Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL024-092 02/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **403 WASHINGTON STREET** WASHINGTON HOUSE WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 A complaint and follow up survey was completed on February 25, 2020. The complaint was unsubstantiated (Intake #NC00161268). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. V 132 G.S. 131E-256(G) HCPR-Notification, V 132 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). Facilities must have evidence that all alleged acts are investigated and must make every effort Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES-SIGNATURE

TITLE

STATE FORM

KQRC11

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING MHL024-092 02/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) V 132 Continued From page 1 V 132 to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the Health Care Any allegations against health care personnel will be Submitted into the Iris system section of Allegations of abuse/Neglects. Personnel Registry was notified of all allegations against health care personnel. The findings are: Review on 2/25/2020 of the Group Home 3-20-20 Manager's personnel file revealed hire date 11/1/2010. Review on 2/25/2020 of client #6's record revealed: -18 year old female admitted 4/1/19. Diagnoses included schizoaffective disorder. bipolar type; mild intellectual developmental disorder; asthma; borderline diabetes; anemia; and, unspecified trauma/and stressor related disorder. Review on 2/25/2020 of the internal investigation, signed 2/11/2020, for an allegation of abuse by client #6 against the Group Home Manager revealed: -The Department of Social Services (DSS)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CORRECTION	DENTIFICATION NOMBER.	A. BUILDING:		COMP	CETED
	·	MHL024-092	B. WING		02/2	₹ 25/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WASHIN	GTON HOUSE	403 WASI	HINGTON ST	REET		
WASHIN	GION HOUSE	WHITEVIL	LE, NC 284	172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 132	Continued From pa	ge 2	V 132			
	arrived at the Licen	see's day support program				
	after receiving a rep	port of abuse from client #6's				
		2020. The high school				
	reported an allegation	on by client #6 "regarding				
		igation documented, "After all				
	findings occurred, if	t was determined that client				
		e situation because she wants				
		e an go home to her family to finish going to school				
		nd to be unsubstantiated.				
	Client has a history of telling untruths to get her way."					
	-No further actions documented.	or reporting were				
	Interview on 2/25/20 stated:	020 the Group Home Manager				
		ed on administrative leave				
		5/2020 for an investigation of				
	-The allegation occi	against her by client #6. urred on 1/31/2020.				
	Interview on 2/25/20	020 the QP stated:				
		allegation that the Group				
	Home Manager hit	her on 1/31/2020. ade aware of the allegation on				
		employee was placed on	!			
	administrative leave					
		mployee at her high school				
		manager on 1/31/2020. The				
		ed DSS, and DSS made a port program owned by the				
		iving the report on 2/7/2020.				
	-The facility determ	nined the allegation was				
	unsubstantiated.					
	- I ne facility had not against the Group k	t reported the allegation Home Manager to the Health				<u> </u>
	Care Personnel Re					
		<i>yy</i> -				

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: _____ B. WING 02/25/2020 MHL024-092 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **403 WASHINGTON STREET** WASHINGTON HOUSE WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 366 V 366 Continued From page 3 Carolinas Hone Care Agency-enc Will implements the proper reoponse to all Level 2 3/20/20 and Level 3 incidents as V 366 27G .0603 Incident Response Requirments V 366 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: required by DHHS. All attending to the health and safety needs (1)internal investigations will be documented and of individuals involved in the incident: (2)determining the cause of the incident: (3) developing and implementing corrective Securely Kept for later review. No transitioning any client will be permitted unless authorited for measures according to provider specified timeframes not to exceed 45 days; developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days: (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures: that service on site. adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164: and maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond

