - diagnoses of Severe IDD; Seizure Disorder; Sleep Apnea; Schizoaffective Disorder and Diabetes II & IED Review on 11/18/19 of an incident report dated 10/4/19 for client #3 revealed: - "...[client #3] displayed a behavior and sat on floor...bruising was discovered on both upper arms, on back of his right arm and underarm on his left arm....we believe the bruising in these locations are a result of third shift [staff #7] assisting [client #3] off of the floor picked him up under his arms on the morning of 10/1/19..." During interview on 12/16/19 the Program Manager (PM) reported: - she had been the PM for 1 year - she over saw the running of the facility - she was notified of any abuse/neglect allegations...any incidents which involved staff or clients - she was aware of the 10/4/19 incident...she completed the incident report - staff #7 was removed from the schedule while management looked into client #3's bruises - HCPR was not checked when she completed the incident report - she will resubmit the incident report to include HCPR	V 132		
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	V 291		03/01/2020

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V 291	Continued From page 16 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 safety issues become a primary concern. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to coordinate with other Qualified Professionals (QP#1) for 1 of 3 clients (#3). The findings are: Review on 11/18/19 of client #3's record revealed: - admitted 5/19/15 - diagnoses of Severe Intellectual Developmental Disability; Seizure Disorder; Sleep Apnea; Schizoaffective Disorder and Diabetes II & Intermittent Explosive Disorder - the facility's medical consultation report dated 11/19/19: "benign skin nodule on left lower leg.."	V 291	**V291** **Inservice staff on incident and injury reporting. Residential manager will be Inservice on follow-up practices after medical appointments.** **Overseeing QP and residential manager are currently working with the Care coordinators to update ISP and crisis plans to document illness, behaviors, and skin issues.** **QP and residential manager are coordinating with Care coordinators to develop Behavioral Support Plans and establishing specialized consultations and trainings for the group home facility staff.**	

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V 291	Continued From page 17 signed by the Family Nurse Practitioner A. Review on 11/18/19 of the facility's head and body check sheets for client #3 revealed: - staff documented on each shift (first - third) of bodily observations - a small knot on left leg documented on each shift's head & body check sheets since August 2019 Review on 1/16/20 of the staff communication log revealed: - "12/17/19...new head and body check sheets. Every single staff on shift has to complete one while working. The form has to be turned in at the end of your shift. If I'm (house manager (HM)) not here on your shift, slide it in the desk drawer...Thanks [HM]" Observation on 11/18/19 at 1:38pm revealed the following: - a small knot the size of a quarter below client #3's left knee - QP#1 observed client #3's lower left leg - QP#1 pressed on the knot - QP#1 asked client #3 if it hurts and he shook his head "no" - QP#1 asked client #3 if he was able to walk and he shook his head "yes" During interview on 11/18/19 staff #1 reported: - she was client #3's 1:1 worker - she had worked at the facility since the summer of 2019 - the knot had been on client #3's lower left knee since she started at the facility - the knot had remained the same size with no redness - client #3 has not complained of any pain - she took client #3 to his physician's	V 291	**V291 Continued** **Overseeing QP and house manager will continue to work with other members of treatment team to ensure each member receives and maintain the proper individualized treatment. Any updates and/or revisions to member's plan will be discussed and shared with all staff providing services. Client specific trainings will be identified and provided to support staff.**	

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V 291	Continued From page 18 appointments - she did not mention the knot to the physician During interview on 11/18/19 staff #6 reported: - he had worked at the facility for 2 years - he noticed the knot a couple of weeks ago - he documented it on the head & body check sheet - client #3 does not complain about the knot - he did not think it was "a big deal" During interview on 12/4/19 staff #7 reported: - she had worked for the facility 4 - 5 months - she thought client #3 just had a growth on his leg - she did not inform management - she documented it on the head & body check sheet - other staff documented it there - client #3 had not complained about the growth on his leg During interview on 11/18/19 & 12/16/19 the HM reported: - she started at the facility in October 2019 - she reviewed the head & body sheets weekly - she was not sure what the knot on client #3's leg was - he fell in the grass a couple of days ago - on 12/16/19, she saw the knot being documented but did not think to look into it - she thought QP#1 was aware since it had been documented so many times During interview on 11/18/19 QP#1 reported: - he was responsible for reviewing the head & body sheets until a HM was hired - there had been no HM since spring of 2019 - he was not aware of the knot on client #3's leg until questioned by the surveyor	V 291	**V291 Continued** **Home Manager will review head and body checks daily. Home manager will address any concerns noted on the head and body sheets daily, with follow up questions and appointments as needed.** **QP will review all head and body sheets weekly for 30 days to ensure that all issues are addressed immediately, and all appointments are scheduled as needed to address concerns.** **QP will monitor all med consult forms to ensure members have received the proper medical attention, and all follow-up appointments scheduled and attended monthly.**	

