STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HILLPARK GROUP HOME	175 ELSON AVENUE HENDERSONVILLE, NC 28739

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V 000	INITIAL COMMENTS A complaint survey was completed on 9/18/20. The complaint was substantiated (Intake #NC00167324). 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	DHSR - Mental Health NOV 0 2020 Lic. & Cert. Section	
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision	V 109	The Director of Operations, Regional Vice President of Operations, or Quality Assurance Specialist will provide weekly supervision of the Administrator and QP/Program Specialist. The supervision is documented weekly and includes: Needs of people supported in the home (Behavioral, Adaptive Equipment and Medical), guardian contacts (issues or concerns), staffing and ensuring appropriate staff ratio, and any other operational needs for the home. Supervision of the Administrator and QP/Program Specialist will be completed weekly for the next 60 days through weekly Supervision Meetings and then on a routine basis through Corporate QA Assessments, review of Discipline Sign In sheets to ensure presence in the home, routine chart reviews, and observations conducted by the Director of Operations, Regional Vice President of Operations, or Quality Assurance Specialist. In the future Operations will ensure Qualified Professionals have the skill, knowledge and competencies to complete all required job responsibilities. By: 10-20-20	

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V 109	Continued From page 1 plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that 1 of 1 Qualified Professionals (QP #1) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 9/15/20 of medical records emailed from the guardians of Client #1 on 9/7/20 and 9/15/20 revealed: -Date of Admission: 9/3/19. -Age 42. -Diagnoses: Spastic Quadriplegic Cerebral Palsy, Chronic static encephalopathy, partial epilepsy, chronic pain, flexion contractures, neurogenic bladder, chronic constipation, spasticity, gastroesophageal reflux disease (GERD, gastrointestinal tube (G tube) developmental delay, blindness, diabetes, c difficile enterocolitis, dysphagia, anxiety, non-verbal, and is bed bound with total care. Diet: -History and physical dated 8/8/19 reported: "Continued g tube feeding at night and is on a pureed diet with thin liquids during the day." -Hospital Evaluation of the feeding tube date 10/3/19 reported: Client #1 was seen with a group home caregiver who reported Client #1 recently	V 109		

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V 109	Continued From page 2 moved to the group home and they (staff) were interested in having her feeding tube changed to a different type of low-profile feeding tube. The doctor reported in the encounter note that he was not provided client records/medical history as to what type of feeding tube Client #1 had or where it was placed and by whom. "Her past surgical history is only known as gastrostomy tube placement with no other details noted" and "Since we have absolutely no idea what we are dealing with, I have recommended obtaining both a plain abdominal x-ray as well as a feeding tube study with oral contrast to determine the location and type of feeding tube." No coordination of care between medical providers had occurred by QP #1 in preparation for the facility's request to change the type of feeding tube Client #1 had. -Treatment plan dated 6/26/20 Diet: "It is important that [Client #1] maintain as much of her current abilities as possible. She really enjoys eating and should continue to do so orally for as long as it is safe to do so. It may be helpful to talk her through what she will be eating. Starting and ending the meal with sweeter tasting foods can improve her eating." -Barium Swallow Test 9/1/20: "The patient managed all trials with no airway compromise ...recommend puree diet and NTL (Nectar-thick liquids. Patient has PEG (Percutaneous endoscopic gastrostomy) for nutritional support. Recommend oral feeding for comfort when desired by patient...The was no penetration or aspiration of barium during the study...Material does not enter airway." Review of the record on 9/8/20 for Client #2 revealed: -Date of Admission: 8/24/16. -Age: 28. -Diagnoses: Autistic Disorder, Disruptive Mood	V 109		