MHL024-092 NAME OF PROVIDER OR SUPPLIER WASHINGTON HOUSE WASHINGTON HOUSE R 02/25/2020 STREET ADDRESS, CITY, STATE, ZIP CODE 403 WASHINGTON STREET WHITEVILLE, NC 28472 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
MAME OF PROVIDER OR SUPPLIER **ASHINGTON HOUSE** **ASHINGTON HOUSE** **ASHINGTON HOUSE** **ASHINGTON HOUSE** **ASHINGTON STREET** WHITEVILLE, NC 28472** **TAG** **CROCK DEFICIENCY WIST BE PRECEDED BY FULL TAGE (FACH CORRECTIVE ACTION SHOULD BE CARS - REPERLED TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D	AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:	1 ' '			
MALE OF PROVIDER OR SUPPLIER WASHINGTON HOUSE WASHINGTON HOUSE WASHINGTON TREET WHITEVILLE, NC 28472 (X4) ID SUMMARY STATEMENT OF DEFICIENCES WHITEVILLE, NC 28472 (X4) ID SUMMARY STATEMENT OF DEFICIENCES WHITEVILLE, NC 28472 V 366 Continued From page 4 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and complete team within 24 hours of the incident. The internal review team shall consist of individuals who were not responsible for the clients direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME lent resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and		!	!			[,
MASHINGTON HOUSE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG V 366 Continued From page 4 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and to transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall complete all off the activities as follows: (A) review the copy of the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all off the activities as follows: (A) review the copy of the client excord to determine the facts and causes of the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all off the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within thre months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME lent resides, if different; and (E) Where the client resides, if different is the client resided, if different is client resided and to the LME where the client resided, if different is the client resided, if different is client resided. The		!	MHL024-092	B. WING		•	
CAN ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLET TAG V 366	NAME OF	PROVIDER OR SUPPLIER	STREET ADI		•	<u> </u>	
Company Comp	WASHIN	GTON HOUSE					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 366 Continued From page 4 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact stabil be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The					I		
by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
(1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The	V 366	Continued From pa	ige 4	V 366			
identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not		by: (1) immediate by: (A) obtaining to (B) making a (C) certifying (D) transferring review team; (2) convening review team within to the convening the convening the convening the convening the convening the convening the time review team shall convening to the convening the convening to	the client record; a photocopy; a the copy's completeness; and and the copy to an internal 24 hours of the incident. The m shall consist of individuals wed in the incident and who alle for the client's direct care or onal oversight of the client's of the incident. The internal complete all of the activities as a copy of the client record to and causes of the incident endations for minimizing the endations for the incident. The shall written report signed by the months of the incident. The endations of the incident. The endations of the incident. The endations of the incident and to the entresides, if different. The shall address the issues ernal review team, shall ocuments pertinent to the make recommendations for turrence of future incidents. If				

Division (of Health Service Re	egulation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.= 1=0
	•				R	
		MHL024-092	B. WING		02/2	5/2020
				TATE TO CODE		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
WASHING	STON HOUSE		INGTON ST			
***************************************		WHITEVIL	LE, NC 284			
(X4) ID		TEMENT OF DEFICIENCIES	ID D	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
IAG		,		DEFICIENCY)		
14,000	Osstinus d Faces no		V 366			
V 366	Continued From pa	ige o	V 300			
		ee months of the incident, the				
	LME may give the	provider an extension of up to	}			
		bmit the final report; and				Ï
	\ <i>I</i>	ely notifying the following:	1			
	(A) the LME r	esponsible for the catchment				
		vices are provided pursuant to				
	Rule .0604; (B) the LME	where the client resides, if				
	different;	Whele the chefit resides, ii				
		der agency with responsibility				
		l updating the client's				
		ifferent from the reporting				
	provider;					
	(D) the Depar					
		's legal guardian, as				
	applicable; and					
	(F) any other	rauthorities required by law.				
	This Rule is not m	et as evidenced by:				
		eviews and interviews, the				
	facility failed to imp	element a written policy				
	governing their res	ponse to Level II and III				
	incidents as require	ed. The findings are:				
		20 of client #6's record				
	revealed:	4/4/4				
	-18 year old female					
		ed schizoaffective disorder,				
		ntellectual developmental				
		oorderline diabetes; anemia; auma/and stressor related				
	disorder.	aumaranu siressoi reialeu				
		f Approvals by the Managed				
		(MCO) for Residential				

