

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on March 5, 2020. Two of the complaints were unsubstantiated(Intakes #NC160926, #NC160382). One of the complaints was substantiated(Intake #NC161172). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 109	<p>27G .0203 Privileging/Training Professionals</p> <p>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS</p> <p>(a) There shall be no privileging requirements for qualified professionals or associate professionals.</p> <p>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(d) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. <p>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.</p>	V 109		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 109	<p>Continued From page 1</p> <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.</p> <p>(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure 1 of 1 Qualified Professional(QP) demonstrated competency for the population served. The findings are:</p> <p>Review on 2/25/20 of client #1's record revealed: -admission date of 12/13/97; -diagnoses of Intellectual Developmental Disabilities-Severe, Cerebral Palsy, Seizure Disorder and Parkinson's Disease; -treatment plan dated 5/2/19 documented client #1 had unpredictable behaviors, easily agitated, did not like to be told what to do, exhibited verbal and physical aggression, screamed, used profanity; -client #1 walked with a walker and used a manual wheelchair.</p> <p>Interview on 2/25/20 with the QP revealed: -had no internal investigations on any staff from 1/8/20 until present regarding any allegations of mistreatment of clients; -had no Level II or III incident reports from 1/8/20 until present; -only have a few Level I incident reports from</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 109	<p>Continued From page 2</p> <p>1/8/20 until present.</p> <p>Observation on 2/25/20 at approximately 2:00pm revealed:</p> <ul style="list-style-type: none"> -QP obtained incident report binder from table; -placed incident report binder on the copier; -flipped through incident report binder and removed some documentation; -presented the documentation to be reviewed. <p>Review on 2/25/20 of the facility's incident report documentation presented by the QP from 1/8/20(exit date of last survey) to 2/25/20 revealed:</p> <ul style="list-style-type: none"> -an incident report dated 1/9/20 regarding client #2; -an incident report dated 2/4/20 regarding client #6; -no incident reports regarding client #1. <p>Interview on 3/2/20 with staff #1 revealed:</p> <ul style="list-style-type: none"> -worked on second shift with staff #2; -on 1/22/20, client #1 became irate and aggressive over showers; -client #1 was yelling and cussing at staff #1; -client #1 lunged at staff #1 to hit her and she moved out of the way; -client #1 lost her balance and landed on her knee; -staff #2 had come into client #1's room; -asked staff #2 to leave client #1's room to give her time to try to calm client #1 down; -client #1 escalated more if additional people entered her space when she was upset; -was in the process of trying to calm client #1 down; -she and staff #2 got into a loud verbal altercation; -was not aware staff #2 had called the QP; -client #1 was calm by this point; 	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 109	<p>Continued From page 3</p> <ul style="list-style-type: none"> -when the QP arrived, she and staff #2 talked to the QP; -staff #2 accused her(staff #1) of pushing client #1 in front of the QP; -she informed the QP she did not push client #1; -the determination was for she and staff #2 not to continue working together the rest of the shift; -the QP allowed staff #2 to go home and staff #1 finished the shift; -completed incident report regarding client #1's fall; -had another verbal altercation with staff #2 at a later date on their shift at the facility; -not had any staff meetings or individual supervisions with the QP regarding the issues and conflict between her and staff #2. <p>Interview on 2/25/20 with staff #2 revealed:</p> <ul style="list-style-type: none"> -worked on second shift with staff #1; -had "words" with staff #1; -felt staff #1 did not do any work and she had to do all the work at the facility; -created conflict between them; -called the QP on 1/22/20 because she and staff #1 were arguing; -the QP arrived at the facility; -staff #1 told the QP client #1 fell; -asked staff #1 in front of the QP "did she fall or did you not hit her?" -staff #1 denied she did anything to client #1; -told the QP she felt there needed to be a meeting to address all the conflict between her and staff #1; -there was an incident report completed on client #1; -incident report completed by staff #1; -staff #1 documented client #1 fell; -incident report in incident report binder. <p>Observation at 2/25/20 at approximately 2:29pm</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 109	<p>Continued From page 4</p> <p>of the incident report binder book presented by staff #2 revealed an incident report on client #1 dated 1/22/20.