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V 000	INITIAL COMMENTS A complaint survey was completed on March 5, 2020. The complaint was substantiated (intake #NC00160801). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (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. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision	V 109		

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V 109	Continued From page 1 plan upon hiring each associate professional. (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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 Program Integrity Administrator/Supervising Qualified Professionals (PIA/SQP) demonstrated the knowledge, skills and abilities required by the population served. The findings are: Review on 2/18/20 of the PIA/SQP's personnel record revealed: Date of hire: 6/1/09; Education: Bachelor of Science; -A printed and signed job description dated 7/7/15 which included her job responsibilities to: -manage and supervise the community and residential services under the Licensee; -supervise and monitor the Qualified Professionals (QPs) and administrative staff except for the Executive Director; -participate in weekend on-call coverage as a part of a rotating schedule for residential services. Review on 2/18/20 of Client #1's record revealed: -Date of admission: 2/1/16; -Diagnoses: Mild Intellectual Developmental Disability (IDD), Adjustment Disorder with Mixed Anxiety and Depressed Mood, Adult Physical Abuse, Disorder of Written Expression; -His 8/1/19 treatment plan revealed a statement that "[Client #1] requires around the clock	V 109		

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monitoring to ensure his safety."

Review on 2/18/20 of Client #2's record revealed:
-Date of admission: 6/1/09;
-Diagnoses: Smith-Magenis Syndrome (SMS), Attention-Deficit Hyperactivity Disorder (ADHD), Intermittent Explosive Disorder, Moderate IDD;
-His 12/1/19 treatment plan revealed a statement that he needed "constant supervision."

Review on 2/18/20 of 3 written incident reports for Client #2 revealed:
-1/25/20, which was a Saturday and at 8:00 PM, he physically hit Client #1 in the stomach and face, which led to Client #2 having been physically restrained by local law enforcement to de-escalate, and Client #1 transported by ambulance to a local emergency department (ED) to be evaluated for medical treatment;
-Client #2 de-escalated and remained at the facility without further incident;
-Client #1 was discharged from a local ED and returned to the facility;
-The House Manager (HM) stayed as a second staff overnight at the facility.
-2/2/20, which was a Sunday and at 4:30 PM, Client #2 walked off from the facility for approximately 5-10 minutes after his guardian told him he would have to call and ask for the PIA/SQP's permission to have his video games returned to him;
-His video gaming activity was removed as a consequence to his aggression toward Client #1 on 1/25/20.

Interview on 2/17/20 with Client #1 revealed:
-Client #2 came into his room and hit him over headphones Client #2 thought belonged to him;
-He was "a little bit" afraid of Client #2 due to the 1/25/20 incident;

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-He did not want Client #2 to go to jail;
-He wanted Client #2 to stop hitting him;
-Client #2 had hit him before over headphones he thought were his.

Interviews on 2/17/20, 2/18/20, and 2/19/20 with the PIA/SQP revealed:
-2/17/20, She was the assigned QP for the facility and not Staff #5;
-Staff #5 was a QP but filled in as a direct care staff for the House Manager (HM) on 2/17/20;
-2/18/20, a treatment team meeting was held for Client #2 on 2/4/20 in response to his physical aggression toward Client #1;
-His treatment team was made up of his legal guardian, Local Management Entity (LME) Care Coordinator, facility and administrative staff that included herself, and a behavioral specialist who developed a behavioral support plan (BSP) for Client #2;
-The BSP was not implemented because staff had to be trained on the plan and she was waiting on a training date to be scheduled;
-She requested his level of residential service to be increased from a Level 3 to a Level 4, which meant more funding for additional staff;
-Client #2 had a one-on-one (1:1) worker 6-7 years ago who came to the facility at 3:30 PM to take him on outings when his housemates returned home from their day program, but he refused to leave the facility when they returned home;
-The afternoon 1:1 service was dropped because there was nothing for this staff to do at the facility with Client #2;
-He continued to have the HM as his 1:1 staff during the day, Monday-Friday from around 8:00/8:30 AM-3:30 PM while Clients #1 and #3 were at their day program;
-Client #1 felt nervous and scared after the

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physical altercation with Client #2;
-"An incident like that would make you scared- would make anyone scared in that moment; it's a natural response;"
-Other than have a second staff overnight at the facility, fix Client #1's bedroom door the next day so it would shut, set up a treatment team meeting for Client #2, she did not know of anything she could have done;
-Because there were times Client #2's behaviors were unpredictable, staff knew they were to call the local emergency service and then call her if something happened;
-2/19/20, She went to the facility on the evening of 2/18/20 and had a "family meeting" at the dining table with Clients #1, #2 and #3 and asked them if they felt safe at the facility;
-She talked with them about what they would do if they felt unsafe;
-Client #2 got up and went to his bedroom;
-Clients #1 and #3 told her they would go to their bedrooms if they felt unsafe;
-She confirmed she did not talk with Clients #1, #2 and #3 individually about their level or thoughts of personal safety;
-"They said if they felt unsafe, they would go to their rooms like a disaster drill for any incident."

Additional interviews on 2/26/20 and 3/4/20 with the PIA/SQP revealed:
-2/26/20, If Client #2 was approved through the LME for the Level 4 residential services that increased funding, an additional 1:1 staff was not required and this service would not be used except when Client #2 needed extra supervision in the community or when he had a "bad day;"
-3/4/20, Client #2 would be aggravated more with increased 1:1 staff present in the facility because this service had not worked for him in the past;
-She did not set up a treatment team meeting

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V 109	Continued From page 5 or an appointment for Client #1 with his local mental health provider after the 1/25/20 incident with Client #2's aggression toward him; -An appointment was not set up because she believed his mental health provider knew about the 1/25/20 incident; -Her belief was based on an assumption that Client #1's mental health provider might have written the multiple letters that were sent to various county department of social services (DSSs) and LMEs with the allegation that Clients #1 and #3 were not being kept safe from Client #2's aggressive behaviors; -She stated this was why she made the statement on 2/17/20 that DSS and DHSR (Division of Health Service Regulation) needed to "set up out at Thermal" and find out who had the perception that staff were not keeping the clients safe; -If Clients #1 and #3 felt scared that they may have to be moved out of the facility, their fear was from DSS having told them if they received one more letter with the same allegation, they would have to move; - She indicated her practice of a "family meeting" with Clients #1, #2 and #3 at the dining table on 2/18/20 to ask them about their personal safety as a group was not an intimidating action; -Former Client (FC#4) chose to move out of the facility and into another facility after Client #2 physically attacked him; -This incident occurred prior to Client #1's admission. This deficiency is cross-referenced into 10A NCAC 27G 5601 Scope (V289) for a Type A1 and must be corrected within 23 days.	V 109		

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V 110	Continued From page 6	V 110		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (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. This Rule is not met as evidenced by: Based on record review, observation and	V 110		