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V 109	Continued From page 3 Dysregulation Disorder, Severe Intellectual Disabilities, Attention Deficit Hyperactivity Disorder, Dysmenorrhea (painful menstruation), chronic constipation, allergic rhinitis. -Treatment plan signed 3/20/20 reported the following: "Needs 1:1 services through-out her day for behavioral supports and being at risk to self ... She is at risk of harm to self/others." Review on 8/26/20 of the staff personnel file dated 5/20/19 for QP #1 revealed: Date of Hire: 10/25/13. The following are examples of QP #1's lack of competency: 1) Failed to provide oversight, supervision and training to staff. Three of 4 staff (#2, FS #3, FS #4) reported they had not seen the QP in the house for 2 years. Supervision and training were reported by staff to be minimal/5 minutes long (Staff #2, FS #4) or not done by QP #1 at all (FS #3). 2) Failed to implement effective corrective measures for Client #1's incident on 6/18/20, as the staff Inservice dated 6/30/20 and prepared by QP #1 did not address Client #1's injury, wound care, documentation needs, or compliance with specific Incident Reporting policy directives to call the QP about any incident reported to the nurse. 3) Failed to update the treatment plan for Client #1 and Client #2 (Refer to V112 for details). 4) Failed to ensure client rights were not being violated regarding phone calls (See Tag 367 for details). 5) Failed to ensure coordination of services for Client #1 (See Tag 291 and 112 for details). 6) QP #1 hung up on the surveyor on 9/8/20 after the facility's Administrator and Chief Executive	V 109		

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V 109	Continued From page 4 Officer (CEO) were contacted regarding documentation not submitted by QP #1 after 4 written requests. Interview on 9/8/20 with Staff #2 revealed: - "Had not seen [QP #1] in the group home in over 2 years, then in March - August 2020, saw [QP #1] in the group home 3 times due to Covid-19." - "June in-service was piece of paper passed around that you read and signed that you read it." -QP #1 "tried to have in-person trainings but those were not successful. They were 5 minutes long or canceled at the last minute." -Former House Manager left in February 2020 and QP #1 still had not hired another one. - "There was no one in charge of daily house needs ... staff kept on top of things- grids, clothing, food ... [QP #1] left us alone as we were getting things done." Interview on 9/17/20 with Former Staff (FS) #3 revealed: -Worked there 11 years. Left fulltime employment in December 2019, was part time until February 2020. - "Communication is very bad between direct care and [QP #1] and administration." - "Nobody ever came out there. In the last 2 years, saw [QP #1] maybe once at the house, that was last year due to complaint on [Client #3]." - "[QP #1] never came out to the house. She said she didn't want to drive out there, said she had no gas or gas money. Staff jokingly offered to collect cash for gas money for her." - "[QP #1] was shared between 2 houses, then was offered another position at the office of Program Manager. Then was still the QP for 2 houses with another full-time role."	V 109		

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V 109	Continued From page 5 -Did not receive training from QP #1. "I always trained the staff, [QP #1] gave me the training paperwork to do the training, [QP #1] deferred to me to train staff. Used to be 2-3 weeks of training in the beginning for new staff, now its crammed all in one week." - "I think should've been more supervision and training. [QP #1] didn't know anything about clients. She was supposed to do a monthly staff meeting and we would go and half time it was cancelled. She'd run a supervision paper out for us to sign saying we attended supervision and then we'd leave." Interview on 9/16/20 with FS #4 revealed: -Worked there 7 years. Left 7/6/20. - "There was a lack of support and concern for staff. There was a lack of communication, supervisors [QP #1 and Administrator] never came to the home and there was no other type of communication between staff and administration." - "[QP #1] never came to the house. The last time she was there was 2 years ago, the Administrator was the same way." "[QP #1] refused to come to house. Once she said she had no more than 3 dollars in her bank account and couldn't afford to pay for gas." - " There was no oversight at all. Seriously. None. Staff was self-contained. No one came out there." - "[QP #1] never did supervision. When we had a house meeting, she'd just have staff sign a piece of paper at office and we'd leave." - "[QP #1] didn't like doing much of anything. She didn't do her job." Interview on 8/31/20 with the guardian of Client #1 revealed: -Only had a team meeting 1 time per year to discuss clinical information. -Client #1 was medically complex with IDD	V 109		