</p> <p>Additional interview on 2/25/20 with the QP revealed: -found an incident report regarding client #1; -forgot about it.</p> <p>Review on 2/25/20 of an incident report dated 1/22/20 regarding client #1 completed by staff #1 documented the following: -client #1 was in her bedroom with staff #1; -client #1 tried to lunge at staff #1; -client #1 fell on one knee beside her bed; -client #1 had a small bruise on her right knee; -staff #1 called the manager; -client #1 was checked and assessed; -client #1 had no pain; -staff continued to monitor client #1.</p> <p>Further interviews on 2/25/20 and 2/26/20 with the QP revealed: -staff #1 and staff #2 worked second shift together; -got a call from staff #2 on 1/22/20; -staff #2 reported she and staff #1 "got into it" and were arguing; -staff #2 did not report any concerns regarding staff #1's treatment with client #1 when she called the QP; -QP had to come back to the facility to diffuse the situation between staff #1 and staff #2; -when she arrived at the facility, staff #1 and staff #2 were no longer arguing and were in separate areas of the facility; -staff #2 stated she and staff #1 were not getting along; -staff #1 reported client #1 fell earlier but she was fine now;</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 109	<p>Continued From page 5</p> <ul style="list-style-type: none"> -staff #2 made the comment to staff #1"are you sure she fell or did you push her" in front of the QP; -staff #1 and staff #2 began arguing and staff #1 denied the allegations; -QP checked on client #1 who was in her room watching television; -client #1 reported she fell and did not report how she fell; -staff #1 reported to the QP client #1 was upset because she wanted a shower at a particular time; -staff #1 reported to the QP client #1 was not able to get into the shower due to another client taking a shower at that particular time; -staff #1 told the QP client #1 was screaming and threatened to hit her; -staff #1 stated client #1 lunged at her to try and hit her; -staff #1 stated to the QP she moved away to avoid getting hit and client #1 fell; -the QP observed a mark like a scrape/bruise on client #1's knee where she had hit the ground; -QP asked if either staff wanted to leave the facility to de-escalate the situation; -staff #2 stated she wanted to leave the facility; -staff #2 left and QP remained at the facility until all the clients went to bed; -QP left and staff #1 remained at the facility with the clients; -did not document anything regarding her conversations with staff #1 and staff #2; -did not interview any other clients regarding allegations staff #2 made against staff #1; -did not notify anyone of the allegations and did not initiate an internal investigation; -checked on client #1 the next day and client #1 did not bring anything up about the night before; -was not able to determine what started the argument between staff #1 and staff #2 on 	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 109	<p>Continued From page 6</p> <p>1/22/20; -was on leave from work from 1/29/20-2/8/20 due to family bereavement and then from 2/13/20-2/24/20 for surgery; -on 2/12/20 the night before her surgery, received a phone call from staff #1's cell phone between 8pm-9pm; -received phone call during staff #1 and staff #2's shift; -said "hello? hello?" but received no answer; -overheard staff #1 and staff #2 arguing with raised voices; -heard staff #1 and staff #2 using profanity; -heard staff #1 and staff #2 use the words f**k, S**t and b****h words in a loud tone of voice; -staff #1's cell phone cut off; -QP tried to call back staff #1's cell phone multiple times but never got an answer; -QP emailed her supervisor regarding the phone call; -her supervisor was on medical leave; -also emailed the Quality Management Director regarding the phone call; -did not have documentation of any supervision/meetings regarding the issues and conflict between staff#1 and staff #2.</p> <p>Interview on 2/26/20 with a sister facility QP revealed: -assisted with the facility during times the QP was on leave; -staff #1 contacted her and reported client #1 said something to her(staff #1) about her pushing client #1; -staff #1 stated client #1 tried to hit her(staff #1) and client #1 fell; -asked if the QP was aware of this information and staff #1 reported yes; -staff #2 never mentioned anything about this to her(sister facility QP) during their contact while</p>	V 109		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2020
NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205		