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V 110	Continued From page 7 interview, the facility failed to ensure 5 of 5 current staff (the House Manager (HM), Staff # 1, Staff #2, Staff #3 and Staff #4) demonstrated the knowledge, skills and abilities required by the population served. The findings are: Review on 2/18/20 of the HM's personnel record revealed: -Date of hire: 5/1/15. Review on 2/18/20 of Staff #1's personnel record revealed: -Date of hire: 6/1/09. Review on 2/18/20 of Staff #2's personnel's record revealed: -Date of hire: 6/1/09. Review on 2/18/20 of Staff #3's personnel record revealed: -Date of hire: 6/1/09. Review on 2/18/20 of Staff #4's personnel record revealed: -Date of hire: 3/6/17. Reviews on 2/18/20 of the personnel records of the HM and Staff #1, Staff #2, Staff #3 and Staff #4 revealed: -Their client competency training was completed on Client #1 on 1/31/20; -Their client competency training was completed on Client #2 on 2/1/20; -The client competency training was provided by the Program Integrity Administrator/Supervising Qualified Professionals (PIA/SQP); -The HM and PIA/SQP shared in the supervision of Staff #1-Staff #4. Review on 2/18/20 of Client #1's record revealed:	V 110		

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V 110	Continued From page 8 -Date of admission: 2/1/16; -Diagnoses: Mild Intellectual Developmental Disability (IDD), Adjustment Disorder with Mixed Anxiety and Depressed Mood, Adult Physical Abuse, Disorder of Written Expression; -His 8/1/19 treatment plan included a statement that "[Client #1] requires around the clock monitoring to ensure his safety." Review on 2/18/20 of Client #2's record revealed: -Date of admission: 6/1/09; -Diagnoses: Smith-Magenis Syndrome (SMS), Attention-Deficit Hyperactivity Disorder (ADHD), Intermittent Explosive Disorder, Moderate IDD; -His 12/1/19 treatment plan included a statement that "[Client #2] requires constant supervision and some supports and prevention of stealing, tantrums/emotional outbursts, self-injurious behaviors, wandering, and mental health maintenance." Review on 3/3/20 of Client #3's record revealed: -Date of admission: 6/1/09; -Diagnoses: Schizoaffective Disorder, Oppositional Defiant Disorder (ODD), Mild IDD, Diabetes, Obesity, Asthma, Sleep Apnea; -Her 7/1/19 treatment plan included a statement that "[Client #3] requires 24-hour supervision." Review on 3/3/20 of a written staff communication log for Client #2 that was completed by the HM on 2/18/20 revealed: -"[Client #2] asked first thing if we needed to go anywhere; I said yes and he went straight to bed;" -"Came out for lunch around 2 pm and that's all." Observation and interview on 2/18/20 that began at 11:41 am to approximately 1:05 PM of Client #2 and the HM at the facility revealed: -The HM requested to go into the living room; she	V 110		

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wanted to watch a video;
-She stated Client #2 was asleep in bed;
-She walked from the dining room into the living room without checking on Client #2 until 1:00 PM when a request was made to see Client #1's bedroom door, which was directly across from Client #2's bedroom;
-At 1:05 PM, Client #2 was observed laying in his bed and appeared to be asleep.

Observation and interview on 3/3/20 from 1:31 PM to 2:36 PM of Client #2 and the HM at the facility revealed:
-At 1:31 PM, the HM stated she would be in the living room and Client #2 was in his room asleep;
-From 1:31 PM-2:36 PM, a soap opera was observed playing on the television in the living room where the HM remained present and did not check on Client #2 during this time;
-At 2:31 PM, Client #2 stood in the hallway briefly, turned around and left.
-From 2:31 PM to 2:42 PM, Client #2 was heard walking around, the toilet flushed one time, and he was heard making sounds as if clearing his throat;
-The HM did not check on Client #2 nor did she engage with him until after 3:00 PM when Staff #1 came into the facility.

Observation and interview on 3/3/20 with Client #1 between 4:49 pm to 5:00 pm revealed:
-At 4:49 PM, Client #1 was observed walking by himself along the road of the facility;
-There was no staff present outside the facility to monitor or supervise him;
-Client #1 stated he was walking to exercise.

Interview on 2/18/20 with the HM revealed:
-She had worked as the HM for 3-4 years;
-She was Client #2's 1:1 staff Monday through

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Fridays from around 8:30 AM to 3:30 PM;
-She confirmed that 1/25/20 was the 2nd incident in which Client #2 had physically attacked Client #1 over headphones Client #2 thought belonged to him;
-The first incident was over a year ago and Client #1 went to a local ED to be checked out and was discharged back to the facility without any treatment provided by the hospital;
-She was aware of Client #2's treatment team meeting on 2/4/20 but had not been told by her supervisor, the PIA/SQP, of any changes that had been put into place as a result of the meeting.

Interviews on 2/17/20 and 3/3/20 with Staff #1 revealed:
2/17/20, She had worked as direct support staff for 11 years;
-Her usual work schedule was 4:00 PM to 12:00 Midnight;
-Her duties included meal preparation, medication administration, helping Clients #1, #2 and #3 with their goals although most of Client #2's goals were run by his 1:1 staff (the HM) during the day;
-There were no group home rules;
-The rules for Client #2 were set by his guardian and were not written;
-One rule was that he was allowed 1 soda at 3:00 PM each day and 3 sodas each day on the weekends if he had no behaviors;
-If Client #2 had a behavior, his consequence was loss of his 3:00 PM soda;
-An additional rule, which was set by his guardian, was to lock up his electronics before bedtime every night because of his tendency to break his electronics.
-3/3/20, She understood Client #1 was allowed to walk outside without staff present as long as staff kept him within eyesight "periodically," which

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meant she could look out from the living room window to check on him;
-She asked if Client #3 had to be "continuously monitored or supervised."

Interview on 2/27/20 with Staff #3 revealed:
-Client #2 walked away from the facility on 2/2/20, which was a Sunday after the incident with Client #1 because he wanted his video games back that had been taken away because of his aggression on 1/25/20;
-He called his guardian who told him to call the Program Integrity Administrator /Supervising Qualified Professional (PIA/SQP);
-Instead, he took off running from the facility on the left side of the road toward the stop sign;
-He (Staff #3) called the HM who instructed him to keep an eye on Client #2;
-He did not call local emergency services for assistance to return Client #2 to the facility;
-Clients #1 and #3 were inside the facility.

Interview on 2/17/20 with Staff #4 revealed:
-Client #1 was transported to a local emergency department by ambulance on 1/25/20 after he was physically attacked by Client #2 at around 8:00 PM;
-She and Staff #2 were at the facility when Client #1 was transported to the hospital;
-He made the decision to go to the hospital;
-Because he went by ambulance, she did not think he needed to be supervised;
-She transported Client #1 back to the facility about 2 hours after he was attacked.