KQRC11

PRINTED: 03/04/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R B. WING MHL024-092 02/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) V 366 V 366 Continued From page 6 Supports Level 4, and Community Networking Service. No approval for Day Support Services. Review on 2/25/2020 of client #6's North Carolina Incident Response Improvement System (IRIS) report for incident dated 1/31/2020 revealed: -1/31/2020 client #6 ran from staff. Staff caught the client and led her back to the group home. Client #6 became physically aggressive and hit the staff. Staff placed client #6 in a therapeutic hold to de-escalate the behavior. -The restrictive intervention sections of the IRIS report had not been completed. -There was no documentation regulatory policy requirements were implemented to include developing and implementing corrective measures with timeframes; developing and implementing measures to prevent similar incidents with timeframes; or, assigning person(s) to be responsible for implementation of the corrections and preventive measures. Review on 2/25/2020 of client #6's IRIS report for incident dated 2/6/2020 revealed: -The facility identified in the IRIS report was the Whiteville Day Supports (See interview with the Qualified Professional (QP) below.) -2/6/2020 client #6 arrived at the day support program after her modified day of school instruction. Client #6 became verbally aggressive, began pushing furniture, then charged at a staff with a spray can in an effort to hit the staff. The staff took the can from the client; client #6 began fighting and hitting the

Division of Health Service Regulation

staff. The staff put client #6 in a therapeutic hold.
-The restrictive intervention sections of the IRIS

-There was no documentation regulatory policy requirements were implemented to include developing and implementing corrective

report had not been completed.

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 02/25/2020 MHL024-092 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 366 Continued From page 7 V 366 measures with timeframes; developing and implementing measures to prevent similar incidents with timeframes; or, assigning person(s) to be responsible for implementation of the corrections and preventive measures. Review on 2/25/2020 of the internal investigation, signed 2/11/2020, for an allegation of abuse by client #6 against the Group Home Manager revealed: -No documentation of convening a meeting of an internal review team within 24 hours of the incident. (See QP and Group Home Manager Interviews for date facility aware of allegation.) -The Department of Social Services (DSS) arrived at the Licensee's day support program after receiving a report of abuse from client #6's high school on 2/7/2020. The high school reported an allegation by client #6 "regarding incident that occurred on 1/31/2020." -The internal investigation did not identify specific allegations or concerns investigated. -The Group Home Manager was taken out of work until the investigation was over. (Dates of leave not documented. (See interviews with the QP and Group Home Manager for dates.) -The internal investigation documented, "After all findings occurred, it was determined that client had manipulated the situation because she wants to leave group home an go home to her family and does not want to finish going to school... Allegation was found to be unsubstantiated. Client has a history of telling untruths to get her way." -No further actions or reporting were documented. Interview on 2/25/2020 client #6 stated: -She liked the Group Home Manager. She would seek out the manager when she needed to talk

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
	<i>t</i>				,	R
	!	MHL024-092	B. WING			25/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE	<u> </u>	OI E O E O
WASHIN	IGTON HOUSE		HINGTON ST			!
***			LLE, NC 284	1'		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 366	Continued From pa	ane 8	V 366			
		ige o			!	
!	with someone.	the season will a miniff	1		!	
ı		any altercations with staff. en put in a therapeutic hold.			i	
1		en put in a therapeutic hold. en mistreated by a staff.			i	
ŀ	-Sile Had Hevel boo	Illistreated by a stant			i	
ŀ	Telephone interviev	w on 2/25/2020 the MCO staff			i	
		t services were not part of			i	
	client #6's approved	d services for Residential			i	
	Supports Level 4, a	and Community Networking			i	
	Service.	- -			i	
	Interview on 2/25/20 stated:	2020 the Group Home Manager			l	
		ced on administrative leave			i	
. !		/5/2020 for an investigation of	l j		ļ	
!		against her by client #6.	l j		ļ	
	-The allegation occi	curred on 1/31/2020.	l j		ļ	
	-On 1/31/2020 clien	nt #6 had been on a bowling			i	
	outing. Following th	he outing, they returned to the			i	
		m and then, back to the group			i	
		ing to the group home client			i	
	#6 became physica	ally aggressive. She "darted		·	i	
	Out into traine.	e Group Home Manager put peutic wrap. There was			i	
		ne Manager there that helped			i	
	"talk client #6 down	1 P			i	
					ĺ	
Í	Interview on 2/25/20			l	İ	
. !		allegation that the Group			l	
ļ	Home Manager hit I				l	
1		nesses to this allegation	1	ı	I	
J		clients were at their day nanager was the only staff on			1	
ļ	program and the ma	anager was the only stanton in	1		ļ	
ļ	1 2	ade aware of the allegation on	1		ļ	
ļ	1/31/2020 and the e	employee was placed on	1		I]
J	administrative leave	e on 1/31/2020.			İ	
	-Client #6 told an er	mployee at her high school			I	
	she was hit by the n	manager on 1/31/2020. The	1		I	
	high school contact	ted DSS, and DSS made a			I	