(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 109	Continued From page 7 the QP was on leave; -did talk to staff #2 one time about her conflict with staff #1; -felt it was all very petty issues between staff #1 and staff #2; -issues were communication and personalities. Review on 3/2/20 of an email dated 2/17/20 from staff #1 to the Quality Management Director revealed the following documented: -staff #2 was very rude to staff #1 during "the day of the incident;" -staff #2 accused staff #1 of telling others staff #2 was not doing her job; -staff #2 started screaming at staff #1; -staff #2 accused staff #1 of reporting to the QP she was stealing food and trying to get her fired; -called the QP while the argument was taking place; -was not the first time staff #2 had antagonized her and she(staff #1) had reached out to management on multiple occasions when she had been at her "wits end." This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Individuals of All Disability Groups-Scope V289 for a Type B rule violation and must be corrected within 45 days. -	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 110	<p>Continued From page 8</p> <p>10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS</p> <p>(a) There shall be no privileging requirements for paraprofessionals.</p> <p>(b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.</p> <p>(c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(e) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.</p> <p>This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure paraprofessional staff were supervised and demonstrated competency for the population served for 2 of 5 staff (#1, #2).</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 110	<p>Continued From page 9</p> <p>The findings are:</p> <p>Review on 2/26/20 of the staff #1's personnel records revealed: -hired on 6/10/19 with the job title of Direct Support Professional; -completed trainings in the following areas: Client Rights, Crisis Avoidance Techniques, Core Values, Client Specifics.</p> <p>Review on 2/26/20 of staff #2's personnel records revealed: -hire date of 10/21/19 with the job title of Direct Support Professional; -no prior experience working in facilities with mental health issues and developmental disabilities; -completed trainings in the following areas: Client Diagnostic Needs, Crisis Avoidance Techniques, Core Values, Client Rights.</p> <p>Interview on 3/2/20 with staff #1 revealed: -worked on second shift with staff #2; -on 1/22/20, client #1 became irate and aggressive over showers; -client #1 was yelling and cussing at staff #1; -client #1 lunged at staff #1 to hit her and she moved out of the way; -client #1 lost her balance and landed on her knee; -staff #2 had come into client #1's room; -asked staff #2 to leave client #1's room to give her time to try to calm client #1 down; -client #1 escalated more if additional people entered her space when she was upset; -was in the process of trying to calm client #1 down; -she and staff #2 got into a loud verbal altercation; -"raised our voices;"</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 110	<p>Continued From page 10</p> <ul style="list-style-type: none"> -she was in the hallway to the kitchen and staff #2 was in the kitchen; -was not aware staff #2 had called the QP(Qualified Professional); -client #1 was calm by this point; -when the QP arrived, she and staff #2 talked to the QP; -staff #2 accused her of pushing client #1 in front of the QP; -she informed the QP she did not push client #1; -the consensus was made not to continue working together the rest of the shift; -the QP let staff #2 go home and let staff #1 finish the shift; -had another verbal altercation with staff #2 at a later date on their shift at the facility; -not had any staff meetings or individual supervisions with the QP regarding the issues between her and staff #2; <p>Interviews on 2/25/20 and 3/4/20 with staff #2 revealed:</p> <ul style="list-style-type: none"> -worked on second shift with staff #1; -did all the work while staff #1 sat on her phone all the time; -caused conflict between her and staff #1; -"us bickering everytime on shift;" -had "words" with staff #1; -staff #1 "never comes to work:" -always felt like she(staff #2) was getting into trouble; -felt staff #1 did not do any work and she had to do all the work at the facility; -created conflict between them; -called the QP on 1/22/20 because she and staff #1 were arguing; -told the QP she felt there needed to be a meeting to address all the conflict between her and staff #2; -staff #1 "starts confusion among staff;" 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 110	<p>Continued From page 11</p> <p>-"toxic work environment;"</p> <p>-"all he said she said does affect the residents;"</p> <p>-"a lot of drama, too much."</p> <p>Interview on 2/25/20 with client #4 revealed:</p> <ul style="list-style-type: none"> -was in her room in her bed watching television; -staff #2 came in her bedroom and shut the door; -was talking to someone on her cell phone; -told someone on her phone that staff #1 hit client #1. <p>Interview on 2/28/20 with staff #4 revealed:</p> <ul style="list-style-type: none"> -worked 3rd shift at the facility; -also had worked some first shifts at the facility; -heard from staff #2 that staff #1 called her curse words; -staff #2 made allegations against staff #1 for mistreating client #1; -staff #1 told everyone staff #2 did not do her job; -"[staff #1] so messy;" -staff #1 talked about "everybody;" -staff #2 told her that staff #1 was trying to set up her(staff #4) and her coworker on third shift to get in trouble. <p>Interview on 2/25/20 with staff #3 revealed:</p> <ul