Interview on 3/4/20 with the PIA/SQP revealed:
-There were written house rules for all the facilities in the policies and procedures book and client handbook;
-The house rules were posted at one time at the

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V 110	Continued From page 12 facility; -Client #2's rules set by his guardian to follow used to be posted on the wall at the facility; -She would have to make sure the staff were aware of what supervision levels Clients #1, #2 and #3 are required to have; -A staff could have met Client #1 upon his arrival the ED on 1/25/20; -If a client eloped, it was facility policy that staff called local law enforcement so that staff remained with the other clients. This deficiency is cross-referenced into 10A NCAC 27G 5601 Scope (V289) for a Type A1 and must be corrected within 23 days.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or	V 112		

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V 112	Continued From page 13 responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to implement treatment strategies for 3 of 3 clients (Client #1, Client #2 and Client #3). The findings are: Review on 2/18/20 of Client #1's record revealed: -Date of admission: 2/1/16; -Diagnoses: Mild Intellectual Developmental Disability (IDD), Adjustment Disorder with Mixed Anxiety and Depressed Mood, Adult Physical Abuse, Disorder of Written Expression; -Behavioral history included shyness, difficulty understanding his verbal communications of his wants and needs, lying about incidents, elopement, and fire-setting; -His 8/1/19 treatment plan revealed: -He needed a Care Coordinator to assist in obtaining services and a guardian for help with decision-making skills; -He required "around the clock monitoring" to ensure his safety; -He was his own guardian and he had limited to no family involvement; -He had difficulty expressing his wants and needs; -His treatment goals and the strategies to support his goals included: -Attend all medical and psychological appointments with staff responsible to schedule	V 112		

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his appointments quarterly and more often as needed;
-Self-expression of his needs or opinions (e.g., state his needs and opinions, and self-advocate) with staff responsible to provide encouragement, assistance, model behavior, role-play, prompts and praise;
-There was no written assessment or documentation that he was found capable of being in the community without supervision;
-A printed letter from the current Local Management Entity (LME) dated 2/4/20 that informed him that he was added to the LME's Registry of Unmet Needs List for the NC Innovations Waiver Section that was a transfer from the prior LME but no Innovations Waiver slot was being made available to him at that time.

Review on 2/18/20 of Client #2's record revealed:
-Date of admission: 6/1/09;
-Diagnoses: Smith-Magenis Syndrome (SMS), Attention-Deficit Hyperactivity Disorder (ADHD), Intermittent Explosive Disorder, Moderate IDD;
-Behavioral history included yelling and screaming at staff, punching and kicking holes in the facility's walls, physical fights with other clients (Former Client #4 who moved to another facility prior to Client #1's admission), stealing personal items belonging to others (e.g., car keys that belonged to Former Staff #7, earphones from Client #1's bedroom, and food items from the facility's kitchen), and elopement;
-His 12/1/19 treatment plan revealed:
-His treatment team included his legal guardians, an LME Care Coordinator, and a behavioral support specialist;
-He had family and a community support individual who took him on outings (e.g., bowling and to church on Sundays);
-His one-on-one (1:1) worker was with him on

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V 112	Continued From page 15 Monday through Friday from around 8:00 AM-3:00 PM; -There needed to be "reliable" and "backup" staff available at the facility "when [Client #2] 'high-jacks' the house so that the other individuals cannot go out ...;" -His treatment goals and strategies to support his goals included: -Compliance with house rules and staff direction with staff responsible for ensuring he was reminded of the rules and the guidelines from his guardian; -Demonstrate appropriate anger management skills daily (e.g., inform staff when he is angry, use breathing techniques, take a walk with a staff, refrain from physical aggression) with staff responsible for instruction of coping skills, providing meaningful activities, and prompting; -Refrain from property damage (e.g., putting holes in the walls) with staff responsible for providing encouragement, modeling behaviors, redirection, and prompts; -He had a printed Behavioral Support Plan (BSP) with an implementation date of 2/4/20 which included strategies for his targeted behaviors of agitation, verbal and physical aggression, property destruction and non-compliant behaviors. Review on 3/3/20 of Client #3's record revealed: -Date of admission: 6/1/09; -Diagnoses: Schizoaffective Disorder, Oppositional Defiant Disorder, Mild/Moderate IDD, Diabetes, Asthma, Sleep Apnea; -Her 7/1/19 treatment plan revealed: -She got upset "occasionally" over a housemate when he became noisy and argumentative; -It was important for her to be seen by her mental health provider when needed; -She required 24-hour supervision to support	V 112		

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her daily living and safety needs;
-Her treatment goals and strategies to support her goals included:
-Attend all psychiatric and medical appointments with staff responsible to schedule her appointments quarterly and more often as needed;
-There was no written assessment or documentation that he was found capable of being in the community without supervision.

Review on 2/18/20 of a printed North Carolina Incident Response Improvement System (IRIS) report with an incident date of 1/25/20 revealed:
-At 8:00 PM during a shift change, Client #2 told a staff (not identified) that Client #1 had his earbuds;
-Although one of the two staff told Client #2 the earbuds were bought by Client #1 at a local store, Client #2 went into Client #1's bedroom where he was watching television and hit him in the stomach and face "a few times;"
-Client #1 freed himself from Client #2, ran down the hall and ran out the front door;
-While Client #2 was blocked a staff from exiting the front door to get to Client #1, Client #2 ran out the back door while a 2nd staff called local emergency services;
-Client #1 re-entered the house as Client #2 ran around the house;
-Client #1 went into his bedroom and shut his door as one of the two staff stood in front of his bedroom door to prevent Client #2 from entering Client #1's room;
-"[Client #2] repeatedly kicked and hit the door while yelling and cursing trying to get in to attack [Client #1] again;"
-Client #2 resisted and physically struggled with local law enforcement at the facility for "10+ minutes" before he de-escalated;

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-The Qualified Professional (QP) was notified by staff and she arranged for the House Manager (HM) to come to the facility for two staff to be available overnight as a precaution at the facility;
-Client #1 chose to go to a local emergency department (ED) to be medically evaluated;
-He was discharged from the ED 2 hours later with no treatment needed.

Review on 2/27/20 of a written incident report dated 2/2/20 revealed:
-At 4:30 pm, Client #2 eloped from the facility after he called his guardian and was told to call the QP about the return of his video games;
-He had his video games taken away because of the physical fight Client #2 had with Client #1 on 1/25/20;
-Client #2 called the "home supervisor" and apologized for the fight between him and Client #1;
-Client #2 received his games back;
-Staff #3's statement was, "There are no corrective measures put in place at this time;"
-This report was signed by Staff #3.