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V 109	Continued From page 6 (Intellectual and developmental delays) and had continually changing medical care plans and needs. -Were not informed of important care plans by QP #1 such as how/what Client #1 was eating vs. what was given via a feeding tube. -QP#1 only communicated via text on clinical issues. Did not believe texts adequate communication about medical and treatment issues. Interview on 8/26/20 with QP #1 revealed: - When asked about medical care provided to Client #1 from 6/18/20 to 6/24/20, QP #1 stated: "There was no change in the area (wound), so it was considered a non-issue." - There was a delay in getting Client #1 to urgent Care due to the Covid-19 procedures for permission to the facility. - The Guardians "went through a list of complaints .... I apologized. All I could do was apologize." Interview on 9/8/20 with QP #1 revealed: -Believed she had not previously been asked for requested survey documents that were requested from the Administrator and Chief Executive Officer on 9/4/20. -Was silent for approximately ten seconds. -Hung up the phone. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals	V 110		

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V 110	Continued From page 7 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that 1 of 1 current paraprofessional staff (Licensed Practical Nurse) demonstrated knowledge, skills and abilities	V 110	The Regional RN in-serviced the LPN's on the following: Notification to the medical provider of all medical issues that arise and document any order/recommendations given by the medical provider, to complete a double check of the Medication Administration Record orders to ensure they match the orders written by the medical provider to reduce risk of errors. The Regional RN will provide supervision and increased clinical oversite bi-weekly to the LPN's. The supervision is documented and includes: Documentation review of Medication Administration Record weekly, notification to the medical provider, double checking the Medication Administration Record to ensure they match written verbal orders made by medical provider, receiving and reviewing Medication Administration Records to ensure no transcription errors, and review of medical issues/needs of clients. Medication Administration records will be obtained from the group home weekly for the LPN to review and have on site. Supervision of the LPN's will be completed bi-weekly for the next 60 days and then on a routine basis through Corporate QA Assessments, Nursing On Call Logs, routine chart reviews, and observations conducted by the Regional RN. In the future Operations will ensure LPN's have the skill, knowledge and competencies to complete all required job responsibilities. Copies of Medication: Administration Records will be sent and reviewed for accuracy and are in compliance with physician orders. By: 10/10/20	

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V 110	Continued From page 8 required by the population served. The findings are: Review on 8/26/20 of the staff personnel file for the Licensed Practical Nurse (LPN) revealed: -Date of Hire: Not provided. -Active LPN license since 2014. The following are examples of the LPN's lack of competency in Client #1's medical care: 1) Failed to complete nursing notes for 6/18/20, 6/23/20 and 6/24/20 for Client #1's injury detailing what direct care staff was advised to do to treat the injury (bandage or not, clean wound, warm or cold compresses, duration of prescribed treatment). 2) Failed to complete nursing notes from 7/2/20 to 7/7/20 to ensure Urgent Care and Physician Assistant (PA) orders were documented. 3) Failed to document "daily check-ins with staff" per a 7/2/20 email from QP #1 that indicated this nursing intervention occurred to monitor the infected wound. 4) Failed to document the medical orders in nursing notes and/or on the MAR. 5) Failed to correctly report dates on Client #1's medical procedures as follows: --Nursing note dated 7/2/20 reported Client #1's wound was lanced on 7/2/20. This occurred 6/30/20. --Nursing portion of IR reported Client #1 went to urgent care on 6/29/20. Client #1 went on 6/30/20. 6) Failed to accurately transcribe a medical order on the MAR for 7/7/20 for Client #1 (See V118 for details). 7) Failed to complete/document "24-hour follow-up" per facility policy on Incident Reporting (See V367 for details).	V 110		

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V 110	Continued From page 9 Interview on 9/17/20 with Former Staff (FS) #3 revealed: -The LPN was "always overwhelmed, nursing was short staffed and there was always something was going on. [The LPN] was shared between 6 houses. There are two nurses total I think." - "If a nurse ordered something or the doctor had a new order, it was the nurse's job to update the MAR and add new orders. If something is not on MAR, staff are not to be doing it." Interview on 9/16/20 with FS #4 revealed: -The LPN "is stretched pretty thin. She is shared between 6 houses." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible;	V 112	On next page	