style="list-style-type: none"> -heard rumors about staff #1; -rumors came from staff #2 about staff #1. <p>Further interviews on 2/25/20 and 2/26/20 with the QP revealed:</p> <ul style="list-style-type: none"> -staff #1 and staff #2 work second shift together; -got a call from staff #2 on 1/22/20; -staff #2 reported she and staff #1 "got into it" and were arguing; -QP had to come back to the facility to diffuse the situation between staff #1 and staff #2; -staff #2 stated she and staff #1 were not getting along; -never was able to determine what started the 	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 110	<p>Continued From page 12</p> <p>argument between staff #1 and staff #2 on 1/22/20;</p> <p>-was on leave from work from 1/29/20-2/8/20 due to family bereavement and then from 2/13/20-2/24/20 for surgery;</p> <p>-on 2/12/20 the night before her surgery, received a phone call from staff #1's cell phone between 8pm-9pm;</p> <p>-received phone call during staff #1 and staff #2's shift;</p> <p>-said "hello? hello?" but received no answer;</p> <p>-overheard staff #1 and staff #2 arguing with raised voices;</p> <p>-heard staff #1 and staff #2 using profanity;</p> <p>-heard staff #1 and staff #2 use the words f**k, S**t and b****h words in a loud tone of voice;</p> <p>-staff #1's cell phone cut off;</p> <p>-QP tried to call back staff #1's cell phone multiple times but never got an answer;</p> <p>-QP emailed her supervisor regarding the phone call;</p> <p>-her supervisor was on medical leave;</p> <p>-also emailed the Quality Management Director regarding the phone call;</p> <p>-no documentation of any supervision/staff meetings regarding issues between staff.</p> <p>Interview on 2/26/20 with a sister facility QP revealed:</p> <p>-assisted with facility during times the QP was on leave;</p> <p>-did talk to staff #2 one time about her conflict with staff #1;</p> <p>-felt it was all very petty issues between staff #1 and staff #2.</p> <p>Review on 3/2/20 of an email dated 2/17/20 from staff #1 to the Quality Management Director revealed the following documented:</p> <p>-tension between her and staff #2 when she</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 110	<p>Continued From page 13</p> <p>came on shift; -staff #2 made comments about others thinking she may be trying to steal food; -staff #2 was very rude to staff #1; -staff #2 accused staff #1 of telling other staff she(staff #2) was not doing her job; -staff #2 started screaming at staff #1; -staff #2 accused staff #1 of reporting to the QP she was stealing food and trying to get her fired; -when staff #1 arrived at work on 2/17/20, client #1 told her "[staff #2] said you couldn't hurt my foot anymore;" -staff #1 did not know why client #1 said this.</p> <p>Review on 3/2/20 of an email dated 2/27/20 from a parent of a client at the facility revealed the following documented: -a staff from another provider was at the facility with a client providing other services; -this staff reported to the parent staff #2 was walking around the facility yelling into her cell phone; -this staff also reported to the parent staff #2 was yelling about "she" who worked at the facility who never did anything and spent all her time on the cell phone; -this staff reported staff #2 "was going up to [client #1] saying, 'Tell them...tell them how she slapped you on the back. Tell them';" -parent had observed staff #2 on her cell phone when at the facility and did not even acknowledge the parent's statements to her.</p> <p>Review on 3/4/20 of an email dated 2/28/20 from another parent of a client at the facility revealed the following documented: -when visiting the facility, staff #2 "is typically sitting and on her phone constantly;" -"there seems to be tension between the two of them(staff #1 and staff #2);"</p>	V 110		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 110	Continued From page 14 -"from everything I've seen and heard, I feel very strongly that the accusations against [staff #1] is either misinterpreted or a vindictive attempt to get her fired." This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Individuals of All Disability Groups-Scope V289 for a Type B rule violation and must be corrected within 45 days.	V 110		
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 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).	V 132		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 132	<p>Continued From page 15</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure the Health Care Personnel Registry(HCPR) was notified of all allegations against health care personnel, failed to ensure all alleged acts were investigated and failed to protect residents from harm while the investigation was in progress affecting 1 of 4 clients (#1). The findings are:</p> <p>Interview on 3/2/20 with staff #1 revealed: -worked on second shift with staff #2; -on 1/22/20, she and staff #2 got into a loud verbal altercation; -was not aware staff #2 had called the QP(Qualified Professional); -when the QP arrived, she and staff #2 talked to the QP; -staff #2 accused her of pushing client #1 in front of the QP; -she informed the QP she did not push client #1; -the consensus was for staff #1 and staff #2 to</p>	V 132		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 132	<p>Continued From page 16</p> <p>not continue working together the rest of the shift; -the QP let staff #2 go home and let staff #1 finish the shift.