Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-176	A. BUILDING: _____ B. WING _____	04/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES GROUP HOMES LLC	2201 RILEY ROAD KINSTON, NC 28504

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V 000	INITIAL COMMENTS A complaint survey was completed on April 27, 2020. The complaint was substantiated (intake #NC00161196). 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	This plan of correction is submitted to serve as credible allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.	
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.	V 110	Citation #1 V110 27G .0204 Training/Supervision Paraprofessionals Staff #12 Hire Date was 02/17/2020. What measures will be put in place to correct deficiencies? A staff meeting was held on April 10th, 2020. The purpose of the meeting was to review each client's crisis intervention plan, discuss de-escalation techniques, review client's rights/protection from abuse and harm. Also, confidentiality, infection control, and documentation reporting were addressed during the meeting. Lastly, all staff has been notified that the crisis intervention telephone number has been visibly posted on all company vehicle and in the facility effective April 24th, 2020. Staff #12 attended the meeting on April 10th, 2020. Staff #12 was suspended without pay for a week due failure to de-escalate the incident on March 30th, 2020. Staff was subsequently transitioned from working in the facility due to threats of bodily harm made by Client #5 directed to Staff #12.	6/15/2020

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V 110	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 Paraprofessionals audited (Staff #12) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 4/24/2020 of Staff #12's personnel information revealed: -Hire date requested, not received. -Employed as a Personal Care Aid -NCI+ (National Crisis Intervention Plus) - Prevention training completed 2/14/2020. -Certificate of completion for online education course, "Understanding Alzheimer's and Dementia" on 3/1/2019. Review on 4/24/2020 of client #5's record revealed: -55 year old male admitted December 2018. -Diagnoses included seizure disorder, dementia, mood disorder, and Rhabdomyolysis. (The breakdown of damaged skeletal muscle.) -Client #5's "Crisis Prevention and Intervention Plan" documented a history of becoming "agitated and exhibiting inappropriate behavior." Early intervention strategies to help client #5 avoid a crisis included: -Remove peers/others from around him when he gets agitated and is exhibiting inappropriate behavior. -Encourage him to use anger management and coping skills.	V 110	What measures will be put in place to prevent the problem from occurring again? A training will be completed by June 15th, 2020 pertaining to core competency skills. The following core skills that will be reviewed including technical knowledge, cultural awareness, analytical skills, decision-making; interpersonal skills, communication skills, and clinical skills. The entire ISP of each client will be reviewed with all staff by the QP by June 15th, 2020. QP will continue to conduct monthly staff supervisions, document observations, and interventions. Who will monitor the situation to ensure it will not occur again and how often? The QP will continue to monitor each staff monthly and review company policies and procedures to ensure compliance. Also, Resident Service Director will monitor the facility weekly to ensure compliance of policies and procedures for the company and safety of the clients.	

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V 110	Continued From page 2 -If staff "feels" client #5 is becoming agitated, he should be allowed to retreat to a quiet and calm place. Review on 4/27/2020 of Staff #12's "Employee Reprimand" signed 3/31/2020 revealed: -"Date of Discipline Action Given" and "Date of occurrence," documented 3/30/2020. -"Description of Violation: Failure to de-escalate client behavior appropriate" -"Description of Corrective Actions to be Taken: Reviewed each client's crisis intervention plan, de-escalation techniques client's rights/protection from abuse and harm. Posted intervention Crisis telephone number in company vehicles and in facility effective 04/24/2020. QP (Qualified Professional) will continue to monitor each staff monthly to ensure compliance." -Signatures documented for QP and Staff #12 and dated 3/31/2020. Review on 4/24/2020 of the undated internal incident "In House Report" signed by the QP revealed: -"Date/Time of Accident/Incident: 3/30/2020 at 3:45p" -"Date/Time of Notification of Administrator/Supervisor: 3/30/2020 at 4:20pm(approximately)" -While transporting the clients back to their residence from an outing, the staff, [Staff #12] asked 2 clients to adjust the volume level down on their "walkie talkies." -"One of the residents with a walkie-talkie replied to her using profanity (b....)." -Client #5, who had no radio, stated, "Black b...., I will kill you." -"[Staff #12] asked [client #5] not to call her that term. (Do not call me a black b...)" -Client #5 moved from his 3rd row seat to the row	V 110		

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behind Staff #12.
-"[Staff #12] pulled the van over ... when the staff noticed that [client #5] changed his seating directly behind her."
-She stopped the van and client #5 proceeded to walk toward the staff. Staff #12 exited the van and "slammed the door while fearing that [client #5] was going to attack her."
-Staff #12 called "911."
-"When police arrived [client #5] proceeded to get out of the van and started walking towards the staff. A police officer interjected and proceed to talked with the client, [client #5]."
-The Licensee arrived, checked client #5 and found no physical bruises or bleeding.
-Staff #7 relieved Staff #12 and transported the clients back to the facility.