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V 112	Continued From page 10 (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop, implement and update treatment plans in partnership with the client or legally responsible person for 2 of 2 audited clients (Client #1 and #2). The findings are: Finding #1: Client #1 did not have a current, signed treatment plan inclusive of her dietary and medical needs. Review on 9/8/20 of emails sent by the surveyor between 8/26/20 and 9/8/20 to QP #1 requesting documentation to include the treatment plan revealed: -Documentation was requested on 8/26/20, 8/28/20, 9/4/20, and 9/8/20. As of 5PM on 9/8/20, the following were not submitted for Client #1: treatment plan, client assessments, June MAR, daily/shift notes, team meeting notes, and all pages of Urgent Care Discharge summaries (submitted with missing pages).	V 112	The Director of Operations and Administrator met with guardians of client #1 on 9/25/20. The guardians did not want to make any revisions to client #1 Treatment Plan until the next scheduled meeting on 11/20/20. Client #1 Treatment Plan has been signed by her legal guardians. At the guardians request the team will meet every 2 months to discuss revisions to client #1 Treatment Plan. Client #2 Treatment Plan was written by Vaya Care Coordination. ICF-ICC level of care is a requirement to receive Innovation Funding. Staffing and ensuring appropriate staff ratio, is discussed weekly on supervision calls with Director of Operations, Regional Vice President of Operations, or Quality Assurance Specialist. Treatment Plans will be monitored weekly for the next 60 days during supervision oversite to ensure compliance. The Administrator will monitor all Treatment plans to ensure they are in compliance, guardian participation and signatures. The Quality Assurance Specialist will monitor through QA Audits to ensure compliance. In the future the Qualified Professional and Administrator will ensure Treatment Plans are developed, implemented, and updated in partnership with people supported and legal guardians. By: 10/10/20	

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V 112	Continued From page 11 Review on 9/15/20 of medical records emailed from the guardians of Client #1 on 9/7/20 and 9/15/20 revealed: -Date of Admission: 9/3/19. -Age 42. -Diagnoses: Spastic Quadriplegic Cerebral Palsy, Chronic static encephalopathy, partial epilepsy, chronic pain, flexion contractures, neurogenic bladder, chronic constipation, spasticity, gastroesophageal reflux disease (GERD, gastrointestinal tube (G tube) developmental delay, blindness, diabetes, c difficile enterocolitis, dysphagia, anxiety, non-verbal, bed bound with total care and is bed bound with total care. Review on 9/8/20 of the physicians' orders for Client #1 revealed: -Ancillary Orders on MAR dated 9/2/19 report "Puree Diet, Osmolite 1.5 via G-tube (gastrointestinal tube) at 50 milliliters (ML) per hour with water prior to feed and after feed. Review on 9/15/20 of a Barium Swallow test and Speech Pathology report dated 9/1/20 revealed: -Recommended puree diet and NTL (Nectar-thick liquids. Patient has PEG (Percutaneous endoscopic gastrostomy) for nutritional support. Recommend oral feeding for comfort when desired by patient." Review on 9/15/20 of medical records emailed from the guardians of Client #1 on 9/7/20 and 9/15/20 revealed: -History and physical dated 8/8/19 reported diet as: "Continued g tube feeding at night and is on a pureed diet with thin liquids during the day." Review on 9/15/20 of a treatment plan emailed from the guardians of Client #1 on 9/7/20	V 112		

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V 112	Continued From page 12 revealed: -Dated 6/26/20. -Signed by Qualified Professional (QP) #1 but signature was not dated. -Guardians had not signed the plan. -Plan was missing page 3 and page 6. -How to best Support Client #1:Used a wheel chair for mobility, limbs were stiff and constricted resulting in limited mobility, needed support from staff to reposition regularly to support "skin integrity," was legally blind, had g-tube for feeding, required 100% staff support, and was non-verbal with receptive language and "understands most of what it happening around her." Diet: "It is important that [Client #1] maintain as much of her current abilities as possible. She really enjoys eating and should continue to do so orally for as long as it is safe to do so. It may be helpful to talk her through what she will be eating. Starting and ending the meal with sweeter tasting foods can improve her eating." -Goals as follows: -#1: "Will grasp and hold an item for 30 seconds" -#2: "With no more than 3 verbal prompts, [Client #1] will raise her arm and/or push her arm through the sleeve to assist with dressing." -#3: "Will choose an activity by indicting 'yes' or 'no' ..." -#4: "Will indicate her preference of beverage by nodding/shaking her head to indicate 'yes' or no' ..." -#5: "Will work with staff to take 5 slow breathes before engaging in personal care tasks ..." -#6: "Will participate in passive range of motion stretches for arms, wrists and ankles ..." -There were no goals added or updated specific to Client #1 receiving a pureed diet daily. -There were no goals added or updated to address wound care that was ordered or	V 112		

