STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-288	A. BUILDING: _____ B. WING _____	R-C 04/09/2020

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INDEPENDENT LIVING GROUP HOME AT OLD SALISI	2415 OLD SALISBURY ROAD WINSTON-SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 4/9/2020. The complaints were substantiated (intake #NC161434 & NC161694). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.	V 000		
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	V 110		

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V 110	Continued From page 1 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, 1 of 3 audited staff (the House Manager (HM)) and 1 of 1 former staff (FS # 2) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Review on 3/10/2020 of client #1's record revealed: - Admission date: 7/13/2017 - Diagnoses: Major Depressive Disorder; Post Traumatic Stress Disorder (PTSD); Cocaine Abuse, uncomplicated; Moderate Intellectual Disability; Seizure Disorder; - A treatment plan dated 11/1/2019 that revealed a history of self-injury, tantrums/emotional outbursts, may make statements about and attempt to harm herself if she does not get her way, property destruction, wandering, substance abuse, stealing, and hospitalizations due to suicide attempts; - Documentation of treatment at a local hospital emergency department (ED) on 1/23/2020 for "suicidal ideation, homicidal", and on 2/2/2020 for "psychiatric evaluation" Review on 3/11/2020 of FS #2's employee record revealed: - Hire date: 9/6/2019 as a paraprofessional - Termination date: 2/26/2020 - Documentation of client-specific training for	V 110		

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client #1 on 9/9/2019.

Review on 3/11/2020 of the HM's employee record revealed:
- Hire date: 9/3/2019 as a paraprofessional House Manager;
- Documentation of client-specific training for client #1 on 9/5/2019.

Observation at approximately 3:45PM on 3/10/2020 of the facility's interior revealed:
- A doorway in the dining room/kitchen area opened into a bathroom that contained a washer and dryer alcove and storage space;
- The door to the bathroom/laundry area was locked;
- No chemicals or cleaning supplies were present in unlocked areas accessible to clients.

Review on 3/10/2020 of the on-line Incident Response Improvement System (IRIS) reports for the facility revealed:
- At an unknown time on 2/25/2020, "[Client #1] told the staff (FS #2) on 2/25/2020 that she swallowed a bleach tablet and the staff (FS #2) did not seek medical treatment. The staff did not notify the QP (Qualified Professional) or the Director of the group home. When we spoke with the staff on 2/26/2020 about the incident he stated that he did not think she took the tablet."
- "[Client #1] was taken to the emergency room on the morning of 2/26/2020 and labs were done which came back normal."
- The Health Care Personnel Registry (HCPR) was notified of an allegation of neglect by FS #2.
- The allegation of neglect was substantiated, and FS #2 was terminated from employment.

Interview on 3/11/2020 with client #1 revealed:
- On 2/25/2020, client #1 had been thinking about

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her children, and this caused her to feel suicidal;
- She had not seen her children in several years;
- Client #1 told FS #2 that "I miss my kids and stuff ... They (facility staff) really don't care ..."
- Client #1 then obtained a bleach tablet from the laundry room area and swallowed the tablet;
- Client #1 told FS #2 that she had swallowed the bleach tablet "right after that. I said, 'What will this do to me?' He (FS #2) laughed and said 'Nothing. It will make you throw up and have the s**t's' ... About five minutes later, I had to go throw up ..."
- FS #2 was the only staff present at the time client #1 swallowed the bleach tablet;
- The day after the incident, client #1 and client #3 got into an argument which required police intervention;
- Client #1 told the police that she had swallowed the bleach tablet, which resulted in facility management being notified and client #1 getting medical treatment at a local hospital ER;
- The incident could have been prevented if facility staff had talked to her and asked her what was wrong.

Interview on 3/11/2020 with client #2 revealed:
- On 2/25/2020, client #2 could not provide details about what happened to client #1 because "I basically got out of the way as quick as possible."
- Facility staff stored the bleach tablets on a shelf in the laundry area;
- Facility staff usually kept the door to the laundry area locked;
- Clients were allowed to use the bleach tablets for cleaning, but facility staff watched clients when they did use them to ensure clients did not ingest the tablets.

Interview attempt with client #3 on 3/11/2020 was unsuccessful due to client #3 having a behavioral incident at the time the interview was planned.