Interview on 4/22/2020 client #5 stated:
-Staff #12 slammed the van door in client #5's face. The door hit his nose and made it bleed. Client #5 had told the Licensee what happened.
-All of the clients were in the van when this happened.
-Staff #12 had the van radio "blasting wide open."
-They had just left the other group home where they had dropped off other residents.
-Staff #12 had pulled the van to the side of the road.
-He (client #5) could not wear his glasses for too long because his nose would start to hurt.

Interview on 4/22/2020 client #3 stated:
-He (client #3) was in the van when client #5 was hit by the van door, hurting his nose and hand. Client #5's nose and hand bled.
-Clients #1 and #4 had their radios turned up loud. Staff #12 "yelled" at them and told them to "turn it down."
-Staff #12 pulled the van over to the side of the

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road.
-Staff #12 started yelling and cursing after she pulled over. Clients #1 and #4 were "arguing" with Staff #12 and client #5 was getting upset.
-After Staff #12 pulled the van over she got out. Client #5 started toward the door. Staff #12 was on the outside and slammed the door, hitting client #5.
-Staff #12 "called the cops on him (client #5)."
-The Licensee was called and came.
-The police talked to Staff #12 and the Licensee.
-After the clients "settled down," Staff #7 was called and drove them home.
-Staff #12 liked to "yell and curse." Staff #12 had never cursed at him and did not target any particular person. She worked the afternoon shift.

Interview on 4/22/2020 client #2 stated:
-Staff #12 and client #5 were "fussing at each other." Staff #12 pulled the van over to the side of the road. He did not hear Staff #12 curse, but he heard client #5 curse. Client #5 was mad; he did not know why.
-Staff #12 got off the van and slammed the door.
-Client #5 did not try to get out of the van and did not get hurt.
-The police had client #5 get off the van and talk. Everything calmed and everything was "all ok" after that.
-Staff #7 drove them home

Interview on 4/22/2020 client #6 stated:
-He (client #6) was on the van when client #5 got hurt.
-Staff #12 was cursing at client #5.
-Client #5 was upset.
-Staff #12 pulled the van to the side of the road and started cursing.
-Staff #12 got off the van.
-Staff #12 shut the door on client #5 and he was

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V 110	Continued From page 5 hit in the nose. Interview on 4/22/2020 client #4 stated: -He (client #4) was sitting in the front seat. Staff #12 turned up the van radio "real loud." -Staff #12 was upset because client #1 had his radio also turned up too loud. -Staff #12 looked at him (client #4) and said something to him about his radio, but he did not have his radio turned on. He was on his phone. -Staff #12 was arguing and said she was calling the Licensee. -Staff #12 pulled the van over. -Client #5 and Staff #12 started cursing and name calling each other, "going back and forth." -Client #5 got up from the back seat and started rushing up front. Staff #12 got off the van and shut door in client #5's face. -Staff #12 said she was calling "911" and the police showed up. -When the cops came client #5 got off the van. Then the Licensee showed up. -There had been a couple of times before this incident when Staff #12 got upset and cursed at everyone on the van. -Staff #12 had cursed at him once, then told the Licensee he (client #4) "was in the middle of everything and starting trouble." -When Staff #12 was "having a bad day seems she gets upset with everybody." Staff #12 worked from "3-11." -The Resident Service Director had been told about Staff #12 cursing. Staff #12 made sure no one was around when she cursed. -Client #5 was bleeding from his nose. He did not know what they did about this. Interview on 4/23/2020 client #1 stated: -He (client #1) could not recall a situation when he was on the van and Staff #12 had to pull over	V 110		