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V 112	Continued From page 13 additional needs, such as daily bathing, to ensure Client #1's health and safety needs were met after the 6/18/20 injury occurred. Review on 9/7/20 of an email from the guardians to the surveyor dated 9/7/20 revealed: - "We have stated to [QP #1] that we want [Client #1] to have a goal of eating, drinking and taking medicines by mouth and get to the point of having the feeding tube removed. [Client #1] has no problem with swallowing foods or liquids." Interviews between 8/26/20 and 9/15/20 with the guardians for Client #1 revealed: -A Person Centered Plan (PCP) was presented to them to sign during visitation on 8/29/20 and the guardians refused to sign it without reading or getting a copy provided to them. They did not want to use their visitation time to read the plan, so they took the copy they were to sign home with them. -Guardians were not involved in the development of the PCP and wanted to be. -Only had team meetings 1 time per year to sign the PCP. Wanted more frequent team meetings to discuss Client #1's medical and treatment needs. -Client #1 was not offered pureed meals and this was on her treatment plan. -Wanted a goal pertaining to diet/oral feeding on the PCP to reflect needs regarding oral feeding along with a feeding tube. Interview on 9/17/20 with Former Staff (FS) #3 revealed: -Was doing pureed meals for Client #1 twice daily prior to her resignation as House Manager (December 2019). -Was fed via feeding tube for 12 hours through the night.	V 112		

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V 112	Continued From page 14 Interview on 9/8/20 with FS #4 revealed: -Worked there 7 years. Left 7/6/20. - "Yogurt was only thing fed to her, staff never pureed food for her." - Client #1 did not get breakfast. - Often fed in her room and not at dinner table with others. Refer to Tag 291 for additional information. Finding #2: Client #2's treatment plan did not evidence a step-down from an Intermediate care facility (ICF) to a non-ICF 5600C facility nor was there evidence that 1:1 staff were implemented to ensure clients safety. Review of the record on 9/8/20 for Client #2 revealed: -Date of Admission: 8/24/16. -Age: 28. -Diagnoses: Autistic Disorder, Disruptive Mood Dysregulation Disorder, Severe Intellectual Disabilities, Attention Deficit Hyperactivity Disorder, Dysmenorrhea (painful menstruation), chronic constipation, allergic rhinitis. -Assessment: 8/26/2016 psychological evaluation reported Client #2 had just moved from her mother's home into a sister facility on 8/24/16 that was an ICF level of care. Hillpark Group Home reported Client #2 was admitted to their facility on 8/24/16, which is a non-ICF 5600C level of care. -Managed Care Organization (MCO) Authorization: was authorized for an additional $27, 484.68 a year in Individual Day support services (1:1 staff) through RHA in addition to Level 4 housing and specialized consultation services on 4/1/20.	V 112		

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V 112	Continued From page 15 -Treatment plan dated 4/1/20 reported the following: -- "The individual continues to require ICF-ICC level of care." --There was no update to the plan to indicate a step-down to a non-ICF 5600C level of care had occurred/was appropriate. -- "Needs 1:1 services through-out her day for behavioral supports and being at risk to self ... She is at risk of harm to self/others." --"The team agrees that having 1:1 supervision in the home has been most effective for redirection and completion of ADLs in the home." -Treatment plan dated 2/24/20 reported the following needs: "1:1 assistance compiled with a positive outgoing attitude can cause [Client #2] to fully engage and complete tasks or activities assigned to her." -There was no update to the treatment plan in June/July 2020 to address the 1:1 supervision needs nor was there evidence 1:1 supervision had been implemented in the group home. Interview on 9/17/20 with Former Staff (FS) #3 revealed: - "After the complaint last year that [Client #2] was involved in, we were supposed to get a 3rd staff for [Client #2] and that never occurred from 5/23/19 until I left in February 2020. I was always told 'we are working on that' when I asked about the 3rd staff being hired." - "[Client #2] required 1:1 for stealing, she was a choking hazard, she was physically aggressive ...It was really bad for a while. She needs all the attention." Refer to Tag 290 for additional information. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1	V 112		