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ 02/25/2020 B. WING MHL024-092 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 366 Continued From page 9 V 366 visit to the day support program owned by the Licensee. -Client #6 did not attend the day support program for services. On 2/6/2020, the staff and client #6 arrived at the day support program to pick up other facility clients to "transition" them back to the facility. V 367 V 367 27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (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: reporting provider contact and (1) identification information: client identification information; (2)(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. (b) Category A and B providers shall explain any missing or incomplete information. The provider

Division of Health Service Regulation

KQRC11

PRINTED: 03/04/2020 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING MHL024-092 02/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 367 Continued From page 10 V 367 shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit. upon request by the LME, other information obtained regarding the incident, including: hospital records including confidential (1) information: (2) reports by other authorities; and (3)the provider's response to the incident, (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

Division of Health Service Regulation

(1)

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).

(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:

medication errors that do not meet the

restrictive interventions that do not meet

definition of a level II or level III incident;

the definition of a level II or level III incident:

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 02/25/2020 MHL024-092 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 367 Continued From page 11 V 367 (3)searches of a client or his living area; (4) seizures of client property or property in the possession of a client; the total number of level II and level III incidents that occurred; and 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) through (4) of this Paragraph. All level 2 and Level 3
incident reports will be
reported within the 72
hour catchment period
within gaining Knowledge
of the incident. When
all clients are placed in
a therapeutic hold to This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II and level III incidents to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incidents. The findings are: Review on 2/25/2020 of client #6's record revealed: -18 year old female admitted 4/1/19. -Diagnoses included schizoaffective disorder, bipolar type; mild intellectual developmental disorder; asthma; borderline diabetes; anemia; and, unspecified trauma/and stressor related de-escalate an disorder. aggressive behavior, the restrictive intervention Section will be completed -12/18/19 Notice of Approvals by the Managed Care Organization (MCO) for Residential Supports Level 4, and Community Networking Service. No approval for Day Support Services. Review on 2/25/2020 of client #6's North Carolina in the IRIS system. Incident Response Improvement System (IRIS) report for incident dated 1/31/2020 revealed:

Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING MHL024-092 02/25/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 367 V 367 Continued From page 12 -1/31/2020 client #6 became physically aggressive and hit the staff. Staff placed client #6 in a therapeutic hold to de-escalate the behavior. -The restrictive intervention sections of the IRIS report had not been completed. Review on 2/25/2020 of client #6's IRIS report for incident dated 2/6/2020 revealed: -The facility identified in the IRIS report was Whiteville Day Supports, not the facility rendering services at the time of the incident. -2/6/2020 client #6 arrived at the day support program after her modified day of school instruction. Client #6 became verbally aggressive, began pushing furniture, then charged at a staff with a spray can in an effort to hit the staff. The staff took the can from the client; client #6 began fighting and hitting the staff. The staff put client #6 in a therapeutic hold. -The restrictive intervention sections of the IRIS report had not been completed. Review on 2/25/2020 of the internal investigation for an allegation of abuse by client #6 against the Group Home Manager on 1/31/2020 revealed: -The Department of Social Services (DSS) arrived at the Licensee's day support program on 2/7/2020 after receiving a report of abuse from client #6's high school. The high school reported an allegation by client #6 "regarding incident that occurred on 1/31/2020." -No level III IRIS report had been submitted. Interview on 2/25/2020 the Group Home Manager stated: -She had been placed on administrative leave from 1/31/2020 - 2/5/2020 for an investigation of an allegation made against her by client #6.

Division of Health Service Regulation

-The allegation occurred on 1/31/2020.

