The Arc
Davidson County

1900 South Main Street
Lexington, NC 27292

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March 6, 2020

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



From: Lyndsay Martin, Residential Program Director
Renee Bellemore, Cynthia Morris, Qualified Professional's
The Arc of Davidson County, Inc.
1900 South Main Street
Lexington, NC 27292
Email Address: lyndsaymartin@arcdavidson.org

Re: Annual Survey and Complaint Survey completed 2/18/2020
Davidson #4, 125 Delta Street, Lexington, NC 27295
MHL#029-029

Enclosed is the Plan of Correction for the deficiencies listed on the Statement of Deficiencies form dated February 18, 2020.

**Time Frame for Compliance:**

Standard level deficiencies identified during Annual Review and Compliant Review dated February 18, 2020 were corrected immediately on March 6, 2020.

A Formal plan of correction has been implemented and will be completed by March 6, 2020.

Thank you in advance for your review of this plan of correction and for assisting us as we strive at all times to provide quality services and health care to the individuals residing in residential homes operated by The Arc of Davidson County, Inc.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

February 25, 2020

Teresa McKeon, Executive Director
The ARC of Davidson County, Inc.
1900 South Main Street
Lexington, North Carolina 27292



Re: Annual Survey completed February 18, 2020
Davidson #4, 125 Delta Street, Lexington, NC 27292
MHL # 029-029
E-mail Address: teresamckeon@arcdavidson.org

Dear Ms. McKeon:

Thank you for the cooperation and courtesy extended during the annual survey completed February 18, 2020.

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**

- All tags cited are standard level deficiencies.

**Time Frames for Compliance**

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is April 18, 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 Barbara Perdue, North Piedmont Team Leader at 336-861-6283.

Sincerely,

Barbara Perdue

Barbara Perdue
Facility Compliance Consultant II
Mental Health Licensure & Certification Section

Kathy Young

Kathy Young
Facility Compliance Consultant II
MHL & Certification Section

Cc: qmemail@cardinalinnovations.org
Pam Pridgen, Administrative Assistant

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL029-029 | A. BUILDING: _____ B. WING _____ | 02/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DAVIDSON #4 | 125 DELTA STREET LEXINGTON, NC 27295 |

| (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 |
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| V 000 | INITIAL COMMENTS<br><br>An annual survey was completed on February 18, 2020. Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for adults whose primary diagnosis is a developmental disability.<br><br>A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and clients will be identified using the letter of the facility and a numerical identifier. | V 000 | DHSR - Mental Health<br>MAR 9 2020<br>Lic. & Cert. Section | |
| V 105 | 27G .0201 (A) (1-7) Governing Body Policies<br><br>10A NCAC 27G .0201 GOVERNING BODY POLICIES<br>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:<br>(1) delegation of management authority for the operation of the facility and services;<br>(2) criteria for admission;<br>(3) criteria for discharge;<br>(4) admission assessments, including:<br>(A) who will perform the assessment; and<br>(B) time frames for completing assessment.<br>(5) client record management, including:<br>(A) persons authorized to document;<br>(B) transporting records;<br>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;<br>(D) assurance of record accessibility to authorized users at all times; and<br>(E) assurance of confidentiality of records.<br>(6) screenings, which shall include:<br>(A) an assessment of the individual's presenting problem or need;<br>(B) an assessment of whether or not the facility | V 105 | | |

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| V 105 | Continued From page 1<br>can provide services to address the individual's needs; and<br>(C) the disposition, including referrals and recommendations;<br>(7) quality assurance and quality improvement activities, including:<br>(A) composition and activities of a quality assurance and quality improvement committee;<br>(B) written quality assurance and quality improvement plan;<br>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;<br>(D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service;<br>(E) strategies for improving client care;<br>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges:<br>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;<br>(H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; | V 105 | | |