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V 110	Continued From page 6 to the side of the road. -Client #1 could not recall any information to share. Interview on 4/23/2020 Staff #7 stated: -On 3/30/2020 she was called to transport the clients to the facility from where Staff #12 had pulled the van over. -When she arrived client #5 was out of the van talking with the police. -Client #5 looked upset but she could not say what made him look upset. -The other clients were on the van. -Staff #7 did not see any blood on client #5's face or nose. After Staff #7 drove the van back to the facility, she worked the evening shift. -Client #5 never complained of pain and she never saw any injuries. -The distance between where Staff #12 had pulled the van over to the side of the road was about a 20 minute drive to the facility. -The distance between where Staff #12 had pulled the van over was very close, "just around the corner," to the sister facility. Interview on 4/23/2020 the responding Police Officer stated: -When the Officer arrived on the scene client #5 was irate at Staff #12 and agitated. Staff #12 was "cool, calm, collected." The Officer did not know why the client was upset, but they were able to calm him down. -Client #5 told the Officer that he hurt his nose. Client #5 said he was trying to get out of the van and the door hit his nose. The Officer did not see any blood on client #5's face or any other injuries. -Staff #12 reported to the Officer that she was taking the clients to their group home when client #5 began calling her names. Staff #12 pulled the van over when client #5 threatened to hit her.	V 110		

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V 110	Continued From page 7 Staff #12 said she had to "hop out of the van." The Officer understood from Staff #12 she did this for her safety. -This incident happened near a "T" intersection very close to the sister facility they had just left. The sister facility was located near the corner of the "T" intersection. After leaving the sister facility, Staff #12 made a left turn. She had stopped the van about 3 houses down from the "T" intersection. -When the Officer arrived Staff #12 had walked away from the van and was standing approximately 1½ houses away from the van going toward the intersection, talking on her phone. The van could be seen from where she stood. Client #5 was standing beside the van. He was not moving toward Staff #12, but that may have been because he heard the police coming. -Three (3) police cars responded to the scene from 3 different directions. All other clients stayed on the van. He did not speak to any of the other clients. Interview on 4/22/2020 Staff #12 stated: -The incident happened on 3/30/2020. -It had been a "good day" and she had dropped off the clients at a sister facility. -She then proceeded to make a turn to transport the clients to their facility. -The van radio was "on" and the clients had turned on their "walkie talkies." -She pulled the van over and told them to turn off their "walkie talkies." -Client #4 cursed at her and called her a "b***h." -She was talking to client #4 when client #5 "went off" on her and called her a "black b***h." -She had never seen client #5 "go off" like that before. -She told client #5 he shouldn't talk to staff like that. Client #5 continued to call her a "b***h," and	V 110		

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said, "I'll kill you."
-She tried to calm him down but it didn't work. He started toward her with his hands up, and she got off the van. Client #5 closed the van door.
-She stated, "I think he scratched himself up."
-She called "911."
-If client #5 had any scratches it was because he was hitting himself inside the van.
-She saw a small scratch on client #5's nose and it was red.
-She did not know how he could have hit his nose. "He put them bruises on himself."

Interview on 4/23/2020 the Resident Service Director stated:
-Her position was similar to a group home manager. In her role as the Resident Service Director she may address issues with staff, or may address staff issues along with the Licensee and the Qualified Professional.
-She heard of one incident recently when a client was "acting out" and tried to hit Staff #12 and the staff closed the door.
-She had never had a client complain about Staff #12 before.
-She had never heard a staff cursing at the clients.

Interviews on 4/9/2020 and 4/22/2020 the Licensee stated:
-On 3/30/2020 Staff #12 had to pull the van over because of client #5's aggressive behaviors.
-Some of the other clients on the van were playing music loudly on their radios and she (Licensee) thought this may have contributed to client #5's behaviors.
-Staff #12 told client #5 to calm down, and he "went off."
-Client #5 said Staff #12 slammed the door on him.

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V 110	Continued From page 9 -Staff #12 told the Licensee she (Staff #12) slammed the door to keep client #5 from "getting to her." -Staff #12 called "911" because client #5 was threatening her and saying he was going to get her fired, and she (Staff #12) was afraid client #5 was going to attack her. -The Licensee checked client #5 for injuries and he had a red spot over the bridge of his nose and he said his hand was sore from hitting the door. -Staff #12 denied cursing at the clients. -Staff #12 told the Licensee that client #5 would call her a "B" and use a curse word. Staff #12 would repeat back to client #5 in his own word, "I'm not a "*** B," to say she was not whatever he called her. -Staff #12 was transferred to work at another home because client #5 said he was going to "get her fired." -There was no mention Staff #12 had been suspended or received additional training for failure to de-escalate client behaviors appropriately. Review on 4/24/2020 of a "Plan of Protection" signed and dated on 4/24/2020 by the QP revealed: -"What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm. Staff that was involved in the incident on March 30th, 2020 on the company van was suspended without pay and written up for her infraction of failure to deescalate the incident effective March 30th, 2020. A staff meeting was held on April 10th, 2020 at 10am - 12:30pm. The purpose of the meeting was to review each client's crisis intervention plan, discuss de-escalation techniques, review client's rights/protection from abuse and harm. Also, confidentiality, infection	V 110		