Observation on 2/17/20 at 2:00 pm of the facility living room wall revealed:
-a white-colored drywall patch on both sides of the doorway that led into the kitchen/dining room;
-The color of the living room wall was a peach/pink tone.

Observation on 2/18/20 of the facility between 1:00 PM- 1:05 PM revealed:
-1:00 PM, Client #1's bedroom door was cracked from the door knob across to the lower door panel;
-The left lower door panel opposite from the door knob appeared with cracks and holes;
-1:05 PM, Client #2 had a hole in his bedroom

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sheetrock wall at the head of his bed where he was laying;
-The hole appeared to be about the size of a basketball and the wall studs were exposed;
-One small hole about the size of a fist was located beside this large hole in the sheetrock wall;
-There were 3-4 white-patched holes on his bedroom wall but were not painted.

Interviews on 2/17/20 and 3/3/20 with Client #1 revealed:
-2/17/20, He had been living at the facility for 3 years and he liked living there;
-He lived with Clients #2 and #3;
-Client #2 had hit him in the stomach and in the left eye because Client #2 thought the headphones were his;
-He did not remember when this incident occurred but knew it was on a weekend;
-He ran out of the house after Client #2 chased him out of his bedroom;
-He (Client #1) ran back inside the house and into his bedroom;
-The police came to the house and cuffed Client #2 before he (Client #2) calmed down;
-He (Client #1) went to a doctor who checked him out and told him nothing was broken;
-The headphones did not belong to Client #2;
-This had happened before between he and Client #2, and it was over headphones;
-His response to whether he was afraid of Client #2 was "a little bit;"
-"I don't want him to hit me;"
-He did not want Client #2 to go jail;
-There were 2 staff who watched him-HM who worked at 8:00 in the mornings and Staff #1 who worked around 4:00 in the afternoons;
-He did not remember the last time he saw his mental health provider or regular medical doctor

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for an appointment;
-The PIA/SQP, his mental health provider, and staff at his vocational program helped him with services and decisions;
-3/3/20, He had a telephone call with someone that the PIA/SQP set up to get him to be paid at his workshop;
-He had not worked at the workshop to be paid but a letter was sent to him about being put on a service to get paid and he was so happy.

Interview on 3/4/20 with Clients #1 and #3's mental health provider revealed:
-He saw these two clients at individual sessions at least once every two months for a counseling session, which included a review of their individual treatment plan, addressing any behavioral and/or medication issues or concerns, and consultation with the PIA/SQP about how to best support each client;
-He was Client #2's former mental health provider;
-Client #2 needed more specialized behavioral care the reason he was seen by another provider;
-Client #1 was last seen by him on 1/21/20 and his next appointment was scheduled on 3/20/20;
-He was concerned Client #1 was not receiving needed services from the Local Management Entity (LME) to have a Care Coordinator so he could secure meaningful vocational work and pay;
-He had completed a psychological evaluation in 2016 for Client #1 for the former LME to link him with Care Coordination but this had not occurred;
-He initially stated he was pleased with the care and services Clients #1 and #3 received at the facility;
-He had no knowledge of the 1/25/20 incident in which Client #1 was assaulted by a housemate and that Client #3 was present when the incident

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V 112	Continued From page 20 occurred; -He stated he was concerned the PIA/SQP had not contacted him about this incident; -"This was not like Synergy (the Licensee) not to contact me;" -He stated that he was supposed to be contacted if there was aggression toward one of his clients or by one of his clients; -Had he known even the day after the incident, he would have rearranged his work schedule to meet with Clients #1 and #3 to assess their response to the incident and determine if additional support was needed. Interview on 2/27/20 with Staff #3 revealed: -Client #2 walked away from the facility the Sunday after the 1/25/20 incident with Client #1 because his mother told him he had to call the PIA/SQP to ask for his games back; - His games were taken away from him as his consequence for his physical aggression toward Client #2 on 1/25/20; -Instead of calling the PIA/SQP , Client #2 ran off the property and into the yard on the left side of the road toward the stop sign; -He (Staff #3) called the House Manager (HM) who instructed him to keep an eye on Client #2; -He remained outdoors where he could monitor Client #2 who was gone approximately 5-10 minutes before he returned to the facility on his own; -"No corrective measures were taken" on his incident report meant that Client #2 did not have a consequence in place to correct his elopement behavior; -When he returned to the facility the day after he walked away and talked with the PIA/SQP, he had to shower and clean his room to get his game returned to him.	V 112		

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V 112	Continued From page 21 Interviews on 2/18/20 and 3/3/20 with the HM and Staff #1 revealed: -These two staff were present at the facility when a copy of the written rules and/or guidelines for the facility and Client #2 were requested; -They each stated there were no written group home rules; -Client #2's rules were set up by his legal guardian and the rules were not written; -His rules included a 2 soda a day limit, loss of his 3:00 PM soda if he had a behavior, his electronic games were locked up before he went to bed because of his history of breaking his electronic gaming systems, and loss of game time if he punched holes in the walls; -Client #2 knew the rules and he did not need them written as visual prompts to follow them. Interviews from 2/17/20 through 2/24/20 with current and former staff revealed: -Each staff requested anonymity with their following disclosures; -Client #2 seemed to be favored by "the company" (Synergy in Action, Incorporated) over Clients #1 and #3 having his treatment strategies and services implemented; -Client #2's guardian owned the facility which was rented by Synergy in Action, Inc.; -Client #2 referred to the facility as "his house," which probably explained why he did not seem to care about the holes he puts in the walls; -When Client #1 was first admitted, he went through a period where he set fires inside the facility on his window sill and the PIA/SQP made him pay for the repairs out of his personal spending allowance; -When Client #2 punched a lot of holes in the facility walls with his fist, he had his games withheld for a few days and his guardian paid for the repairs;	V 112		

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V 112	Continued From page 22 -Client #3 watched as staff gave Client #2 more than his 2 sodas a day limit after he called his guardian; -She asked staff why she could not have more than 2 sodas a week; -There were no group home rules for Client #2 because if he wanted something outside of a rule, limit or strategy, he called his guardian and was usually granted his request; -Client #2's behavior outbursts were not always predictable by staff; -There had been times he had been asked politely by staff to gather his clothes for laundering and he complied and other times when the same request was made by the same staff, his response was to yell and punch holes in the walls; -When Client #2 was out of the facility on home visits or at church on Sundays, Clients #1 and #3 stayed out of their bedrooms and were engaged in watching television (TV) in the living room and spent time eating together at the dinner table and interacting with staff; -When Client #2 was present in the facility, Clients #1 and #3 stayed in their own bedrooms with Client #1 watching his TV and Client #3 stayed in her room as long as she could; -Client #3 periodically came out of her room and checked to see where everyone was; -Clients #1 and #3 interacted with Client #2 but their actions were done to prevent a behavior outburst from Client #2 and/or they were afraid they might be moved by the management staff if they did not participate with Client #2 in an activity or a game; -"If [Client #1] was out of his room doing something with [Client #2], it is certain that [Client #1] didn't initiate it-someone else had too;" -Clients #1 and #3 rode the bus to their workshop because Client #2 had refused to get up in the	V 112		

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mornings to ride with the HM to transport the two clients to their program;
-"[Client #2]'s so unpredictable-with him, you do not know what will set his behaviors off;"
-" I don't know if it's his mental illness or if he knows he can call the shots because it's his parents' house or both;"
-"We try to help [Client #2] follow the rules but he knows he can call his mother and she will give him what he wants so there are no rules or guidelines for him to follow."