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V 291	Continued From page 19 - he had not reviewed any head & body check sheets - he would have staff schedule a physician's appointment for client #3 During interview on 12/12/19 client #3's guardian reported: - client #3 had the knot on his lower left leg for years - prior physicians had requested she not bother with the knot During interview on 12/16/19 & 1/16/20 the Program Manager (PM) reported: - she had been the PM for the last year - anything abnormal during body checks (bruises, scratches...) needed to be reported to management immediately - she was not aware of the knot on client #3's left leg - future measures would be put in place - the HM will review the head & body check sheets daily - the head & body check sheets would be brought to the office monthly instead of being kept at the facility - QP#1 will review the head & body check sheets and sign off on them - she will request care coordinators to put any medical concerns/diagnosis in the clients' treatment plans B. Observation on 12/16/19 at 12:54pm of client #3's bed revealed: - electric hospital bed with rails - HM was able to adjust the mattress up & down with a remote control - the mattress was lifted by the HM - 4 holes the size of dimes under the bottom portion of the mattress	V 291		

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V 291	Continued From page 20 - there were different size rips on the top & bottom portions of the mattress During interview on 12/16/19 staff #1 reported: - QP#1 had text her on Friday (12/13/19) - he asked her to check client #3's bed to see if it had any issues - she had already left work & did not check the bed until 12/14/19 - there were no issues with the mattress on 12/14/19 - she did not see any holes or rips in the mattress During interview on 12/16/19 the HM reported: - she just found out about the mattress this morning by staff - she put in a work order During interview on 1/16/20 the facility's business manager reported: - due to client #3's bed being a hospital bed, medicaid had to be notified - she notified the medical supply store about the mattress on 1/3/20 - the medical supply store would notify medicaid - the facility's company will not purchase a mattress until they heard back from medicaid - she has not reached out to medicaid - she has not contacted the medical supply store since 1/3/20 Review on 1/16/20 of the Plan of Protection dated 1/16/20 written by the PM revealed: - "all staff will report findings to Home Manager. Home Manger will review medical consults to ensure all follow up appointments are made. QP will review all body checks and medical consults weekly. Speak with entire treatment	V 291	**V291 Continued** **Proper Medicaid procedure for purchasing supplies such as hospital bed/mattress was followed. Replacement Mattress was purchased. Home manager will inspect furniture including mattresses and bed frames monthly, and report issues to QP for necessary actions (repair/replacement). QP will immediately report issues to Business Manager for funding.**	

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V 291	Continued From page 21 team to schedule treatment updates & revisions to address behaviors and medical concerns. In the future we will be sure to coordinate services with all involved clients care (care coordinators, guardian, medical professionals & natural supports). Program Manager will supervise QP on follow up and documentation of all findings. Documentation training and supervision forms with QP & Home Manager on 1/21/20. QP will coordinate with care coordinators to schedule treatment plan updates by 1/25/20." Client #3 was admitted to the facility on 5/19/15. On 11/18/19, client #3 was observed to have a small knot the size of a quarter below his left knee. The knot had been documented on the facility's head & body check sheets by staff since August 2019 but had not been followed up with the physician. The head & body check sheets were to be reviewed by the HM & QP#1. The HM saw the knot documented but did not follow up. She assumed QP#1 was aware of the knot since it had been documented numerous times. QP#1 had not reviewed any of the head & body check sheets. He was not aware of the small knot below client #3's left knee. Client #3 was seen medically on 11/19/19 and diagnosed with a benign skin nodule. This deficiency constitutes a Type B rule violation as failure to ensure coordination of care is detrimental to the client's health, safety and welfare. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 291		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON	V 536		02/15/2020

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V 536	Continued From page 22 ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with	V 536	**V536** **All facility staff will be retrained on YSIS restrictive intervention on 2/3/20. This training is competency based. Client specifics forms and test will be documented. House Manager will supervise staff and members during interactions to ensure staff is utilizing training techniques as necessary.** **The facility will administer and provide the necessary supervision to ensure the safety and welfare of all consumers. The facility will continue to monitor consumers during all activities and interactions with house mates.** **Staff will immediately redirect negative behaviors of members by utilizing restrictive intervention training at the start of the behavior.**	

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V 536	Continued From page 23 disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning	V 536	**V 536 Continued** **Protocol is being put in place, and staff trained, on protecting [redacted] and responding when he responds to the actions of [redacted] and [redacted]**	

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V 536	Continued From page 24 objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	R-C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