PRINTED: 03/04/2020 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ R B. WING 02/25/2020 MHL024-092 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (X5) COMPLETE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 367 V 367 Continued From page 13 Interview on 2/25/2020 the QP stated: -Client #6 made an allegation that the Group Home Manager hit her on 1/31/2020. -The facility was made aware of the allegation on 1/31/2020 and the employee was placed on administrative leave on 1/31/2020. -Client #6 told an employee at her high school she was hit by the manager on 1/31/2020. The high school contacted DSS, and DSS made a visit to the day support program owned by the Licensee after receiving the report from the high school on 2/7/2020. -Client #6 did not attend the day support program for services. On 2/6/2020, the staff and client #6 arrived at the day support program to pick up other facility clients to "transition" them back to the facility. -The allegation of abuse had been unsubstantiated by the facility; therefore, a level III IRIS report had not been submitted. Refer to V366 for additional information. V 500 V 500 27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59. G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: all instances of alleged or suspected (1)

Division of Health Service Regulation

G.S. 7A, Article 44; and

abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or

procedures and safeguards are instituted in accordance with sound medical

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
Alle I	Of CONTECTION	IDENTITION TO THE STREET	A. BUILDING:			
		MHL024-092	B. WING		02/2	R 2 5/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WASHIN	IGTON HOUSE		HINGTON ST LLE, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	present serious risk Particular attention neuroleptic medicar (c) In addition to the 10A NCAC 27E .01 each facility shall determine that identifies: (1) any restrict prohibited from use (2) in a 24-hounder which staff at the rights of a client (d) If the governing	nose procedures prohibited in 102(1), the governing body of levelop and implement policy ictive intervention that is a within the facility; and our facility, the circumstances are prohibited from restricting it.				
	restrictive interventithe restrictions of clause-62(b) and (d) identify: (1) the permiallowed restrictions (2) the individent the client; and (3) the due prinvoluntary client with restrictive interventities. If restrictive interventities within the facility, the develop and implend compliance with Sulvariance with Sulvariance to use provide written authorestrictive interventities interventities. The design has been trained and competence to use provide written authorestrictive interventities interventities. The design has been trained and accordance with the NCAC 27E .0104(e)	tions or if, in a 24-hour facility, client rights specified in G.S.) are allowed, the policy shall itted restrictive interventions or is; dual responsible for informing process procedures for an who refuses the use of tions. The reventions are allowed for use the governing body shall ment policy that assures subchapter 27E, Section .0100, anation of an individual, who had who has demonstrated a restrictive interventions, to horization for the use of tions when the original order is a total of 24 hours in the time limits specified in 10A				

Division	<u>of Health Service Re</u>	egulation			T		
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE :		
AND FLAN	OF CONNECTION		A. BUILDING:		_		
			B. WING		R		ı
		MHL024-092	D. WING		02/2	5/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
1575 61 1161	OTON HOUSE	403 WASH	IINGTON ST	REET			
WASHIN	GTON HOUSE	WHITEVIL	LE, NC 284	72			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 500	Continued From pa	nge 15	V 500				
	responsible for revi interventions; and (3) the estab appeal for the reso	iews of the use of restrictive lishment of a process for lution of any disagreement se of a restrictive intervention.					
	Based on record re facility failed to rep suspected abuse, i to the County Depa The findings are:	et as evidenced by: eviews and interviews, the ort all instances of alleged or neglect or exploitation of clients artment of Social Services . 20 of the Group Home nel file revealed hire date		all allegeded allegations of all or exploitation of elients will be rep to DSS within all of being reporte	buse fa orted 4 how	3/20/2	C
	Review on 2/25/20 revealed: -18 year old female -Diagnoses include bipolar type; mild ir disorder; asthma; l	20 of client #6's record e admitted 4/1/19. ed schizoaffective disorder, ntellectual developmental porderline diabetes; anemia; auma/and stressor related		of being reporte	d.		
	for an allegation of Group Home Mana -The investigation was aware of the atthe Group Home M -The investigation Department of Sociof the allegation or been notified by the -The investigation	20 of the internal investigation abuse by client #6 against the ager revealed: did not document the facility allegation by client #6 against fanager on 1/31/2020. did not document the cial Services (DSS) was notified a 1/31/2020 before DSS had be high school on 2/7/2020. did not document the dates fanager had been suspended					