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| V 105 | Continued From page 2<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to follow their policy for discharge of clients. The findings are:<br><br>Review on 2/18/20 of the facilities policy titled "Criteria for Discharge" revealed:<br>-" ...The individual and/or their legally responsible person and/or designated representative will be notified in writing of the intent to discharge and the specific reasons the agency cannot continue to provide services ..."<br>-" ...'Discharge' is defined as moving the individual to another facility, or to live independently in the community."<br><br>Review on 2/12/20 of former client #4's (FC#4) record at the Sister Facility A revealed:<br>-Many facility documents were labeled as documents from Davidson #4.<br>-Date of admission was documented as 2/20/19<br>-Diagnoses included Intellectual Developmental Disabilities Moderate, Autism, Major Depressive Disorder, Gastroesophageal Reflux Disease, Type 2 Diabetes and Anxiety.<br>-A "Resident Registry" form for FC#4 listed Davidson #4 instead of Sister Facility A.<br>-An "Admission Application" dated 1/16/19 revealed, "needs 24-hour supervision ongoing."<br>-A "Quarterly Summary" for FC#4 written by the Qualified Professional (AQP) dated 5/1/2019. The summary was for the months of February, March and April 2019. There was no mention of any concerns, issues or reasons that would necessitate discharge or transfer of FC#4 to Sister Facility A.<br>-A "Vacancy Form" with "Property Name" listed as | V 105 | This Rule is not met as evidenced by:<br>Based on record reviews and interviews the discharge of clients.<br><br>Plan of Correction<br><br>1. The Arc of Davidson County Direct Support Professionals will notify Qualified Professionals by entering into the Electronic Health Care Record (Therap), any information relating to health and safety of individuals.<br><br>2. The Arc of Davidson County will follow the policy titled "Criteria for Discharge," when an individual undergoes an internal move within the agency, as well as when an individual undergoes external move.<br><br>3. The Arc of Davidson County Qualified Professionals will review all information in regards individuals discharge/transfer. QP's will meet with individuals and or legally ResponsiblePerson to make a decision if discharge/transfer will be in the best interest of the individual. Discharge will not occur without the proper documentation to warrant a discharge.<br><br>4. The Arc of Davidson County Qualified Professionals will notify in writing the individual and/or legally Responsible Person if final decision with specific details of why discharge/transger will happen and when it will take place.<br><br>5. The Arc of Davidson County QP's will document discharge/transfer onto the Resident's Register. | |

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| V 105 | Continued From page 3<br><br>Davidson #4. Included on this form was "Move-out Date: 05/15/2019 ...Guardian Request move to provide increased supervision for safety of individual." The form was signed and dated 04/15/2019 by FC#4 and the AQP for Sister Facility A.<br>-There was no other documentation which revealed specific reasons the agency could not continue to provide services to FC#4 in Davidson #4.<br><br>Interviews on 2/12/20 and 2/13/20 with the Qualified Professional (AQP) for the Sister Facility A revealed:<br>-The "Resident Registry" indicated Davidson #4 because FC#4 was admitted to Davidson #4 on 2/20/19 and he was later "transferred" to Sister Facility A.<br>-There was no discharge paperwork regarding this move as the Agency saw it only as a transfer.<br>-She thought the move occurred sometime in May or June of 2019.<br>-The reason for the move was because all the clients at Davidson #4 had unsupervised time and FC#4 "did not do well with that because he was opening the door to anyone and then was walking away" (from the facility).<br>-FC#4 was not left totally alone at the facility but was left unsupervised with his peers only.<br>-Would have to look at the office to see if there were any "ABC" sheets (behavior reports) which documented behaviors that would have warranted the discharge/transfer of FC#4.<br>-After searching for "ABC" sheets, the AQP was unable to locate any documentation other than the "Vacancy Form" which revealed "05/15/2019 ...Guardian request move to provide increased supervision for safety of individual."<br>-She could find no other documentation of the reasons why the agency could no longer provide | V 105 | | |

| **Policy Area**: Service Records | **Title of Policy:** Residents Register |
|---|---|
| **Effective Date:** 3/19/2013 | **Number:** SR8 |
| **Revision Date:** 4/21/2014 | **Approved by:** Board of Directors 3/19/2013 |

**Policy:** A Residents Register will be a part of the individuals' record at all times. The Residents Register is completed at the time of admission and annually at the time of the development of the person's annual service plan or when changes occur.

