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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
	MHL026-964	A. BUILDING: ______ B. WING ______	05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE LAKES	**5104 FLATROCK DRIVE FAYETTEVILLE, NC 28311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on May 28, 2020. The complaint was unsubstantiated (Intake #NC00160949). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 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	DHSR-Mental Health JUN 24 2020 Lic. & Cert. Section	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE QP (X6) DATE 6/19/2020

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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 Former Staff (FS #6) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 04/22/2020 of FS #6's record revealed: -Hired in the year 2018, specific date not provided. -Hired as a Paraprofessional. -Separation date 02/12/2020. Review on 04/21/2020 of client #1's record revealed: -28 year old male. -Admission date of 06/26/06. -Diagnoses of Autism, Attention Deficit Hyperactivity Disorder and Obsessive Compulsive Disorder and Limited Communication. -Individual Support Plan dated 05/01/2020-"About me: [Client #1] is non-verbal, [Client #1] communicates primarily through sounds and gestures." Review 05/28/2020 of client #2's record revealed: -28 year old male. -Admission date of 07/2006. -Diagnoses of Autism, Mental Retardation and Tourette Syndrome.	V 110		

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V 110	Continued From page 2	V 110		

Review on 04/21/2020 of the facility's incident report dated 02/07/2020 revealed:
"-Director of Services [Qualified Professional (QP)] received a phone call from staff on February 7, 2020 stating that individual (client #1) had got out of the company van and went to the store next to the office (Corporate Office). Store manager came over to get a staff from the office to go get individual. Once staff went over individual was brought back to office. During this time, [FS #6] had already left the office not realizing that individual was not in van. Due to this being a situation that has never occurred, staff didn't think to turn around and check before driving off. Staff at office contacted [FS #6] asking him was he missing anyone, he stated no and turned around noticing that individual was not in the van. He immediately turned back around and went back to the office to pick up individual.
-Incident report Follow up- After speaking with [FS #6] about his incident report, [QP] stated to him that he needed to take responsibility for the bad judgment he made. It was stated for him and the individual to assist with moving a bookshelf, which means the individual should have been in the office with him. I also stated to him, that it was never communicated the individual was not allowed in the office. It was stated that if individual begins to become destructive while at the office, staff would have to escort him out due to the high number of property damage that had already occurred by [Client #1] and its hard for our office staff to focus, two in particular, if he is banging on items, stomping his feet, and yelling."

Review on 04/21/2020 of the termination letter dated 02/12/2020 for FS #6 revealed:
"-On February 7, 2020, while on shift, [FS #6] were given instructions to report to the office. [FS #6] arrived and proceeded to enter the office

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leaving two individuals, unsupervised, in the company vehicle. [FS #6] left office without making sure all individuals were in the vehicle leaving one of the individuals behind. [FS #6] received a write-up in December 2019 for a similar incident that had occurred. Due to that incident it was communicated to him, via the write up, if the policies put in place were violated again it would lead to further disciplinary action which may include termination. The incident that occurred on February 7, 2020 was a bad judgement call made by staff which threatened the safety of the individual. As a result, [FS #6] will be terminated from Shine Light, Inc. effective immediately. [FS #6] will be notified via email of any documentation that needs to be completed before receiving his last pay check."

Review on 05/27/2020 of the website Google Maps revealed aerial views of the office and location of the gas station. In front of the office was a very busy road with high traffic volume consisting of approximately 4 lanes and two turning lanes going in both directions of the road. The gas station was on the same side of the office with a small building separating the two.

Atempted interview was made with client #1 on 04/22/2020 but could not be interviewed because client #1 is mostly non-verbal and only able to make sounds and gestures to communicate.

Attempted interview was made with FS #6 on 04/22/2020 and a female answered the phone and stated FS #6 did not reside at that residence and she did not have an alternative number for him to be reached.

During interview on 05/28/2020 the gas station clerk revealed:

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-His sister was working the check out line the day of the incident.
-He was in the office when client #1 entered the store.
-Client #1 started opening honey buns and eating them.
-He told client #1 he had to pay for the items.
-He recognized client #1 as a client from the agency next to them because he had been in the store before with staff.
-He had to restrain client #1 by putting him in a sitting position and holding his hands because client #1 was upset.
-The police were called to assist and he sat with client and held his hands until the police arrived.
-Client #1 was pinching him.
-The police arrived and walked to the corporate office and told them client #1 was in the store.
-Client #1 was at the store for approximately 30 minutes.
-The police arrived and put client #1 in the back of the police car.
-A lady from the agency came over and identified client #1.
-Client #1 was making and yelling noises.