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V 112	Continued From page 16 rule violation for serious neglect and must be corrected within 23 days.	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118	Cross Reference V110	

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V 118	Continued From page 17 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have MARs, failed to ensure MARS were accurate, and failed to follow physician orders for 1 of 2 audited clients (Client #1). The findings are: Review on 9/15/20 of medical records emailed from the guardians of Client #1 on 9/7/20 and 9/15/20 revealed: -Date of Admission: 9/3/19. -Age 42. -Diagnoses: Spastic Quadriplegic Cerebral Palsy, Chronic static encephalopathy, partial epilepsy, chronic pain, flexion contractures, neurogenic bladder, chronic constipation, spasticity, gastroesophageal reflux disease (GERD, gastrointestinal tube (G tube) developmental delay, blindness, diabetes, c difficile enterocolitis, dysphagia, anxiety, non-verbal, bed bound with total care and is bed bound with total care. Review on 9/8/20 of the medical records for Client #1 revealed: -Client #1 had an injury of unknown origin that required treatment by a licensed health professional on 6/18/20, 6/23/20, 6/24/20, 6/25/20, 6/30/20, 7/2/20, 7/7/20, 7/16/20, and 7/28/20. Review and interview on 8/31/20 of images taken by the guardian of the wound revealed: -Guardian took a cell phone picture of the wound on 6/25/20. -The wound was not covered by any type of bandage. -Wound was raised from the skin in a large "knot"	V 118		

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V 118	Continued From page 18 protruding from the right shoulder, it appeared yellow and white with a flaky scab over it, and the area around the wound was a deep red color. Review on 9/8/20 of the Urgent Care Encounter Note for Client #1 dated 6/30/20 revealed: -Was seen for an Abscess. - "Caretakers first noticed a wound pop up on the right anterior shoulder 2 weeks ago and they state it has gotten progressively more and more red and elevated and now there is active fluctuance (pus which has accumulated beneath the epidermis). The patient was put on Clindamycin 4 days ago which they described helped the surrounding erythema (reddening of the skin from injury) but the fluctuant still remain." - "Patient had a 3 x 4-centimeter (cm) area of fluctuance and erythema" and "5 x 5 cm of erythema." -Local anesthetic was used and the area was lanced with "about 10 cc (cubic centimeters) of purulence (pus) was expressed." -Drainage: "copious" amount and "purulent and bloody." - "Culture of purulence was obtained and 4cm (centimeters) of 1-inch gauze packing was placed (in the wound). Non-adhesive bandage and 4 x 4 dressing was applied to the site of the wound." -Ordered: "Caretakers were told to continue the Clindamycin which has 5 days left and to follow-up in 2 to 3 days for wound recheck. In the meantime, they were told to change bandages daily and to seek medical care for any new or worsening symptoms." Review on 9/8/20 of the physicians' orders for Client #1 revealed: -6/25/20: "Clindamycin 150 mg per pgt (percutaneous gastrostomy tube) TID (3 times daily) x 10 days and "We will monitor very closely.	V 118		

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V 118	Continued From page 19 The nurse will check her frequently and call [PA] with any concerns." -6/29/20: Bactroban 2% ointment, apply to affected area twice a day x 5 days." -6/30/20: "Caretakers were told to continue the Clindamycin which has 5 days left ..." -7/2/20: "Continue Clindamycin ..." -7/7/20: "Extended Clindamycin 150 Mg per pgt, TID for an additional 7 days." Review on 9/8/20 of emails dated between 8/26/20 and 9/8/20 to Qualified Professional (QP) #1, the Administrator, and Chief Executive Officer from the surveyor to request records revealed: -MARs for June and July 2020 were requested by email on 8/26/20, 8/28/20, and 9/4/20, and 9/8/20. Review on 9/8/20 of an email dated 9/8/20 from QP #1 to the surveyor revealed: - "The message passed on to me from our CEO (Chief Executive Officer) lists a few things that were not previously asked of me (MAR, client service plan, follow up about the Hoyer, etc.). This is the first I'm hearing these requests and I will be compiling this information to send you within the hour ...I'm still trying to get my hands on the MAR for June. Our nurses are in clinic today & the MARs are inaccessible to me. I will get that to you as quickly as I can." Review on 9/8/20 of an email dated 9/8/20 from QP #1 to the surveyor revealed: - "Looking back through my messages, I see where I overlooked your request...there was a list you gave in the body of the message, then you cited a highlighted portion, which listed additional needs. I was too focused on the first list and overlooked the part where you referenced another list. My apologies for the confusion. I	V 118		