</p> <p>Interview on 2/25/20 with staff #2 revealed: -worked on second shift with staff #1; -had "words" with staff #1; -felt staff #1 did not do any work and she had to do all the work at the facility; -created conflict between them; -called the QP on 1/22/20 because she and staff #1 were arguing; -the QP arrived at the facility; -staff #1 told the QP client #1 fell; -asked staff #1 in front of the QP "did she fall or did you not hit her?" -staff #1 denied she did anything to client #1.</p> <p>Interviews on 2/25/20 and 2/26/20 with the QP revealed: -got a call from staff #2 on 1/22/20; -staff #2 reported she and staff #1 "got into it" and were arguing; -staff #2 did not report any concerns regarding staff #1's treatment with client #1 when she called the QP; -QP had to come back to the facility to diffuse the situation between staff #1 and staff #2; -staff #1 reported client #1 fell earlier but she was fine now; -staff #2 made the comment to staff #1 "are you sure she fell or did you push her" in front of the QP; -the QP observed a mark like a scrape/bruise on client #1's knee where she had hit the ground; -QP asked if either staff wanted to leave to de-escalate the situation; -staff #2 stated she wanted to leave the facility; -staff #2 left and QP remained at the facility until all the clients went to bed;</p>	V 132		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 132	<p>Continued From page 17</p> <p>-QP left and staff #1 remained at the facility with the clients with no other staff; -did not document anything regarding her conversations with staff #1 and staff #2; -did not interview other clients regarding allegations staff #2 made against staff #1; -did not notify anyone of the allegations and did not initiate an internal investigation.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Individuals of All Disability Groups-Scope V289 for a Type B rule violation and must be corrected within 45 days.</p>	V 132		
V 289	<p>27G .5601 Supervised Living - Scope</p> <p>10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 289	<p>Continued From page 18</p> <p>serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 289	<p>Continued From page 19</p> <p>This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure the residential services provided the care and habilitation for the individuals served affecting 1 of 4 clients(#1). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS V109 Based on records review, observations and interviews, the facility failed to ensure 1 of 1 Qualified Professional(QP) demonstrated competency for the population served.</p> <p>Cross Reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS V110 Based on records review and interviews, the facility failed to ensure paraprofessional staff were supervised and demonstrated competency for the population served for 2 of 5 staff (#1, #2).</p> <p>Cross Reference: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY V132 Based on records review and interviews, the facility failed to ensure the Health Care Personnel Registry(HCPR) was notified of all allegations against health care personnel, failed to ensure all alleged acts were investigated and failed to protect residents from harm while the investigation was in progress affecting 1 of 4 clients (#1).</p> <p>Cross Reference: 10A NCAC 27G .5603 OPERATIONS V291 Based on records review and interviews, the facility failed to ensure</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 289	<p>Continued From page 20</p> <p>coordination was maintained between the facility operator and the qualified professionals who were responsible for treatment/habilitation or case management affecting 1 of 4 clients (#1).</p> <p>Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS V367 Based on records review and interviews, the facility failed to ensure all level II incidents or level III incidents were reported to the LME responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident.</p> <p>Interview on 2/26/20 with the Quality Management(QM) Director revealed: -started an internal investigation on this date, notified all parties and suspended staff #1 this date due to information from 2/25/20 regarding allegations of mistreatment of client #1 by staff #1; -was aware of the conflict between staff #1 and staff #2 within the past month; -had the QP from a sister facility intervene during the QP's absence; -the QP's supervisor had also been on medical leave during this time; -plan was to separate staff #1 and staff #2 on second shift to reduce the conflict; -staff #1 was going to transfer to first shift; -was in the process of training a new staff for second shift to work with staff #2; -thought the conflict and issues between staff #1 and staff #2 had calmed down.