(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 536	Continued From page 25 requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 8 audited staff demonstrated competence in the area of knowledge & understanding of the people being served. The findings are: Review on 12/4/19 of staff #1's record revealed: - a start date of 6/1/19 - You're Safe, I'm Safe completed 6/20/19 Review on 12/4/19 of the House Manager's record revealed: - a start date of 10/1/19 - You're Safe, I'm Safe completed 6/20/19 Review on 11/18/19 of client #1's record revealed: - admitted to the facility on 6/2/15 - diagnoses of Mild Intellectual Development Disability (IDD) & Schizophrenia - a medical summary dated 10/7/19: "...bruise on stomach...patient was in a fight with roommate..." Review on 11/18/19 of client #2's record revealed:	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-057	A. BUILDING: _____ B. WING _____	R-C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 536	Continued From page 26 - admitted to the facility 3/16/15 - Moderate IDD; Autism; Schizoaffective Disorder; Intermittent Explosive Disorder (IED) - a medical summary dated 10/7/19: "...bruise on leg...got hit by another resident (client #1) on left lower leg..." Review on 11/18/19 of an incident report dated 10/4/19 for client #1 revealed: - "...[client #2] was sitting at the dining table when [client #1] came over to him and tried to snatch the television remote out of his hand. They begin to fight. Staff separated them and escorted both of the consumers to their rooms to calm down...the results of this altercation resulted [client #1] having a bruise on his stomach and tailbone and [client #1] having one on his left calf..." During interview on 11/18/19 staff #1 reported: - she had worked at the facility since summer 2019 - she was the 1:1 worker for client #3 - work hours were from 8:30am -2:30pm - she recalled the 10/4/19 incident - she had just took client #3 to a doctor's appointment - she had to complete some paperwork - the Qualified Professional #2 (QP#2) & House Manager (HM) were also present - she did not pay client #1 or #2 any attention...she needed to leave to pick up her daughter - she did not hear the words being exchanged between client #1 or #2 - there ended up being a scuffle and fight between the two...client #1 fell - client #1 & #2 ended up with bruises - the HM separated the two - she did not intervene during the physical	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 536	Continued From page 27 altercation - it was already 3pm & she had to leave During interview on 11/18/19 the HM reported: - she had worked at the facility since 10/1/19 - she recalled the 10/4/19 incident - she was new at the facility - she shadowed staff #1 on that day (10/4/19) - she was at the kitchen table, QP#2 was outside on a call & staff #1 completed paperwork - client #2 was at the kitchen table with the remote control to the television...client #1 came out of his bedroom in attempt to take the remote control from client #2...as client #1 tried to take the remote...client #2 fell backwards in the chair...she yelled for client #1 to leave client #2 alone...client #1 & client #2 hit each other with full blown punches...she got between the two...somehow client #2 was able to pull client #1's pants leg and pull him to the floor and they began to fight again...she was able to get between them again and escort client #2 to his bedroom...she went back and assisted client #1 off the floor...staff #1 remained at the computer and she requested QP#2 to come inside - there were superficial injuries to both - there was very few behaviors with client #1 - she thought because she was a new to the facility, client #1 wanted to be in the area with the new staff During interview on 12/5/19 QP#2 reported: - at the time there was no HM for the facility, therefore, the QPs had to rotate shifts until a HM was hired - QP#1 was the actual QP for the facility - he did not witness the 10/4/19 incident - he was outside approximately 2 minutes - all clients were in their bedrooms prior to him going outside	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 536	Continued From page 28 - when he returned back inside, everything was quite - all clients were in their bedrooms During interview on 12/16/19 the Program Manager reported: - she was aware of the 10/4/19 incident - she was not aware staff #1 did not intervene during the incident - staff #1 should have assisted the HM and separated the two clients - there was enough staff to have intervened prior to the incident becoming a physical altercation - staff #1 may have to be retrained in restrictive interventions [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 536		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL064-057 Y1	A. Building B. Wing Y2	1/16/2020 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROCKY MOUNT HOME	3192 GYPSY TRAIL ROCKY MOUNT, NC 27803

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 V0121 Reg. # 27G .0209 (F) LSC	Correction Completed 01/16/2020	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR rhonda Smith	DATE 1-31-20
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 7/24/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

EVENT ID: 98CJ12

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

January 31, 2020

DHSR - Mental Health
FEB 11 2020
Lic. & Cert. Section

Marika Whack, Executive Director
Educare Community Living Corporation – North Carolina
1600 W. Thomas Street
Rocky Mount, NC 27804

Re: Complaint & Follow up Survey completed January 16, 2020
South Rocky Mount Home, 3192 Gypsy Trail, Rocky Mount, NC 27803
MHL #064-057
E-mail Address: mawhack@rescare.com
Intake #NC00158185

Dear Ms. Whack:

Thank you for the cooperation and courtesy extended during the Complaint & Follow up survey completed January 16, 2020. The complaint was unsubstantiated.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

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

- Type B rule violation is cited for 10A NCAC 27G .5603 Operations (V291).
- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Type B violation must be ***corrected*** within 45 days from the exit date of the survey, which is March 1, 2020. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed deficiency by the 45th day from the date of the survey may result in the assessment of an administrative penalty of $200.00 (Two Hundred) against Educare Community Living Corporation – North Carolina for each day the deficiency remains out of compliance.

- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, which is February 15, 2020.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is March 16, 2020.

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 at (919) 552-6847.

Sincerely,

Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: qmemail@cardinalinnovations.org
DHSRreports@eastpointe.net
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Assistant