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V 110	Continued From page 10 control, and documentation reporting were addressed during the meeting. Lastly, all staff has been notified that the crisis intervention telephone number has been visibly posted on all company vehicle and in the facility effective April 24th, 2020." -"Describe your plans to make sure the above happens. The QP will continue to monitor each staff monthly and review the topics listed about to ensure compliance with protection plan. Any staff that violates this plan will be suspended or terminated." Client #5 was admitted in December 2018, with diagnoses including dementia, mood disorder, and a history of becoming agitated and displaying inappropriate behavior. Early intervention strategies listed in client #5's plan included to remove peers/others from around him and allow him to retreat to a quiet and calm place. On 3/30/2020 Staff #12 was driving 6 clients in the van around 3:45 pm. Staff #12 began to yell at clients #1 and #4 for having their radio volume too loud. Staff #12 pulled the van over to the side of the street, called 911, and as a result, 3 police units responded. Staff #12 began cursing and name calling with client #5. Client #5's behaviors escalated to the point Staff #12 became afraid for her safety. Staff #12 exited the van, and slammed the van door, hitting client #5 in the face. Client #5 and 5 other clients were left in the van without a staff inside the van. This placed client #5 and his peers in an unsafe environment which was detrimental to their health, safety and welfare. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 110		

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V 132	Continued From page 11	V 132	V132	5/20/2020
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132	**What measures will be put in place to correct deficiencies?** **The HCPR Report will be completed by, May 20th, 2020 to correct deficiency V 132.** **What measures will be put in place to prevent the problem from occurring again?** **The Resident Service Director and QP have reviewed the requirements for filing allegations of abuse, neglect, exploitation, and death to the Health Care Personnel Registry.** **Licensee, QP, and Residential Director were not informed of ANY allegations of abuse by Client #5 until a state reviewer presented the allegation on April 27th, 2020 via phone. Client #5's complaint to state surveyor to do not concur with investigations conducted the police and licensee on March 30th, 2020. In the event of any future incidents, the QP, Licensee, and/or Resident Service Director will interview all residents and staff that witness each accident or incident separately. Each individual will complete a written statement with signatures to ensure accurate allegations of abuse, neglect, or exploitation is known and reported. QP and/or Resident Service Director will report all known alleged allegations of abuse, neglect, or exploitation to the HCPR within 24 hours.** **The QP will continue to monitor each staff monthly and review company policies and procedures to ensure compliance.** **Also, Resident Service Director will monitor the facility weekly to ensure compliance of policies and procedures for the company and safety of the clients.**	

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V 132	Continued From page 12 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the Health Care Personnel Registry (HCPR) of all allegations of abuse against health care personnel. The findings are: Review on 4/24/2020 of the North Carolina Incident Response Improvement System (IRIS) reports for the facility between 3/1/2020 and 4/24/2020 revealed there were no level III reports for allegations of abuse on 3/30/2020 by client #5 against Staff #12. Review on 4/22/2020 and 4/24/2020 of client #5's record revealed: -55 year old male admitted December 2018. -Diagnoses included seizure disorder, dementia, mood disorder, and Rhabdomyolysis. Review of on 4/24/2020 of the facility "In House Report" signed by the QP revealed: -"Date/Time of Accident/Incident: 3/30/2020 at 3:45p" -"Date/Time of Notification of Administrator/Supervisor: 3/30/2020 at 4:20pm(approximately)" -Staff #12 became fearful that client #5 might attack her. Staff #12 stopped and got off the van. Staff #12 "slammed the door. -There was no documentation the HCPR had been notified of an allegation of abuse by client #5 against Staff #12.	V 132	Who will monitor to ensure it will not occur again? QP/Resident Service Director will monitor and discuss any complaints with the Licensee and submit a report if warranted according to state guidelines.	