</p> <p>Review on 3/5/20 of the Plan of Protection dated 3/5/20 and completed by the Quality Management Director revealed the following documented: "Type B Plan of protection:</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 289	<p>Continued From page 21</p> <p>We will protect the health and safety of the residents in our care by:</p> <p>For all allegations of abuse, neglect or exploitation an immediate plan of protection followed to assure that the resident does not have contact with the accused until an investigation is completed, documented and resolved.</p> <p>Reporting any allegation of abuse, neglect or exploitation to Health Care Personnel Registry within 24 hours of the allegation.</p> <p>Level III IRIS report will be completed and submitted within 72 hours.</p> <p>Reports will be made to DSS, law enforcement as necessary.</p> <p>For all residents who need assistance with showering, staff will document any marks, bruises, etc. Staff will use gloves when providing personal care.</p> <p>Staff competencies to provide safe, therapeutic and quality care:</p> <p>Staff will receive the work expectations on Monday, March 9, 2020 from Easterseals UCP statewide residential director.</p> <p>Staff will be reminded of their obligation to remain focused on the residents, rather than involving themselves in workplace gossip, etc.</p> <p>Conversations with and in front of residents are expected to be in their best interest and not to involve them in staff or other issues.</p> <p>Staff will receive retraining in confidentiality</p> <p>Staff and management will identify needed training and will develop a plan for providing.</p> <p>Staff individual and group supervision will be provided and documented as per Easterseals UCP policy.</p> <p>Group home manager will receive clinical supervision refresher training.</p> <p>Coordination of Care:</p> <p>Residents with day supports programs will be transported to the extent possible and if they are</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 289	<p>Continued From page 22</p> <p>not able to attend on any given day, the Day Program will be notified.</p> <p>Communication with parents, guardians, service and medical providers will occur to insure that we provide consistent and meaningful services. Easterseals UCP will accomplish and monitor the above by the following:</p> <p>Staff meeting and follow-up including regular visits from management and Quality Management.</p> <p>Weekly touch base for group home manager with either statewide director or QM Director.</p> <p>QM will review staff supervision logs prior to May 1, 2020.</p> <p>QM will review trainings/staff meetings prior to May 1, 2020.</p> <p>QM will review of coordination of care logs as well as spot checking electronic health record documentation prior to May 1, 2020."</p> <p>Client #1 had a diagnoses of Intellectual Developmental Disabilities-Severe, Cerebral Palsy, Seizure Disorder and Parkinson's Disease. Staff #1 and staff #2 were trained in the areas of client needs and Core Values. Staff #2 made allegations in the presence of the QP that staff #1 abused client #1. The QP did not report the allegations to the required entities, did not complete the required documentation, did not initiate an internal investigation and did not establish a plan of protection for client #1 during an internal investigation. Staff #1 and staff #2 also demonstrated ongoing personal conflict at the facility including displaying profanity and arguing with raised voices. The QP also did not maintain communication with client #1's legal guardian and other service providers. The failure to demonstrate competency by the QP, staff#1 and staff #2, the failure to report and investigate the allegations regarding client #1, the failure to</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 289	Continued From page 23 protect client #1 during the investigation and the failure to maintain coordination of care between client #1's legal guardian and other service providers was detrimental to the safety, health and welfare of client #1. This deficiency constitutes a Type B rule violation and must be corrected within 45 days. If the violation is not corrected with 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 289		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices,	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 291	<p>Continued From page 24</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure coordination was maintained between the facility operator and the qualified professionals who were responsible for treatment/habilitation or case management affecting 1 of 4 clients (#1). The findings are:</p> <p>Review on 2/25/20 of an incident report dated 1/22/20 regarding client #1 completed by staff #1 documented the following: -client #1 was in her bedroom with staff #1; -client #1 tried to lunge at staff #1; -client #1 fell on one knee beside her bed; -client #1 had a small bruise on her right knee; -staff #1 called the manager; -client #1 was checked and assessed; -client #1 had no pain; -staff continued to monitor client #1.