PRINTED: 03/04/2020 FORM APPROVED

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: _ B. WING 02/25/2020 MHL024-092 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 500 V 500 Continued From page 16 pending the investigation. -The investigation documented the DSS arrived at the Licensee's day support program after receiving a report of abuse from client #6's high school on 2/7/2020. The high school reported an allegation by client #6 "regarding incident that occurred on 1/31/2020." Interview on 2/25/2020 the Group Home Manager stated: -She had been placed on administrative leave from 1/31/2020 - 2/5/2020 for an investigation of an allegation made against her by client #6. -The allegation occurred on 1/31/2020. Interview on 2/25/2020 the QP stated: -Client #6 made an allegation that the Group Home Manager hit her on 1/31/2020. -The facility was made aware of the allegation on 1/31/2020 and the employee was placed on administrative leave on 1/31/2020. -The facility had not reported the allegation against the Group Home Manager to DSS. V 521 V 521 27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION. PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized. documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being: (B) notation of the frequency, intensity and

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING MHL024-092 02/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 521 V 521 Continued From page 17 duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior: (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used: (D) a description of the intervention and the date. time and duration of its use: (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions: (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion. physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. all clients placed in a therapeutic hold will be documented in IRIS and in the group home note. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document the minimum requirements for restrictive interventions in the client record. The findings are: Review on 2/25/2020 of client #6's record revealed: -18 year old female admitted 4/1/19. Diagnoses included schizoaffective disorder, bipolar type; mild intellectual developmental disorder; asthma; borderline diabetes; anemia; and, unspecified trauma/and stressor related

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ B. WING 02/25/2020 MHL024-092 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **403 WASHINGTON STREET WASHINGTON HOUSE** WHITEVILLE, NC 28472 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 521 Continued From page 18 V 521 disorder. No documentation of restrictive interventions on 1/31/2020 or 2/6/2020. Review on 2/25/2020 of client #6's North Carolina Incident Response Improvement System (IRIS) report for incident dated 1/31/2020 revealed: -1/31/2020 client #6 ran from staff. Staff caught the client and led her back to the group home. Client #6 became physically aggressive and hit the staff. Staff placed client #6 in a therapeutic hold to de-escalate the behavior. -The restrictive intervention sections of the IRIS report had not been completed. Review on 2/25/2020 of client #6's IRIS report for incident dated 2/6/2020 revealed: -2/6/2020 client #6 arrived at the day support program after her modified day of school instruction. Client #6 became verbally aggressive, began pushing furniture, then charged at a staff with a spray can in an effort to hit the staff. The staff took the can from the client: client #6 began fighting and hitting the staff. The staff put client #6 in a therapeutic hold. -The restrictive intervention sections of the IRIS report had not been completed. Interview on 2/25/2020 the Group Home Manager stated: -On 1/31/2020, after returning to the group home. client #6 became physically aggressive. She "darted out into traffic." The Group Home Manager put client #6 in a therapeutic wrap. There was another Group Home Manager there that helped "talk client #6 down." Interview on 2/25/2020 the QP stated: -Client #6 was put in a therapeutic hold at the facility by the Group Home Manager on

	of Health Service Re		0.00 1.00	CONCEDUCTION	(X3) DATE S	SURVEY
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	COMPLE		ETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
					R	
		MHL024-092	B. WING		02/2	5/2020
			NODER OTV S	TATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER					ļ
WASHIN	GTON HOUSE		HINGTON ST			
***************************************			LLE, NC 284		rioti I	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 521	Continued From pa	age 19	V 521			
	1/31/2020.					
	-Client #6 was with	facility staff at the day	1			
	program on 2/6/20:	20 to pick up other clients to				
	"transition" all of th	em back to the facility. Client	1			
	#6 became upset,	became aggressive, and was				
	put in restraint while	le on site at the day program.				
	!					
1						
			1			

Carolinas Home Care Agency, Inc. P.O. Box 1723

Whiteville, NC 28472

Phone: 910-642-3700; Fax: 910-642-5146

FACSIMILIE COVER SHEET

Company Name: NCDHSR Attention: Onya Bridges Fax Number: 919 715 8078 Circle one: URGENT REPLY ASAP TOTAL # OF PAGES, DICT.	From: Cletha Journes Date: 5-13-20 Phone Number: 9106423700 PLEASE REVIEW FOR YOUR INFO
URGENT REPLY ASAP TOTAL # OF PAGES, INCLU	PLEASE REVIEW FOR YOUR INFO
COMMENTS: Sorry	for the Oversight. 24 092 POC