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V 132	Continued From page 13 Interview on 4/22/2020 client #5 stated: -Staff #12 slammed the van door in his face, hit his nose and made it bleed. -Client #5 had told the Licensee what happened. Interviews on 4/22/2020 clients #2, #3, #4, and #6 stated: -All clients recalled the van incident that happened on 3/30/2020. -Clients #3, #4, and #6 reported client #5 was hit when Staff #12 shut or "slammed" the van door. -Client #3 and #4 stated client #5's nose bled. -Clients #4 and #6 stated Staff #12 was cursing at client #5. Interview on 4/22/2020 the Licensee stated: -Client #5 said Staff #12 "slammed the door on him." -Staff #12 told the Licensee she (Staff #12) slammed the door to keep client #5 from getting to her. -The Licensee checked client #5 for injuries and he had a red spot over the bridge of his nose. Client #5 said his hand was sore from when he hit the door. -The Licensee had done an internal incident report of the van incident on 3/30/2020 with Staff #12 and client #5.	V 132		
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	V 289		

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V 289	Continued From page 14	V 289	V 289 **What measures will be put in place to correct deficiencies? A comprehensive /MR Clinical assessment was updated for Client #5 on 5/11/2020 by licensed specialist (MS, LCAS) to re-determine diagnosis. The results concluded that the Client # has a F70.0 (Mild Intellectual Developmental disability) diagnosis. A copy of the assessment is available for review at the facility.** **What measures will be put in place to prevent the problem from occurring again?** **Before admission of future individuals, QP will request a psychological evaluation and FL2 to ensure compliance of 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.** **Who will monitor to ensure the situation will not occur again and how often?** **Each client's file will be audited quarterly by the QP to ensure admission compliance.**	5/11/2020

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;
(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

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V 289	Continued From page 15 .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 and interviews the facility failed to meet the scope of the license by admitting an individual without a diagnosis of a developmental disability. The findings are: Review on 4/24/2020 of the facility's license revealed it was licensed as a 10A NCAC 27G .5600C Supervised Living For Adults With Developmental Disabilities. Review on 4/24/2020 of client #5's record revealed: -55 year old male admitted December 2018. -Diagnoses included seizure disorder, dementia, mood disorder, and Rhabdomyolysis. Interviews 4/24/2020 the Qualified Professional (QP) stated: -He would look through client #5's record to see if there was a developmental disability. -He would contact client #5's guardian to see if she had a documented developmental disability diagnosis.	V 289		

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V 289	Continued From page 16 -He would send documentation of a developmental disability diagnosis if one was documented. Interview on 4/27/2020 the Guardian stated she confirmed with her supervisor client #5 did not have a developmental disability diagnosis. There was no documentation of a developmental disability diagnosis received from the Licensee or QP.	V 289		
V 366	27G .0603 Incident Response Requirments 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: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) 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; (6) 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 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.	V 366	366 6/25/2020 **The Internal Review Committee convened via conference call on May 11th, 2020 at 6:15pm. The final report of the will be completed, signed by the Licensee, and sent to the LME/MCO by June 25th, 2020.** **What measures will be put in place to prevent the problem from occurring again?** **The Licensee will schedule a meeting with the members of the Internal Review Committee within 24 hours of complaint made to facility of a Level III incident.** **Who will monitor to ensure it will not occur again?** **QP/Resident Service Director will monitor and discuss any complaints with the Licensee and submit a report if warranted according to state guidelines.**	

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V 366	Continued From page 17 (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 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,	V 366		

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V 366	Continued From page 18 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 final written report shall address the issues 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 available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement written policies governing their response to level II and III	V 366		

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V 366	Continued From page 19 incidents as required. The findings are: Review on 4/22/2020 and 4/24/2020 of client #5's record revealed: -55 year old male admitted December 2018. -Diagnoses included seizure disorder, dementia, mood disorder, and Rhabdomyolysis. -Client #5 had a guardian. Review on 4/24/2020 of the facility "In House Report" signed by the Qualified Professional (QP) revealed: -"Date/Time of Accident/Incident: 3/30/2020 at 3:45p" -"Date/Time of Notification of Administrator/Supervisor: 3/30/2020 at 4:20pm(approximately)" -Client #5 became upset during the van transport back to their residence from an outing by Staff #12. -Staff #12 stopped the van, got off the van, and "slammed the door while fearing that [client #5] was going to attack her. She called the police." -The police arrived. -"[The Licensee] was called, when she arrived she asked [client #5] to go with her in her van." -"[Client #5] was asked if he were ok and needed medical attention. He stated no, and kept stating he would kill staff. He was encouraged to go to the hospital but still refused." -"A second staff was called and arrived to relieve [Staff #12]. [Staff #7] transported the clients back to the group home. [The Licensee] arrived later with [client #5]. A body check was done no visible bruises or bleeding noted." -"Guardian contacted concerning incident." -"The QP followed up the next day to make sure the individual were ok. [Client #5] also Refused appointment to [Mental Health Provider]." -No documentation the guardian was contacted	V 366		