**Procedures:** The Register will include the following:

- Identifying information
- Resource information, physician, finances
- Personal information: Assistance required/special needs, personal habits, known allergies, food preferences, work history/day programs, activity interest/hobbies/community involvement
- Request for assistance/consents/receipt of information: Consent to handle personal funds and availability of funds, request for lockable space for security of valuables, consent to open mail/consent to assist with mail, consent to provide and/or assist with securing transportation, consent to assist with medication/medical needs, consent to secure routine and emergency treatment, consent to photographs/videos, consent for release and disclosure of information
- Receipt of materials: home's residential rate for services, rules including policies on refunds, smoking and alcohol consumption, visitation, and reason for discharge, grievance procedures, willingness to comply with Title VI of the Civil Rights Act, Rights and confidentiality procedures.
- Signature of the individuals or their legally responsible person verifying receipt of materials and input into the Residents Register, and signature of agency staff completing the Residents Register.
- Discharge/transfer information
- The Qualified Professional is responsible for completing the Residents Register and ensuring that information is current at all times.

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| **Policy Area**: Service Delivery | **Title of Policy:** Criteria for Discharge |
| **Effective Date:** 3/27/2013 | **Number:** SD4 |
| **Revision Date:** 10-4-2012 | **Approved by: Board of Directors** 3/27/2013 |

**Policy:** Individuals are not placed on inactive status or suspended from residential services. All individuals have a right to placement in an alternative facility should The Arc no longer be able to provide the necessary care or treatment to ensure the health and safety of the individual.

**Procedures:** The individual and/or their legally responsible person and/or designated representative will be notified in writing of the intent to discharge and the specific reasons the agency cannot continue to provide services. The Managed Care Organization will be contacted to assist the individual with the coordination of alternative placement.
"Discharge" is defined as moving the individual to another facility, or to live independently in the community. The Arc is no longer responsible for the individual's care.

Criteria for Discharge:

- The needs of the individual cannot be met by services rendered in a Group Living Moderate facility.
- The individual has improved his/her independent living skills and no longer requires services provided by the agency.
- The individual is endangering the health and safety of self or others in the facility.
- Failure to pay for their stay at the facility; or the facility ceases to operate.
- Failure to comply with rules of the Group Home

In emergency situations, the notice to discharge will be waived and procedures put in place to assure the health and safety of the individual(s) being served and the individual being discharged.

Appeals procedure: A request to appeal the discharge should be directed in writing to the Executive Director for review. No appeal will be recognized if there is a danger of harm to the individual or others in the facility.

| **Policy Area**: Service Delivery | **Title of Policy:** Discharge Procedure |
|---|---|
| **Effective Date:** 3/27/2013 | **Number:** SD5 |
| **Revision Date:** 9/12/2013 | **Approved by:** Board of Directors |

**Policy:** Discharge Procedures are in compliance with NC General Statutes 122C-63.

**Procedure**: Assurance of continuity of care:

(a) An individual admitted for residential care has the right to residential placement in an alternative facility if the individual is in need of placement and if the original facility can no longer provide the necessary care or treatment.

(b) A residential facility providing residential care for individuals with intellectual/developmental disabilities shall notify the area authority of the intent to discharge an individual who may be in need of continuing care at least 60- days prior to the discharge.

The operator's notification to the area authority of intent to discharge an individual who is in need of continuing care constitutes the operator's acknowledgment of the obligation to continue to serve the client until:

a. Managed Care Organization determines that the individual is not in need of continuing care
b. The individual is moved to an alternative residential placement
c. Sixty days have elapsed, whichever occurs first.

In emergency situations, when the safety of the individual who may be in need of continuing care, or the staff of the residential facility, or the general public is concerned, this 60-day notification will be waived and immediate procedures put in place to assure the health and safety of the individual(s) being served and the individual being discharged.