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V 118	Continued From page 20 really, really hate that it seems we've given the impression of being uncooperative, that's not at all the intention. At this point, I think that I have sent in everything except for the June MAR..." Review on 9/8/20 of documents submitted by the facility for Client #1 revealed: -No June 2020 MAR was submitted for review. -Due to the failure to accurately document medication administration, it could not be determined if Client #1 received medications as ordered by the physician. Review on 9/8/20 of the July 2020 MAR for Client #1 revealed: -July MAR had the following errors: --The 7/7/20 order for Clindamycin 150 mg reported an incorrect route of "by mouth" vs. "pgt (percutaneous gastrostomy tube) fed." --The Duration of 7 days was missing from the 7/7/20 order for Clindamycin 150 mg. --Due to the failure to accurately document medication orders and administration, it could not be determined if client #1 received medications as ordered during July 2020. Interview on 9/17/20 with Former Staff (FS) #3 revealed: -Direct care staff didn't read nursing notes. If a nurse ordered something or the doctor had a new order, it was the nurse's job to update the MAR and add new orders. If something is not on MAR, staff are not to be doing it." Interview on 8/26/20 with QP #1 revealed: - Wound was "a lump, really red around it, size of a small tangerine or small child's hand. As it was healing it looked really gross, stayed pink and crusted up." -Nurse was called on 6/18 who prescribed	V 118		

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V 118	Continued From page 21 Benadryl cream..." - "Staff put Benadryl cream on the area one time..." -Client #1 saw the PA on 6/25/20 who prescribed an antibiotic. - "It was determined on 6/26/20 or 6/29/20 that client could go to urgent care. Urgent care directed to continue antibiotics. - "On 7/3/20, [Client #1] was taken to Urgent Care again ...Urgent Care lanced the wound and cultured it. No specific infection was determined, just that it was infected." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which	V 289	Cross Reference V109, V110, V112, V118, V290, V291, V364, V367, V540	

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V 289	Continued From page 22 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 .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).	V 289		

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V 289	Continued From page 23 This Rule is not met as evidenced by: Based on records review and interviews the facility failed to provide residential services to adults whose primary diagnoses is a developmental disability within the scope of the facility's 5600C Licensure, affecting 2 of 2 current clients (#1 and #2). The findings are: Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record review and interview the facility failed to ensure that 1 of 1 Qualified Professionals (QP #1) demonstrated knowledge, skills and abilities required by the population served. Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on record review and interview the facility failed to ensure that 1 of 1 current paraprofessional staff (Licensed Practical Nurse) demonstrated knowledge, skills and abilities required by the population served. Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Planning (V112). Based on record reviews and interviews, the facility failed to develop, implement and update treatment plans in partnership with the client or legally responsible person for 2 of 2 audited clients (Client #1 and #2). Cross Reference: 10A NCAC 27G .0209	V 289		

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V 289	Continued From page 24 Medication Requirements (V118). Based on record review, the facility failed to have MARs, failed to ensure MARS were accurate, and failed to follow physician orders for 1 of 2 audited clients (Client #1). Cross Reference: 10A NCAC 27G. .5602 Staff (V290). Based on record review and interviews, the facility failed to provide enough staff to respond to the individualized client needs for 2 of 2 audited clients (Client #1, #2). Cross Reference: 10A NCAC 27G .5603 Operations (V291). Based on record review and interviews, the facility failed to maintain service coordination for treatment/habilitation or case management for 2 of 2 audited clients (Client #1 and #2). Cross Reference: NC G.S. §122C-62. Additional Treatment Rights in 24-hour Facilities (V364). Based on interviews, the facility failed to ensure the right to make and receive phone calls for 1 of 1 audited clients (Client #1). Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements (Tag 367). Based on record review and staff interviews, the facility failed to report a Level II incident to the Local Mental Health Managed Care Organization (LME/MCO) within 72 hours for 2 of 2 audited clients (Client #1 and #2). Cross Reference: 10A NCAC 27F .0103 Health, Hygiene and Grooming (V540). Based on interviews, the facility failed to provide the opportunity for a daily shower for 2 of 2 audited clients (#1 and #2). Interview on 8/26/20 with the facility's	V 289		