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V 366	Continued From page 20 the following day and offered or discussed the need for an appointment with a mental health provider. Interviews on 4/24/2020 and 4/27/2020 client #5's guardian stated she had not been informed of an incident on 3/30/2020 or that client #5 was injured. Interview on 4/22/2020 client #5 stated: -Staff #12 slammed the van door, hitting his nose and making it bleed. -Client #5 had told the Licensee what happened. Interview on 4/22/2020 client #3 stated; -He was in the van when Staff #12 slammed the van door, hitting client #5. Client #5 hurt his nose and hand; his nose and hand bled. -Staff #12 pulled the van over to the side of the road and started yelling and cursing. -Client #5 was getting upset. Interview on 4/22/2020 client #6 stated: -Staff #12 was cursing at client #5. -Client #5 was upset. -Client #5 was hit in the nose when Staff #12 shut the door on him. Interview on 4/22/2020 client #4 stated: -Client #5 and Staff #12 started cursing and name calling each other, "going back and forth." -Client #5 got up from the back seat and started rushing up front. Staff #12 got off the van and shut door in client #5's face. -Client #5 was bleeding from his nose. Interview on 4/23/2020 the responding Police Officer stated: -Client #5 told the Officer he was trying to get out of the van and the door hit his nose. The Officer	V 366		

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V 366	Continued From page 21 did not see any blood on the client #5's face or any other injuries. -When the Officer arrived Staff #12 had walked away from the van and was standing approximately 1½ houses away from the van going toward the intersection, talking on her phone. The van could be seen from where she stood. -Client #5 was standing beside the van. He was not moving toward Staff #12, but that may have been because he heard the police coming. -Three (3) police cars responded to the scene from 3 different directions. All other clients stayed on the van. He did not speak to any of the other clients. Interview on 4/22/2020 the Licensee stated: -The Licensee had done an internal incident report of the van incident on 3/30/2020 with Staff #12 and client #5. -A level II incident report was not done because the incident did not happen in the home. -Client #5 said Staff #12 slammed the door on him. -Staff #12 said she (Staff #12) slammed the door to keep client #5 from "getting to her." -The Licensee checked client #5 for for injuries and he had a red spot over the bridge of his nose. Client #5 said his hand was sore from hitting the door. -Staff #12 called "911" and police responded. -She would fax to the surveyor the internal report and any other documentation related to the incident and investigation.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367		

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V 367	Continued From page 22 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: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:	V 367	V 367 What measures will be put in place to correct deficiencies? An IRIS report Level II report was submitted on May 15th, 2020. An IRIS report Level III will be submitted by May 20th, 2020. What measures will be put in place to prevent the problem from occurring again? The Licensee, Resident Service Director, and QP have reviewed internal policies and procedures and the IRIS manual on what constitutes a Level 1, 2, and 3 Incident and when to file an incident. QP will submit all IRIS reports within 24 state guidelines. Who will monitor to ensure the situation will not occur again and how often? The Licensee will follow-up with QP/Resident Service Director to ensure the report is submitted within state guidelines as needed.	5/20/2020

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V 367	Continued From page 23 (1) hospital records including confidential 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 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: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-176	A. BUILDING: _____ B. WING _____	04/27/2020

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V 367	Continued From page 24	V 367		

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 incident. The findings are:

Review on 4/24/2020 of the North Carolina Incident Response Improvement System (IRIS) reports for the facility between 3/1/2020 and 4/24/2020 revealed:
-There was no level II IRIS report for an incident on 3/30/2020 that resulted in staff calling the police for client #5's aggressive behavior.
-There was no level III report for an allegation of abuse on 3/30/2020 by client #5 against Staff #12.