# The Arc of Davidson County, Inc.
## DISCHARGE SUMMARY
(DOCUMENTATION DURING THE PROCESS OF DISCHARGE FROM RESIDENTIAL SERVICES)

| Name : | Medicaid ID Number: | Record Number: |
|---|---|---|

| DATE | SUMMARY NOTES |
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| V 105 | Continued From page 4<br>services to FC#4 in Davidson #4 and there was no discharge paperwork.<br><br>Interview on 2/13/20 with the Director of Residential Services revealed:<br>-She worked as a Qualified Professional during the time FC#4 was admitted and then moved from Davidson #4 to Sister Facility A.<br>-It was a "quick move in" to Davidson #4 as the Care Coordinator "threatened" the facility with being "out of compliance" if FC#4 was not admitted to Davidson #4.<br>-The legal guardian is the one who initiated the move from Davidson #4 to Sister Facility A a few months after admission. She was informed that FC#4 had unsupervised time and was walking away from the facility without staff knowledge. The Director of Residential Services could not recall who informed the legal guardian of these issues.<br>-There was no specific documentation of the reasons the agency could no longer continue to provide services in Davidson #4.<br>-There was no discharge documentation per facility policy<br><br>Interview on 2/12/20 with staff #A5 revealed:<br>-FC#4 had unsupervised time at Davidson #4 upon admission<br>-FC#4 began "having behaviors" at Davidson #4 such as "walking out of the house," "walking away" so he was moved to Sister Facility A sometime in May 2019.<br>-She did not, however, recall documenting any of these behaviors.<br><br>Interview on 2/17/20 with staff #1 revealed:<br>-She worked with FC#4 when he resided at Davidson #4.<br>-A few months after admission, "he asked to be | V 105 | | |

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| V 105 | Continued From page 5<br>moved where the guys were. Number 4 (Davidson #4) has 5 females and 1 male."<br>-If there were behavioral issues with FC#4, they would have been documented in "ABC" notes (behavioral notes) or on the "comments sheet" where unsupervised time was documented.<br><br>Interview on 2/12/20 with FC#4 at Sister Facility A revealed:<br>-He moved from Davidson #4 to Sister Facility A "because I liked it better" at Sister Facility A.<br>-"They said I walked away" from Davidson #4 but "I didn't."<br><br>Review on 2/12/20 of the "Comment" sheet from February 2019 through May 2019 for FC#4 revealed he walked unsupervised in the community as follows:<br>-2/25/19, 3/6, 3/9, 3/12, 3/13, 3/17, 3/18 thru 3/22, 3/25, 3/26, 14 days in the month of April 2019 and 3 days in the month of May 2019.<br>-No documentation of FC#4 having any behavioral issues in the facility or during unsupervised time that would have warranted discharge/transfer. | V 105 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(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.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be | V 112 | | |

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| V 112 | Continued From page 6<br>achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, facility staff failed to develop goals and strategies in the treatment plan to address 1 of 3 current audited client's (client #3) needs. The findings are:<br><br>Review on 2/14/20 of client #3's record revealed:<br>-Date of admission 5/9/95<br>-Diagnoses of Depressive Disorder, Borderline Intellectual Disability and Congenital Blindness.<br><br>Review on 2/14/20 of a letter from client #3's physician dated 5/1/19 revealed:<br>-Diabetes/Hypertension - Very important that client #3 exercise for 30 minutes 5/7 days per week.<br><br>Review on 2/14/20 of a physician note/order dated and signed on 5/1/19 for client #3 revealed:<br>-"Patient should get 30 minutes of activity (i.e. | V 112 | This Rule is not met as evidenced by:<br>Based on record review and interview, facility staff failed to develop goals and strategies in the treatment plan to address 1 of 3 current audited client's (client #3) needs.<br><br>Plan of Correction<br><br>1. The Arc of Davidson County Qualified Professionals will ensure that all written doctor orders submitted for individuals health and safety are implemented into their treatment plan as a goal. This will ensure that orders are being followed as written.<br><br>2. The Arc of Davidson County QP's will ensure that all information in uploaded into the Electronic Health Care Record (Therap) in order for Direct Support Professionals to document or lack of progress on written goals.<br><br>3. Individuals PCP was revised on 02/18/2020, and included goal of exercising at least 5X a week with exercise of her choice. Plan uploaded into MCO and Electronic Health Care Records (Therap) for immediate implementation by DSP's. | |