During interview on 05/28/2020 the Administrative Staff from the agency's office revealed:
-FS #6 came to the office with client #1 and client #2 to assist moving furniture in the office.
-FS #6 came in the office alone.
-No one knew he had left client #1 and client #2 in the van outside the office.
-Approximately 10 minutes later two police officers came to the office and stated one of our clients may be at the gas station next door to the office.
-She walked over to the gas station and client #1 was sitting in the back of the police officer's car.
-She went back to the office to get assistance to

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get client #1.
-She called FS #6 and told him he had left the client behind and he needed to get back to the office to get client #1.
-FS #6 did not even know he did not have client #1 in the van when he left.
-She did not know how long client #1 was at the gas station because she did not know he was left in the van.
-Client #1 was at the store opening items and eating items in the store.

During interview on 05/21/2020 and 05/28/2020 the QP revealed:
-She did not complete a Level II incident report after the incident.
-FS #6 was asked to go the office to assist in moving furniture.
-FS #6 had client #1 and client #2 when he arrived at the office.
-FS #6 did not take the clients in the office with him and left them in the van outside the office with the door open.
-Client #1 got out of the van and went to the gas station next to the office.
-Client #1 ate some cakes and the store clerk recognized him as a client from the office.
-Staff got back in the van after moving the furniture and left and did not check to see if both clients were in the van when he left the office.
-The staff from the office called FS #6 and told him he had left without client #1.
-FS #6 came back to the office to get client #1.
-FS #6 was terminated due to the incident.
-During client #1's team meeting after the incident adding elopement and wandering was going to be added to his plan as a strategy.

During interview on 05/28/2020 the Licensee revealed:

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V 110	Continued From page 7 which during that time Client #1 eloped from the van and went to a nearby gas station, near a very busy, high traffic street, where he was physically held by the clerk. The police were called and placed client #1 in the back of the police car due to eating items in the store. FS #6 did not know client #1 had eloped from the van and was negligent in checking the van before leaving the office leaving client #1. Administrative staff from the office had to identify client #1 in the police car and required additional staff assistance in returning client #1 to the office. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 110		
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	V 366		

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-She understood and knew a repercussion was going to occur after the incident.
-FS #6 was immediately terminated after the incident due to his poor judgement.
-Client #1 does not have a one to one worker and she has tried to get those services for client #1 and continues to get denied even though the need is evident.

Review on 05/28/2020 of the Plan of Protection dated and completed by the QP on 05/28/2020 revealed:
-"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? In order to correct the above violation, Shine Light, Inc. will continue to train all staff, old and new, on all policies highlighting on the most important such as the supervision policy. We continue to train on the importance of making sure everyone is making, and understand the importance of making good judgement decisions in order to maintain safety, health and wellness of all individuals served.
-Describe your plans to make sure the above happens. Shine Light, Inc. management, or designated trainer, will make sure through training, testing and required online training, all staff remain competent in all areas. Shine Light, Inc. will add, making sure everyone is in place before movement of any vehicle, to our van policy safety check list."

Client #1 was a 28 year old male with diagnoses of Autism, Attention Deficit Hyperactivity Disorder and Obsessive Compulsive Disorder that had very limited ways of communicating and was mainly non-verbal. On February 7, 2020 FS #6 left client #1 and client #2 in a van unsupervised while he went into the office to move furniture in

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V 366	Continued From page 8 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. (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	V 366		

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V 366	Continued From page 9 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 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.	V 366		

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V 366	Continued From page 10	V 366		

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to implement written policies governing their response to level I and level II incidents. The findings are:

Review on 04/21/2020 of client #1's record revealed:
-28 year old male.
-Admission date of 06/26/06.
-Diagnoses of Autism, Attention Deficit Hyperactivity Disorder and Obsessive Compulsive
Disorder and Limited Communication.

Review on 04/21/2020 of the facility's incident report dated 02/07/2020 revealed:
"-Director of Services [Qualified Professional (QP)] received a phone call from staff on February 7, 2020 stating that individual (client #1) had got out of the company van and went to the store next to the office. Store manager came over to get a staff from the office to go get individual. Once staff went over individual was brought back to office. During this time, [FS #6] had already left the office not realizing that individual was not in van. Due to this being a situation that has never occurred, staff didn't think to turn around and check before driving off. Staff at office contacted [FS #6] asking him was he missing anyone, he stated no and turned around noticing that individual was not in the van. He immediately turned back around and went back to the office to pick up individual.
-Incident report Follow up- After speaking with