Review of on 4/24/2020 of the facility "In House Report" signed by the QP (not dated) revealed:
-"Date/Time of Accident/Incident: 3/30/2020 at 3:45p"
-"Date/Time of Notification of Administrator/Supervisor: 3/30/2020 at 4:20pm(approximately)
-Staff #12 became fearful that client #5 might attack her. Staff #12 stopped the van, got off the van, and "slammed the door while fearing that [client #5] was going to attack her."
-Staff #12 called the police and police responded.

Interview on 4/22/2020 client #5 stated:
-Staff #12 slammed the van door in client #5's face, hit his nose and made it bleed.

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V 367	Continued From page 25 -Client #5 had told the Licensee what happened. Interviews on 4/22/2020 clients #2, #3, #4, and #6 stated: -All clients recalled the van incident that happened on 3/30/2020. -Clients #3, #4, and #6 reported client #5 was hit when Staff #12 shut or "slammed" the van door. -Client #3 and #4 stated client #5's nose bled. -Clients #4 and #6 stated Staff #12 was cursing at client #5. Interview on 4/22/2020 the Licensee stated: -The Licensee had done an internal incident report on the 3/30/2020 van incident with Staff #12 and client #5. She did not complete a level II report because the incident did not happen at the facility. -The incident occurred when Staff #12 was transporting the clients to the facility. -Client #5 said Staff #12 slammed the door on him. -Staff #12 said she (Staff #12) slammed the door to keep client #5 from getting to her because she was afraid client #5 was going to attack her. -The Licensee checked client #5 for injuries and he had a red spot over the bridge of his nose. Client #5 said his hand was sore from when he hit the door. -Staff #12 had called "911" and police responded.	V 367		
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	V 500		

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V 500	Continued From page 26 implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who	V 500	500 A report will be submitted to County Department of Social Services by May 20th, 2020. What measures will be put in place to prevent the problem from occurring again? The Resident Service Director and QP have reviewed the requirements for submitting reports to the County of Department of Social Services. The QP will continue to monitor each staff monthly and review company policies and procedures to ensure compliance. Also, Resident Service Director will monitor the facility weekly to ensure compliance of policies and procedures for the company and safety of the clients. Who will monitor to ensure it will not occur again and how often? QP/Resident Service Director will monitor and discuss any complaints with the Licensee and submit a report if warranted according to state guidelines.	5/20/2020

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V 500	Continued From page 27 has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all instances of alleged or suspected abuse to the County Department of Social Services. The findings are: Review on 4/24/2020 of the North Carolina Incident Response Improvement System (IRIS) reports for the facility between 3/1/2020 and 4/24/2020 revealed there were no level III reports for allegations of abuse on 3/30/2020 by client #5 against Staff #12. Review on 4/22/2020 and 4/24/2020 of client #5's record revealed: -55 year old male admitted December 2018. -Diagnoses included seizure disorder, dementia, mood disorder, and Rhabdomyolysis. Review of on 4/24/2020 of the facility "In House Report" signed by the QP revealed: -"Date/Time of Accident/Incident: 3/30/2020 at 3:45p" -"Date/Time of Notification of	V 500		

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V 500	Continued From page 28 Administrator/Supervisor: 3/30/2020 at 4:20pm(approximately) -Staff #12 became fearful that client #5 might attack her. Staff #12 stopped and got off the van. Staff #12 "slammed the door. -There was no documentation the County Department of Social Services had been informed of an allegation of abuse by client #5 against Staff #12, or suspected verbal abuse of client #5 by Staff #12. Interview on 4/22/2020 client #5 stated: -Staff #12 slammed the van door in his face, hit his nose and made it bleed. -Client #5 had told the Licensee what happened. Interviews on 4/22/2020 clients #2, #3, #4, and #6 stated: -All clients recalled the van incident that happened on 3/30/2020. -Clients #3, #4, and #6 reported client #5 was hit when Staff #12 shut or "slammed" the van door. -Client #3 and #4 stated client #5's nose bled. -Clients #4 and #6 stated Staff #12 was cursing at client #5. Interview on 4/22/2020 the Licensee stated: -Client #5 said Staff #12 "slammed the door on him." -Staff #12 told the Licensee she (Staff #12) slammed the door to keep client #5 from getting to her. -The Licensee checked client #5 for injuries and he had a red spot over the bridge of his nose. Client #5 said his hand was sore from when he hit the door. -The Licensee had done an internal incident report of the van incident on 3/30/2020 with Staff #12 and client #5.	V 500		