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| V 112 | Continued From page 7<br>walking) at least 5 days per week.<br><br>Review on 2/14/20 of client #3's treatment plan dated 12/3/19 and an updated plan/review of 1/15/20 revealed:<br>-No strategies or goals to address the need for client #3 to exercise<br><br>Review on 2/14/20 of monthly summary notes for client #3 from May 2019 to October 2019 revealed:<br>-May 2019 - 12 days noted that client #3 walked for exercise<br>-June 2019 - 16 days noted that client #3 walked for exercise<br>-July 2019 - 5 days noted that client #3 walked for exercise<br>-August 2019 - 8 days noted that client #3 walked for exercise<br>-September 2019 - 12 days noted that client #3 walked for exercise<br>-October 2019 - 17 days noted that client #3 walked for exercise<br><br>Interview on 2/14/20 with staff #4 revealed:<br>-Was aware of the physician's order for client #3 to walk for exercise.<br>-"We walk and I document it in Therap" notes that she walks.<br>-Was not aware of any treatment plan goals or strategies that addressed the need for client #3 to exercise.<br><br>Interview on 2/14/20 with client #4 revealed:<br>-"I walk at the workshop."<br>-"I walk at [Department store]. I push a buggy and walk."<br>-"I walk in a big circle."<br>-"I lost ten pounds! I eat salads and I like spicy stuff." | V 112 | | |

| **Policy Area:** Rights and Privacy | **Title of Policy:** Person-Centered Planning |
|---|---|
| **Effective Date:** 2/21/2013 | **Number:** RP14 |
| **Revision Date:** | **Approved by:** Board of Directors |

**Policy:** The Arc of Davidson County will recognize the Best Practice/Person Centered Planning Process as a process whereby individuals with disabilities have the support of family, friends, and professionals to direct the planning and implementation of services and supports meeting their own life vision and goals. The Arc of Davidson County believes that all people are entitled to the same rights, opportunities and choices.

**Procedure:** In order to realize the needs and desires of the individuals we support, all staff will be trained to communicate effectively, listen to the individual's request, and give up control.

The Arc of Davidson County will utilize state-approved Person Centered Plans to develop an individualized service plan for each individual. The person centered plan will involve:

- Getting to know the person
- Who they are
- Their interest
- Their dreams
- Their strengths and talents
- Developing with the person a plan for the future
- Implementing the plan

The individual, family members, friends and staff will jointly contribute feedback to the plan as a means to measure improvements and compare the progress of the individual by documentation of interviews conducted. The development of the person centered plan allows community inclusion, ensures the service reflects how a person wants to live, and how the service being provided helps the person achieve their goals for the future.

The Qualified Professional will be the designated staff person to develop and implement the Person Centered Plan for all individuals receiving services. Contract requirements and state standards will be the method of assuring plans are developed in a timely manner and changes or revisions are made as they occur.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL029-029 | A. BUILDING: _____ B. WING _____ | 02/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DAVIDSON #4 | 125 DELTA STREET LEXINGTON, NC 27295 |

| (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 |
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| V 290 | 27G .5602 Supervised Living - Staff<br><br>10A NCAC 27G .5602 STAFF<br>(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.<br>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.<br>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:<br>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or<br>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.<br>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:<br>(1) at least one staff member who is on duty shall be trained in alcohol and other drug | V 290 | | |