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V 110	Continued From page 4 Interview on 3/12/2020 with FS #2 revealed: - On 2/25/2020, client #1 had a bad day at the day program, which impacted client #1's behavior when she returned to the facility that afternoon; - FS #2 and the HM were working at the facility that evening; - While FS #2 was trying to complete paperwork, client #1 repeatedly asked if she could walk to a nearby sister facility; - FS #2 told client #1 to wait; - Client #1 got into a verbal altercation with client #3; - After client #3 called client #1 a "b***h," client #1 walked away from the facility to a pasture behind the facility; - FS #2 walked with client #1 and attempted to get her to return to the facility - Client #1 sat on the side of the road for approximately 20 minutes; - FS #2 asked client #3 to get the HM from the facility for him; - Client #1 continued to try to walk away from the facility for another 15-20 minutes before FS #2 could get her to return to the facility by bribing her with a cigarette; - This incident occurred at approximately 3:00 or 3:30pm; - After the facility clients ate their dinner later that evening, the HM left to go pick up dinner for himself; - Client #1 may have obtained a bleach tablet from the laundry area while FS #2 was cleaning up after dinner; - FS #2 had unlocked the door to the laundry room/staff bathroom area in order for client #1 to get the mop bucket, a mop and a cleaning product; - The bleach tablets were stored in the locked laundry room/staff bathroom;	V 110		

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- Client #1 was able to independently prepare mop water;
- Client #1 did not tell FS #2 that she had swallowed the bleach tablet. Rather, she asked what would happen if she did eat one;
- FS #2 told client #1 that he did not know, but that she would probably throw up or have diarrhea as that is what the label on the bleach tablet had listed;
- Approximately 8-10 minutes later, client #1 began throwing up;
- Client #1 then went to bed;
- Client #1 may have gotten out of bed to go to the bathroom or get some water during the remainder of FS #2's shift;
- Client #1's incident involving swallowing the bleach tablet occurred at approximately 7:30-7:45pm;
- FS #2 told the HM about the incident when the HM returned to the facility around the time that clients were going to bed;
- Other than telling the HM about client #1's questions about the bleach tablet and her throwing up, FS #2 did not know what else to do;
- When asked if FS #2 thought that client #1 may have actually swallowed the bleach tablet when she began throwing up, he replied: "Yes ... I called the team lead (the HM) and let him handle it ... I guess that's why I got suspended ..."

Interview on 4/8/2020 with the HM revealed:
- On 2/25/2020, client #1 had been upset because she wanted to go to the hospital after she ran out of cigarettes;
- The HM left the facility after dinner to pick up food for himself;
- When the HM returned, FS #2 told the HM about client #1 saying she ate a bleach tablet;
- The HM talked to client #1 around 7:00pm;
- Client #1 told the HM that she was "okay";

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V 110	Continued From page 6 - The HM checked on client #1 several times until client #1 cursed at him and told the HM "don't come in here (into client #1's bedroom) no more. I'm fine."; - The HM did not believe client #1 could have eaten the bleach tablet because they were locked up in the staff office area; - No report of the incident was made to the Qualified Professional or the Director because the HM and FS #2 did not believe client #1 consumer the bleach tablet; - The next day, client #1 was taken to the hospital ED because she had seizures; - There were no results from the hospital that indicated that client #1 had actually swallowed bleach; -The QP and the Director met with the HM and FS #2 on 2/26/2020 about the incident; - The HM was placed on suspension, and FS #2 was terminated. Interview on 4/8/2020 with the Qualified Professional (QP) revealed: - On 2/26/2020, the QP found out about client #1 allegedly swallowing a bleach tablet the night before after client #1 had an incident at the day program requiring police intervention; - As soon as the QP found out about client #1 stating that she swallowed a bleach tablet, the QP and Director had client #1 transported to the local hospital ED for treatment; - In investigation was conducted immediately into the reasons the HM and FS #2 did not report the incident the night before; - The QP did not know why the HM or FS #2 did not inform the QP that client #1 said she swallowed a bleach tablet; - The QP did not think that there had been any bleach tablets in the facility for several months; - FS #2 was terminated and the HM was placed	V 110		

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V 110	Continued From page 7 on suspension the same day that the QP found out about the incident. - There had not been any previous issues with FS #2 or the HM's treatment of clients. Interviews on 4/8/2020 and 4/9/2020 with the Director revealed: - The Director did not find out about client #1 saying she swallowed a bleach tablet until the next morning (2/26/2020); - The HM and FS #2 should have immediately notified the QP and the Director of the incident; -As soon as the Director learned of the incident, client #1 was sent to a local hospital ED for evaluation and treatment; - FS #2 was terminated on 2/26/2020 due to the manner in which he responded to the Director as she was investigating the incident; - FS #2 did not recognize the severity of the incident, nor seem to be bothered that it had occurred; - There had never been any previous issues with FS #2's job performance; - The HM was placed on suspension, and no decision had yet been made about whether he would be allowed to return to work at the facility; - The Director met with all the other facility staff within two days of the incident and informally spoke with them about reporting incidents and providing appropriate supervision of client #1; - The Director had planned to conduct a formal training with all staff but had been unable to because a state of emergency related to Covid-19 went into place before the training could be coordinated.	V 110		