Interviews on 2/18/20, 2/19/20, and 3/4/20 with the PIA/SQP revealed:
-2/18/20, She tried to link Client #1 with an LME Care Coordinator for services with the former LME and current LME but understood there was no proof of his disability being developmental;
-Her communications with the LME had been by email;
-Client #1 "supposedly" received a certified letter from the LME that he was to respond to if he wanted to remain on the NC Innovations waiting list for I/DD individuals;
-The LME said they did not receive his response to the letter;
-She had discussions with the county department of social services (DSS) about a guardian for him and nothing had been done;
-Client #1 felt nervous and scared after the physical altercation with Client #2 on 1/25/20;
-His eyes were red and puffy from his crying;
-"An incident like that would make you scared-would make anyone scared in that moment; it's a natural response;"
-She had followed Client #2 for 15 years regarding his care needs and services;
-She was knowledgeable about his Smith-Magenis Syndrome diagnosis and his past and present behaviors that tend to "cycle;"

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V 112	Continued From page 24 -"Sometimes you don't know what triggered a behavior and that's what we try to figure out and prevent from reoccurring;" -Once Client #2's behavioral support plan (BSP) was implemented, the strategies in his plan would have a "spillover effect" that would keep Clients #1 and #3 safer by him having increased 1:1 attention to his needs; -2/19/20, She had made Client #1 a 1-hour intake appointment with the LME for 2/24/20 at 8:45 AM for the NC Innovations Waivers Program to try and get him linked to a Care Coordinator; -Her response to Client #2's BSP implementation date of 2/4/20 was that the behavioral specialist brought out the paperwork on that date, wanted her to review, and planned to schedule a date to return and train the staff on the BSP and how to chart Client #2's behaviors; -2/26/20, If Client #2's residential service level was increased to a Level 4, additional 1:1 staff with Client #2 would not be used except when he needed extra supervision in the community or when he had a "bad day." -Because Client #2's behavior on 1/25/20 was triggered by a family crisis he witnessed while on an outing, the plan now was that anyone who picked up and dropped off Client #2 at the facility had to communicate with staff about whether he had any behaviors or witnessed any significant events; -Staff were to be trained by the behavioral specialist on Client #2's BSP and how to chart his behaviors on 2/28/20; -3/4/20, She acknowledged no efforts were made to contact Clients #1 and #3's mental health provider to arrange an appointment for each of these two clients to be assessed after 1/25/20; -Clients #1 and #3's mental health provider might have been the author of the multiple letters that had been sent to various county departments	V 112		

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V 112	Continued From page 25 of social services (DSSs) with allegation that Clients #1, #2 and #3 were not being kept safe by staff at the facility; -She was not withholding information from Clients #1 and #3's mental health provider; -She believed he probably knew about the incident on 1/25/20 between Clients #1 and #2. This deficiency is cross-referenced into 10A NCAC 27G 5601 Scope (V289) for a Type A1 and must be corrected within 23 days.	V 112		
V 289	27G .5601 Supervised Living - Scope 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 serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;	V 289		

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V 289	Continued From page 26 (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (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). This Rule is not met as evidenced by: Based on record review, observation and	V 289		

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V 289	Continued From page 27 interview, the facility failed to operate within the scope of the program to provide residential services that met the needs to 3 of 3 clients (Client #1, Client #2 and Client #3) whose primary diagnosis is a developmental disability. The findings are: CROSS-REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) Based on record review and interview, the facility failed to ensure 1 of 1 Program Integrity Administrator/Supervising Qualified Professionals (PIA/SQP) demonstrated the knowledge, skills and abilities required by the population served. CROSS-REFERENCE: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) Based on record review, observation and interview, the facility failed to ensure 5 of 5 current staff (the House Manager (HM), Staff# 1, Staff #2, Staff #3 and Staff #4) demonstrated the knowledge, skills and abilities required by the population served. CROSS-REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review, observation and interview, the facility failed to implement treatment strategies for 3 of 3 clients (Client #1, Client #2 and Client #3). CROSS-REFERENCE: 10A NCAC 27G .5602-Staff (V290) Based on record review, observation and interview, the facility failed to be staffed to meet to the individualized needs of 3 of 3 clients (Client #1, Client #2 and Client #3).	V 289		

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V 289	Continued From page 28 Review on 3/4/20 of a Plan of Protection written, signed and dated by the Executive Administrator (EA) on 3/4/20 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -"27G .0203-Competencies of QP (Qualified Professional)-(The) Administrator will complete a training in competencies, procedures and care coordination with the identified QP in order to ensure that the knowledge and abilities of the QPs of Synergy in Action, Inc. ensure the provision of comprehensive, compassionate and appropriate care at all times. QP will have refresher training on CORE competencies, Getting It Right, and in administrative matters by the end of business Monday, March 9th, 2020 or sooner if possible; -27G .0204-Competencies and Supervision of Paraprofessionals- (The) Administrator has contacted all staff of the group home via text to schedule a mandatory refresher training at 3 PM on March 11. Individuals that cannot attend will be trained on or before March 13th. This training will include, but is not limited to: procedures regarding supervision of clients and ensuring safety, responding appropriately to an issue/crisis/steps to take and in what order, incident reporting guidelines and timeframes and communication with supervisors, clients, families, and each other in order to assure safety and care and that house rules are followed. This training may need to be completed over a two-day span. If so, the completion date would change to on or after March 13th, but will be completed ASAP (As Soon As Possible); -In regards to 27G .0205, failure to implement	V 289		

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V 289	Continued From page 29 treatment strategies, Synergy in Action, Inc., as care responsible agency for Client #1, has contacted the LME (Local Management Entity) to ask for assistance in coordination of care for him, and has obtained an appointment with a psychologist on March 30th, and that will be moved to an earlier appointment if one is available. As of 3/4/20 at 3-4-20 at 2:50 pm, the psychologist has been texted an appointment request (his preferred method). (The) Administrator will attend the appointment to ensure all information is shared and that any recommended changes from the team can be implemented at the home on March 30 or before; -In regards to 27G .5602, failure to staff the facility, Synergy in Action, Incorporated (Inc.) will immediately provide a second staff during all hours there are three clients in the home. In order to meet immediate timeframes, the Administration will seek current staff who may want increased hours, and fill the vacancy in that way until permanent staff can be hired, trained and begin. An interview with a potential new staff member will be conducted by the Administrators before Friday, March 6th end of business day." Describe your plans to make sure the above happens. " (The) Administrator has already ensured the psychologist and LME have been contacted in order to coordinate care; staff have been asked to attend the meeting on March 11th. Contact was made on this date (3/4/20) with a potential employee regarding covering the staffing requirements of the home, and a request will be posted in the group homes 3/5/20 regarding availability for those hours. The posting was also made available on [an internet job search website] and on social media on 3/4/20. Until all	V 289		

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hours are covered, Administrators will cover as many working hours as possible, effective immediately. House rule notices have been printed and will be placed in all group homes by the end of business on 3-5-20."