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| V 290 | Continued From page 9<br>withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and<br>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, facility staff failed to document 1 of 1 former client's (FC#4) capability of remaining in the home or community without supervision for specified periods of time. The findings are:<br><br>Review on 2/12/20 of former client #4's (FC#4) record at the Sister Facility A revealed:<br>-Date of admission was documented as 2/20/19<br>-Diagnoses included Intellectual Developmental Disabilities Moderate, Autism, Major Depressive Disorder, Gastroesophageal Reflux Disease, Type 2 Diabetes and Anxiety.<br>-A "Resident Registry" form for FC#4 listed Davidson #4 instead of Sister Facility A.<br>-An "Admission Application" dated 1/16/19 revealed, "needs 24-hour supervision ongoing."<br>-A "Vacancy Form" with "Property Name" listed as Davidson #4. Included on this form was "Move-out Date: 05/15/2019 ...Guardian Request move to provide increased supervision for safety of individual." The form was signed and dated 04/15/2019 by FC#4 and the AQP for Sister Facility A.<br>-No documentation or assessment of FC#4's capability of having unsupervised time<br><br>Interviews on 2/12/20 and 2/13/20 with the Qualified Professional (AQP) for the Sister | V 290 | This rule is not met as eveidenced by:<br>Based on record reviews and interviews, faciltiy staff failed to document 1 of 1 former client's (FC#4) capability of remaining in the home or community without supervision for specified periods of time.<br><br>Plan of Correction<br><br>1. When an individual and/or Legally Responsble Person makes application for placement with The Arc of Davidson County the Qualified Professional will complete an Individual Assessment.<br><br>2. The Arc of Davidson County QP's will meet with individual and/or Legally Responsible Person and together make final decision based on the completed Individual Assessment.<br><br>3. The Arc of Davidson County Qualified Professionals will include in writing in individuals PCP of ability to have unsupervised time in the home and community. It will be put into writing the length of time allowed for unsupervised time.<br><br>4. The QP's will upload all information into the Electronic Health Care Records system (Therap) for information to be available for all staff to observe unsupervised time.<br><br>5. The Arc of Davidson County QP's will be responsiblefor monitoring that all PCP's are being followed at all times. DSP's are documented in each individuals daily notes of unsupervisted time being utlilized. | |

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| V 290 | Continued From page 10<br><br>Facility A revealed:<br>-The "Resident Registry" indicated Davidson #4 because FC#4 was admitted to Davidson #4 on 2/20/19 and he was later "transferred" to Sister Facility A.<br>-The reason for the move was because all the clients at Davidson #4 had unsupervised time and FC#4 "did not do well with that because he was opening the door to anyone and then was walking away" (from the facility).<br>-FC#4 was not left totally alone at the facility but was left unsupervised with his peers only.<br>-Did not think there was an assessment for unsupervised time for FC#4 which would identify his capability to have unsupervised time nor was there any documentation of this in his treatment plan.<br><br>Interview on 2/12/20 with staff #A5 revealed:<br>-FC#4 had unsupervised time at Davidson #4 upon admission.<br><br>Interview on 2/17/20 with staff #1 revealed:<br>-She worked with FC#4 when he resided at Davidson #4<br>-All the clients at the facility had unsupervised time and FC#4 had "2 hours" of unsupervised time.<br>-Documented unsupervised walks in the community many times for FC#4.<br>-This was documented on Comment sheets.<br><br>Review on 2/12/20 of the "Comment" sheet from February 2019 through May 2019 for FC#4 revealed he walked unsupervised in the community as follows:<br>-2/25/19, 3/6, 3/9, 3/12, 3/13, 3/17, 3/18 thru 3/22, 3/25, 3/26, 14 days in the month of April 2019 and 3 days in the month of May 2019. | V 290 | | |

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| V 290 | Continued From page 11<br><br>Interview on 2/12/20 with FC#4 at Sister Facility A revealed:<br>-Had unsupervised time when he resided at Davidson #4<br>-Walked, unsupervised by staff, many times at Davidson #4<br>-Does not have any unsupervised time currently at Sister Facility A<br><br>Interview on 2/13/20 with the Director of Residential Services revealed:<br>-She worked as a Qualified Professional during the time FC#4 was moved from Davidson #4 to Sister Facility A.<br>-Unsupervised time was "not brought up" at the time of his admission to Davidson #4.<br>-There was no documentation in the treatment plan which identified FC#4's capability to have unsupervised time at Davidson #4 and it must have been "over-looked." | V 290 | | |