</p> <p>Interviews on 2/25/20 and 2/26/20 with the QP(Qualified Professional) revealed: -on 1/22/20, staff #1 reported client #1 fell earlier but she was fine now; -staff #2 made the comment to staff #1"are you sure she fell or did you push her" in front of the QP; -staff #1 denied the allegations; -the QP observed a mark like a scrape/bruise on client #1's knee where she had hit the ground.</p> <p>Interview on 3/2/20 with client #1's day program</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 291	<p>Continued From page 25</p> <p>staff revealed: -been problems with communication with the facility; -also been problems with client #1's attendance; -client #1 normally here all the time; -client #1 missed days in February 2020 which was not normal for her; -heard reasons from the facility including van issues and no staff available to bring her; -client #1 also had a mark on her knee when she came to the facility one time; -facility did not inform day program staff what happened to client #1's knee; -day program staff had to call the facility to determine what happened; -also client #1 was not in attendance today but never received a call from the facility why client #1 was absent this date; -concerned with lack of communication with the facility regarding client #1.</p> <p>Interview on 2/26/20 with client #1's legal guardian revealed: -was not made aware by the facility of any allegations regarding staff #1's mistreatment of client #1; -also not made aware by the facility of client #1's attendance issues at the day program; -had concerns regarding lack of communication with the facility regarding client #1.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Individuals of All Disability Groups-Scope V289 for a Type B rule violation and must be corrected within 45 days.</p>	V 291		
V 367	27G .0604 Incident Reporting Requirements	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 367	<p>Continued From page 26</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:</p> <ol style="list-style-type: none"> (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <ol style="list-style-type: none"> (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. <p>(c) Category A and B providers shall submit,</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 367	<p>Continued From page 27</p> <p>upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1)</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 367	<p>Continued From page 28 through (4) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure all level II incidents or level III incidents were reported to the LME responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 2/25/20 of the Incident Reporting Information System(IRIS) from 1/8/20 until 2/25/20 revealed: -no incident reports regarding client #1; -no Level III incident reports regarding alleged abuse/neglect of client #1.</p> <p>Review on 2/25/20 of the facility's incident reports from 1/8/20 to 2/25/20 revealed: -an incident report dated 1/9/20 regarding client #2; -an incident report dated 2/4/20 regarding client #6; -no incident reports regarding client #1.</p> <p>Interview on 2/25/20 with the QP(Qualified Professional) revealed: -found an incident report regarding client #1; -forgot about it.</p> <p>Review on 2/25/20 of an incident report dated 1/22/20 regarding client #1 completed by staff #1 documented the following: -client #1 was in her bedroom with staff #1; -client #1 tried to lunge at staff #1; -client #1 fell on one knee beside her bed;</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-402	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMONWEALTH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 COMMONWEALTH AVENUE CHARLOTTE, NC 28205
--	--

(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 367	<p>Continued From page 29</p> <ul style="list-style-type: none"> -client #1 had a small bruise on her right knee; -staff #1 called the manager; -client #1 was checked and assessed; -client #1 had no pain; -staff continued to monitor client #1. <p>Interview on 3/2/20 with staff #1 revealed:</p> <ul style="list-style-type: none"> -on 1/22/20, staff #2 accused her of pushing client #1 in front of the QP; -she informed the QP she did not push client #1. <p>Interview on 2/25/20 with staff #2 revealed:</p> <ul style="list-style-type: none"> -on 1/22/20, staff #1 told the QP client #1 fell; -asked staff #1 in front of the QP "did she fall or did you not hit her?" -staff #1 denied she did anything to client #1. <p>Additional interviews on 2/25/20 and 2/26/20 with the QP revealed:</p> <ul style="list-style-type: none"> -on 1/22/20, staff #1 reported client #1 fell earlier but she was fine now; -staff #2 made the comment to staff #1 "are you sure she fell or did you push her" in front of the QP; -the QP observed a mark like a scrape/bruise on client #1's knee where she had hit the ground; -did not complete an incident report of the allegations regarding staff #1 mistreating client #1. <p>This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Individuals of All Disability Groups-Scope V289 for a Type B rule violation and must be corrected within 45 days.</p>	V 367		