Review on 3/5/20 of an amended Plan of Protection signed and dated by the Executive Administrator (EA) on 3/5/20 revealed:

What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?
-"27G .0203-Competencies of QP (Qualified Professional)-(The) Administrator will complete a training in competencies, procedures and care coordination with the identified QP in order to ensure that the knowledge and abilities of qualified professionals of Synergy in Action, Inc. ensure the provision of comprehensive, compassionate and appropriate care at all times. Qualified professional will have refresher training in core competencies, Getting It Right (provided by a licensed trainer), and in administrative matters by the end of business Monday, March 9, 2020 or sooner if possible;

-27G .0204-Competencies and Supervision of Paraprofessionals- (The) Administrator has contacted all staff of the group home via text to schedule a mandatory refresher training at 3 PM on March 11th Individuals that cannot attend will be trained on or before March 13th. This training will include, but is not limited to: procedures regarding supervision of clients and ensuring safety, responding appropriately to an issue/crisis/steps to take and in what order, incident reporting guidelines and timeframes and communication with supervisors, clients, families, and each other in order to assure safety and care

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and that house rules are followed. This training may need to be completed over a two-day span. If so, the completion date would change to on or after March 13th, but will be completed as soon as possible;

-In regards to 27G .0205, Assessment and Treatment/Habilitation, Failure to Implement Treatment Strategies: As care responsible agency for Client #1,Synergy in Action, Inc. has contacted the Local Management Entity to seek assistance in coordination of care for him and has arranged a psychological appointment and treatment team meeting for him on March 9th. The team will identify current needs and strategies to address them. For Client #2, the current plan in effect has contingencies for behaviors and how to identify and document them to identify patterns of behavior/needs. The staff will be provided with a written summary of the behavior plan and documentation requirements March 5, 2020 in order to ensure that the plan is being followed and implemented appropriately;

-In regards to 27G .5602, Failure to Staff Facility: Synergy in Action, Incorporated (Inc.) will immediately provide a second staff during all hours there are three clients in the home. In order to meet immediate timeframes, the Administration will seek current staff who may want increased hours, and fill the vacancy in that way until permanent staff can be hired, trained and begin employment. An interview with a potential new staff member will be conducted by the Administrators before Friday, March 6th end of business day."

Describe your plans to make sure the above happens.
" (The) Administrator has already ensured the

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V 289	Continued From page 32 psychologist and treatment team meeting have been scheduled for Client #1 and the LME has been contacted again in order to coordinate care; staff have been required to attend the training meeting on March 11th in order to improve care. Contact has been made on March 4, 2020 with a potential employee regarding covering the staffing requirement of the home and a request was posted March 4, 2020 on [an internet job search website] as well as a local paper and on Synergy's social media. Until all hours are covered, Administrators will cover as many waking hours as possible, effective immediately. House rule notices have been printed and distributed to all group homes on March 4, 2020." Review on 3/5/20 of a 3rd amended Plan of Protection signed and dated by the Executive Administrator (EA) on 3/5/20 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -"In regards to 27G .0203 Competencies of Qualified Professional: (The) Administrator will complete a training in competencies, procedures and care coordination with the identified QP in order to ensure that the knowledge and abilities of qualified professionals of Synergy In Action, Inc. ensure the provision of comprehensive, compassionate and appropriate care at all times. Qualified professional will have refresher training in core competencies, Getting it Right (provided by a licensed trainer), and in administrative matters by end of business Monday, March 9, 2020 or sooner if possible; -In regards to 27G .204: Competencies and Supervision of Paraprofessionals: (The) Administrator has contacted all staff of the group	V 289		

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home via text to schedule a mandatory refresher training at 3pm on March 11th. Individuals that cannot attend will be trained on or before March 13th. This training will include, but is not limited to: procedures regarding supervision of clients and ensuring safety, responding appropriately to an issue/crisis/steps to take and in what order, incident reporting guidelines and timeframes and communication with supervisors, clients, families and each other in order to assure safety and care that house rules are followed. This training may need to be completed over a two-day span. If so, the completion date would change to after March 13, but would be completed as soon as possible;

-In regards to 27G .205, Assessment and Treatment/Habilitation, Failure to Implement Treatment Strategies: As case responsible agency for Client #1, Synergy In Action, Inc. has contacted the Local Management Entity to seek assistance in coordination of care for him and has arranged a psychological appointment and treatment team meeting for him on March 9th. The team will identify current needs and strategies to address them. For Client #2, the current plan in effect has contingencies for behaviors and how to identify and document them to identify patterns of behavior/needs. The staff will be provided with a written summary of the behavior plan and documentation requirements March 5, 2020 in order to ensure that the plan is being followed and implemented appropriately. For each individual in the home, Administrator or Training Officer will review the current treatment plan and documentation with the staff, provide client-specific training to ensure that the needs and strategies to meet needs in each service plan have been implemented and continue to be implemented correctly and appropriately. In order to obtain training in immediacy, the initial contact

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with staff will have to be conducted via telephone for staff that are not present in the home on the current date and reiterated in person on March 11.

-In regards to 27G .5602, Failure to Staff Facility: Synergy In Action, Inc. will immediately provide a second staff during all hours there are three clients in the home. In order to meet immediate timeframes, the Administration will seek current staff who may want increased hours, and fill the vacancy in that way until permanent staff can be hired, trained and begin employment. An interview with potential new staff member will be conducted by the Administrators before Friday, March 6th end of business day."

Describe your plans to make sure the above happens.
"(The) Administrator has already ensured the psychologist and treatment team meeting have been scheduled for Client #1 and the LME has been contacted again in order to coordinate care; staff have been required to attend the training meeting on March 11th in order to improve care. Contact has been made on March 4, 2020 with a potential employee regarding covering the staffing requirements of the home and a request was posted March 4, 2020 on [an internet job search website] as well as in a local paper and on Synergy's social media. Until all hours are covered, Administrators will cover as many waking hours as possible, effective immediately. House rule notices have been printed and distributed to all group homes on March 4, 2020."