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V 366	Continued From page 11 [FS #6] about his incident report, [QP] stated to him that he needed to take responsibility for the bad judgment he made. It was stated for him and the individual to assist with moving a bookshelf, which means the individual should have been in the office with him. I also stated to him, that it was never communicated the individual was not allowed in the office. It was stated that if individual begins to become destructive while at the office, staff would have to escort him out due to the high number of property damage that had already occurred by [Client #1] and its hard for our office staff to focus, two in particular, if he is banging on items, stomping his feet, and yelling." - No documentation of corrective or preventive measures according to provider specified timeframes. -She did not complete a Level II incident report after the incident. -FS #6 was asked to go the office to assist in moving furniture. -FS #6 had client #1 and client #2 went he arrived at the office. -FS #6 did not take the clients in the office with him and left them in the van outside the office with the door open. -Client #1 got out of the van and went to the gas station next to the office. -Client #1 ate some cakes and the store clerk recognized him as a client from our office. -Staff got back in the van after moving the furniture and left and did not check to see if both clients were in the van when he left the office. -The staff from the office called FS #6 and told him he had left without client #1. -FS #6 came back to the office to get client #1. -FS #6 was terminated due to the incident. -During client #1's team meeting after the incident adding elopement and wandering was going to be	V 366		

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V 366	Continued From page 12 added to his plan.	V 366		
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: (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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE LAKES	5104 FLATROCK DRIVE FAYETTEVILLE, NC 28311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 13 (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: (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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COLLEGE LAKES	**5104 FLATROCK DRIVE FAYETTEVILLE, NC 28311**

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V 367	Continued From page 14	V 367		

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.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to report all level II 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 04/21/2020 of client #1's record revealed:
-28 year old male.
-Admission date of 06/26/06.
-Diagnoses of Autism, Attention Deficit Hyperactivity Disorder and Obsessive Compulsive
Disorder and Limited Communication.

Review on 04/21/2020 of the North Carolina Incident Response Improvement System (IRIS) revealed no IRIS report for the following incident.

Review on 04/21/2020 of the facility's incident report dated 02/07/2020 revealed:
"-Director of Services [Qualified Professional (QP)] received a phone call from staff on February 7, 2020 stating that individual (client #1) had got out of the company van and went to the store next to the office. Store manager came over to get a staff from the office to go get

Division of Health Service Regulation

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	MHL026-964	A. BUILDING: ____ B. WING ____	05/28/2020

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V 367	Continued From page 15 individual. Once staff went over individual was brought back to office. During this time, [FS #6] had already left the office not realizing that individual was not in van. Due to this being a situation that has never occurred, staff didn't think to turn around and check before driving off. Staff at office contacted [FS #6] asking him was he missing anyone, he stated no and turned around noticing that individual was not in the van. He immediately turned back around and went back to the office to pick up individual. -Incident report Follow up- After speaking with [FS #6] about his incident report, [QP] stated to him that he needed to take responsibility for the bad judgment he made. It was stated for him and the individual to assist with moving a bookshelf, which means the individual should have been in the office with him. I also stated to him, that it was never communicated the individual was not allowed in the office. It was stated that if individual begins to become destructive while at the office, staff would have to escort him out due to the high number of property damage that had already occurred by [Client #1] and its hard for our office staff to focus, two in particular, if he is banging on items, stomping his feet, and yelling." During interview on 052/21/2020 and 05/28/2020 the QP revealed: -She did not complete a Level II incident report after the incident.	V 367		

Findings	Corrective Measures	Preventive Measures	Responsible Party	Time Frame	
10A NCAC 27G . 0204 Competencies and Supervision of Paraprofessionals	Agency has began restructuring our training curriculum that will consist of different teaching methods for ex. Online videos, and 1-1 classroom training. The agency has scheduled a training that will deal with topics such as behavior modification and service delivery. We are also working on changing systems to make sure policies are being carried out.	Upon hire and thereafter, all staff will continue to be trained on competency and the agency's supervision policy. Any staff violating policies, depending on severity of incident, automatically be terminated	QP	23 days	
10A NCAC 27G .0603 Incident response requirements for category A and B providers	Agency was not given time to fully investigate and report incident before it was reported by someone else and the incident began an outside	In the event an incident occurs that directly threatens the health, safety and welfare of an individual, the QP and/or admin staff will immediately contact the members of the	QP Human Rights Committee Admin Staff	60 days	

	investigation. Qualified Professional immediately responded to incident once it was brought to her attention, immediately removing staff from schedule.	HRC to come together and review incident within 5 days of the day incident occurred			
10A NCAC 27G .0604 Incident Reporting requirements for category A and B providers	The understanding of when to report consumer behavior was not clear. QP has reviewed the IRIS policy to gain a more understanding of at what point consumer behavior becomes a Level 2 incident that needs to be reported	Any incident that occurs of this nature will be submitted into IRIS within the appropriate time frame	QP Admin Staff	60 days	