Client #1 was admitted 2/1/16 and Clients #2 and #3 were admitted 6/1/09. These clients were admitted to a residence that the landlord is Client #2's parents and the licensee is Synergy in

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V 289	Continued From page 35 Action, Incorporated. Each of these 3 clients have a primary diagnosis of IDD and each have histories of behaviors that include emotional outbursts, verbal and physical aggression, property destruction and elopement. They each have in their treatment plans a need for continuous or 24-hour supervision to keep themselves safe and/or ensure others are kept safe. They did not have an assessment or documentation in their treatment plans that found Client #1, Client #2 or Client #3 capable of having unsupervised time in the facility and/or community. There have been repeated and anonymous letters sent to 2 Local Management Entities and 3-4 county department of social services (DSSs) with a last known letter postmarked in 2/2020 and allegation that staff were not ensuring client safety in the facility. Client #2 has a behavioral history of punching, kicking and picking at holes in the walls at the facility. He perceives the facility as his home to do as he wants. He physically attacked on Client #1 on 1/25/20 which created fear and uncertainty in Client #1 as to whether Client #2's aggression would reoccur. The Program Integrity Administrator/Supervising Qualified Professional (PIA/SQP) responded to Client #2's behavior within 10 days after the 1/25/20 incident with a treatment team meeting and development of a written behavior support plan with strategies, which was not implemented as of 2/17/20. The PIA/SPQ did not implement additional staffing in the facility after the night of the 1/25/20 incident to increase safety measures although Client #2 legal guardian's perception was that Client #2 would benefit from the additional one-on-one (1:1) attention when all 3 clients were present in the home. The PIA/SPQ did not notify Client #1's and Client #3's mental health provider after the 1/25/20 to determine if they needed an additional	V 289		

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V 289	Continued From page 36 counseling session and/or if additional strategies were needed in their treatment plan. The staff had the perception that group home rules or guidelines for Client #2 did not apply to him he was to be treated differently from Client #1 and Client #3, which placed all 3 clients at risk for serious neglect regarding having their individualized needs met. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (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. (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. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:	V 290		

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V 290	Continued From page 37 (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 (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. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to be staffed to meet to the individualized needs of 3 of 3 clients (Client #1, Client #2 and Client #3). The findings are: Review on 2/18/20 of Client #1's record revealed: -Date of admission: 2/1/16; -Diagnoses: Mild Intellectual Developmental Disability (IDD), Adjustment Disorder with Mixed Anxiety and Depressed Mood, Adult Physical	V 290		

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V 290	Continued From page 38 Abuse, Disorder of Written Expression; -Behavioral history included shyness, difficulty understanding his verbal communications of his wants and needs, lying about incidents, elopement and setting fires; -His 8/1/19 treatment plan revealed a statement that "[Client #1] requires around the clock monitoring to ensure his safety." Review on 2/18/20 of Client #2's record revealed: -Date of admission: 6/1/09; -Diagnoses: Smith-Magenis Syndrome (SMS), Attention-Deficit Hyperactivity Disorder (ADHD), Intermittent Explosive Disorder, Moderate IDD; -Behavioral history included yelling and screaming at staff, punching and kicking holes in the facility's walls, physical fights with other clients, stealing items (e.g., keys, earphones, food) from staff, other clients, and the facility kitchen), and elopement; -His 12/1/19 treatment plan included a statement that "[Client #2] requires constant supervision and some supports and prevention of stealing, tantrums/emotional outbursts, self-injurious behaviors, wandering, and mental health maintenance;" -His plan acknowledged Client #2 had behaviors that indicated he "high jacks" the facility at times so the other clients cannot go out if there was not backup staff available. Review on 3/3/20 of Client #3's record revealed: -Date of admission: 6/1/09; -Diagnoses: Schizoaffective Disorder, Oppositional Defiant Disorder, Mild/Moderate IDD, Diabetes, Asthma, Sleep Apnea; -Her 7/1/19 treatment plan included a statement that "[Client #3] requires 24-hour supervision." Review on 2/18/20 of a printed North Carolina	V 290		

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	MHL081-082	A. BUILDING: _____ B. WING _____	C 03/05/2020

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V 290	Continued From page 39 Incident Response Improvement System (IRIS) report with an incident date of 1/25/20 revealed: -Client #2 physically attacked Client #1 in his bedroom over a belief Client #1's earphones belonged to him, which led to law enforcement involvement with Client #2 and a hospital visit for Client #1. Review on 3/3/20 of written staff communication logs from 12/1/19 through 2/26/20 revealed: -On 12/9/19, between 8:00 AM-4:00 PM, the HM wrote that Client #1 had stayed home from his day program due to a swollen red eye and he had a medical appointment the next morning; -Her note added that Client #2 did not get up so Client #3 could be taken to her appointment; -On 12/18/19, between 4:00-12:00 PM, Staff #1 wrote that, "[Client #2] wouldn't let us leave;" -She described Client #2's mood as "horrible," and he was "hateful to everyone;" -On 1/25/20, between 8:00 AM-8:00 PM, Staff #4 referred to Client #2's behavior log, and Staff #2's note dated 1/25/20 indicated Client #2 returned to the facility for 30 minutes prior to the onset of his physical aggression toward Client #1; -On 2/3/20, between 4:00-12:00 PM, Staff #1 wrote "[Client #2] wouldn't let us leave;" -On 2/12/20, between 4:00-12:00 PM, Staff #1 wrote "[Client #2] wouldn't let us leave-grumpy mood." Observation on 3/3/20 from 4:49 pm to 5:00 pm revealed: -Client #1 walked by himself along the road of the facility; -He stopped approximately 500 feet away from the driveway, turned around, walked past the facility in the opposite direction near the driveway at the house beside the facility before he turned around and returned to the facility;	V 290		

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V 290	Continued From page 40 -There were no staff present with Client #1 to monitor him during his walking routine; -The facility was in a populated residential area and had multiple apartment complexes located beside the facility on the right and across from the facility which led to the main road. Interviews on 2/17/20 and 3/3/20 with Client #1 revealed: -2/17/20, He was transported by ambulance when he went to the hospital emergency department (ED) after Client #2 attacked him; -No staff met him at the hospital until he was ready to come home; -Staff #4 transported him back to the facility; -He acknowledged he felt scared returning to the facility because he did not know if Client #2 was still mad; -3/3/20, He walked outside as part of his exercise program and the weather permitted him; -He did not indicate whether staff or Client #3 walked with him when he exercised outdoors. Observation and interview on 2/17/20 at approximately 1:45 pm with Client #2 revealed: -He had been asleep in his bedroom; -He walked into the living room, sat on the couch, and limited his verbal responses to "yes" and "no" and refused to answer open-ended questions; -He did not attend the workshop with Clients #1 and #3; -His verbal communication was directed toward Staff #5 by asking her various questions; -He went bowling this morning with a family member. Interview on 2/24/20 with Client #2's legal guardian revealed: -Client #2 had a history of having an individual worker to be with him daily;	V 290		

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V 290	Continued From page 41 -He believed Client #2 would benefit from a one-on-one (1:1) staff when Clients #1 and #3 are present at the home because once Clients #1 and #3 were at home, there was more opportunity for Client #2's routine to be broken and his behaviors to happen. Interview on 2/17/20 with Client #3 revealed: -She confirmed Client #2 fought with Client #1 over headphones; -She was in her bedroom when the fight started in Client #1's bedroom; -Client #2 had Client #1 down on the floor; -She got out of her bedroom with Staff #4's help, and she sat in Staff #2's van until local law enforcement came and calmed Client #2 down; -The incident made her nervous but when Client #1 calmed down, she went back inside the home and went to bed; -She had never been hit by Client #2 and was not afraid of him; -She asked if Client #1 was going to be moved because Client #2 and a former client who had lived there had fought and the former client was moved. -She had a close friendship with Client #1. Interview on 2/17/20 with Staff #4 revealed: -She was starting work as Staff #2 was going off her shift on 1/25/20 around 8:00 PM when Client #2 walked into the kitchen with his electronic tablet; -She asked him about the games he had played that day and she told him that it was getting time to lock his tablet up for the night; -Locking up his electronics was a rule set by Client #2's guardian; -He said he still wanted to play his game; -He did not appear ill or upset when he made this statement;	V 290		

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V 290	Continued From page 42 -"He turned around, mumbled something under his breath, I heard a noise and the next thing, he was on top of [Client #1]." -Staff #2 tried to talk Client #2 off Client #1, Client #3 was in her bedroom, and she (Staff #4) went into the kitchen and called local emergency services; -When Client #1 went out the front door and Client #2 went out the back door, she got Client #3 into the van outside for safety and they waited on local law enforcement; -Client #1 ran back inside and into his room where Staff #2 blocked Client #2's entry; -Local law enforcement struggled about 30 minutes with Client #2 before he calmed down; -Client #1 went by ambulance without a staff to a local ED where he was medically evaluated and discharged about 2 hours later without treatment provided; -She transported Client #1 back to the facility; -Client #1 cried and was scared on his way back to the facility because he did not know what to expect when he returned; -The HM stayed as a second staff at the facility overnight because they did not know what had triggered Client #2's aggression toward Client #1; -That night, Client #2 stayed up on the living room couch until around 3:00 am and stared at her and the HM as if he were trying to intimidate them. Interview on 2/18/20 with the HM revealed: -She came into the facility on 1/25/20 around 10:00 PM and stayed overnight until 8:00 AM on 1/26/20 as a 2nd staff member to provide continuous supervision to Clients #1, #2 and #3; -Client #2 remained on the couch that night and stared at her and Staff #4 as part of his intimidation behavior; -He generally stood in the hallway and stared at staff as his intimidation behavior toward staff;	V 290		

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V 290	Continued From page 43 -Client #1's face was "puffy and red" with no visible bruises or unusual marks when he returned from the ED with Staff #4 on 1/25/20; -This was the 2nd time Client #2 hit Client #1 because Client #2 thought the earphones Client #1 had were his; -She was Client #2's 1:1 staff on Mondays through Fridays, from 8:00/8:30 AM- 3:30 PM; -She took him on outings (shopping, to the bank, out to eat, with her to other client scheduled appointments) when Client #2 agreed to go on the outings. -She stated that sometimes Staffs #3 and #6 would come in to help but were not always available. Interviews from 2/17/20 through 2/24/20 with current and former staff revealed: -Each staff requested anonymity with their following disclosures; -They did not know when Client #2 would have behaviors; -His behaviors were not predictable; -His behaviors were random, and ranged from yelling and cursing to punching holes in the walls to poking staff (Former Staff #6) and hitting current and former peers (Client #1 and Former Client #4 who moved to another group home); -The monthly calendar that had the scheduled outings and medical appointments was locked up in the medication cabinet because staff observed that Client #2 was "shutting down" on those scheduled dates (he refused to go on the outings and accompany staff to take Clients #1 and #3 to their scheduled appointments) when the calendar was posted in open view; -Although Client #2 was getting better about going on outings when it came to eating out, Client #2 had to be first gotten interested in the outing and in the car before Clients #1 and #3 got	V 290		

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V 290	Continued From page 44	V 290		

in the car; otherwise, if Client #2 said he was not going on the outing, nobody ended up going out;
-"If [Client #2] doesn't want to go somewhere, we don't go anywhere;"
-" There's not enough staff to call in for 20-30 minutes to stay with [Client #2] long enough to run an errand or to take one of the others to an appointment every time he refuses to go."

Interviews on 2/18/20 and 2/26/20 with the Program Integrity Administrator/Supervising Qualified Professional (PIA/SQP) revealed:
2/18/20, She "followed" Client #2 for 15 years and was educated about his SMS diagnosis;
-Client #2's behaviors have varied and included hitting the walls, stealing from stores, and elopement;
-His behaviors "cycled" (reoccurred), and he was remorseful after his negative behaviors;
-His treatment team met on 2/4/20 to address Client #2's aggressive behaviors;
-She had requested his residential services be increased from Level 3 to Level 4, which meant more funding for additional staff;
-"We don't have funding right now to pay someone to sit there with him;"
-Client #2's 1:1 worker was with him all day Monday through Friday from around 8:00 AM to 3:00 PM while Clients #1 and #3 were at the workshop;
-In the past, Client #2 had Level 4 services which paid for a 1:1 staff to come in the facility in the afternoons for outings and he refused to leave the facility;
-His service level was decreased "some time ago" from a Level 4 to a Level 3 because there was no one to accurately monitor a behavior support plan and he no longer had "big behaviors" such as urination in the floor, elopement, and stealing from stores;

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V 290	Continued From page 45 -Because Client #2's behavior on 1/25/20 was triggered by a family event he witnessed prior to his return to the facility that evening, she was implementing a plan that whoever picked Client #2 from the facility or dropped him off a visit had to talk with staff to report any events he may have seen or any of his behaviors; -Client #2's Level 4 services will include the 1:1 staff to individually process events and/or his feelings after he returns from visits, a behavior support plan, individual therapy sessions 3-4 times a month and staff training by the behavior specialists 2-3 times a month; -2/26/20, She stated that a 1:1 staff with Client #2 would be used "as we need it;" -She stated an additional 1:1 staff was not a requirement for the Level 4 service and would be provided to Client #2 when he needed extra supervision in the community or when he had a "bad day." This deficiency is cross-referenced into 10A NCAC 27G 5601 Scope (V289) for a Type A1 and must be corrected within 23 days.	V 290		