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HILLPARK GROUP HOME	175 ELSON AVENUE HENDERSONVILLE, NC 28739

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V 289	Continued From page 25 administrator revealed: -Deferred to QP #1 as contact for the survey. Interview on 9/18/20 with the facility's administrator revealed: - "I'm so sorry, that all sounds awful." Interview on 9/18/20 with the facility's Director of Operations revealed: - "This is not the standard we have here at RHA. We will start making corrections immediately." Review on 9/18/20 of the Plan of Protection (POP) submitted on 9/18/20 by the Director of Operations revealed: "Type A1 Rule Violation for Medical Neglect in: 10A NCAC 27G .5603 Operations (b) Service Coordination (Tag 291) Cross Referenced Tags to also be addressed in this plan: 1. 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (Tag 109) 2. 10A NCAC 27G.0204 Competencies and Supervision of Paraprofessionals (Tag 110) 3. 10A NCAC 27G .0209 Medication Requirements (Tag 118) Type B Rule Violation in: 10A NCAC 27G .5602 Staff (a) (Tag 290) Cross Referenced Tags to also be addressed in this plan: 1.10A NCAC 27F .0103 Health, Hygiene and grooming (Tag 540) Plan of Protection - Completed by Facility Staff (Attach additional pages if needed) "What immediate action will the facility take to ensure the safety of the consumers in your care? 1) Clinical supervision schedule to be implemented on 9/18/20 to include at least 3 unannounced visits per week by any member of	V 289		

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V 289	Continued From page 26 the clinical team including the Administrator and Program Specialist for 60 days. 2) Transfer the Residential Team Leader [RTL] to directly work and supervise the home by 9/20/20 due to ongoing COVID restrictions. RTL will primarily work Monday-Friday full-time at Hillpark and weekends as needed to ensure staffing coverage is in place. 3) Staff will be in-serviced on answering all phone calls on 9/18/20. 4) Staff will be in-serviced on following the Chain of Command to report all incidents, concerns or staffing needs on 9/18/20. The Chain of Command includes: 1) Residential Team Leader, 2) QP/Program Specialist, 3) Facility Administrator, 4) Director of Operations, 5) Regional Vice President of Operations. 5)Provide increased clinical oversite of the LPN to at least twice per week in person or virtually by the Regional RN for 60 days starting 9/18/20. 6) Provide increased supervision of the Paraprofessionals either in person or virtually to at least weekly for 60 days starting 9/18/20. The Administrator will use the RHA House Meeting Agenda each week to facilitate the supervision, discuss the individual needs of the people supported and overall needs of the home and staff. 7) Nursing staff will be in-serviced to notify the medical provider of any and all medical issues as they arise and document any orders/recommendations given by the medical provider. The LPNs will be in-serviced to complete a double check of the MAR orders to ensure they match the orders written by the medical provider to reduce risk of errors in transcription on 9/18/20. 8) The clinical team will develop and implement a personal hygiene schedule routine and checklist for each person and in-service all staff by	V 289		

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V 289	Continued From page 27 9/18/20. 9)Staff will be in-serviced to notify the Administrator immediately if there is not enough staff to complete personal care on 9/18/20. 10) The Administrator will review the house schedule weekly with the RTL to ensure enough staff are in place to provide appropriate care including maintaining appropriate staffing on each shift and to address any changing needs of the people supported in the home starting 9/18/20. 11) Staff will be in-serviced on using mandatory PPE and will be monitored by the clinical unannounced visits & virtual visits weekly by clinical staff on 9/18/20. 12) The Director of Operations, Regional VP of Operations or Quality Assurance Specialist will provide weekly clinical supervision each Monday via [video conference] of the Administrator, QP/Program Specialist, LPNs and RTL starting 9/21/20 to include, but not limited to, ongoing needs of the home, staffing issues, needs of the people supported and any other operational needs for Hillpark for 60 days. Describe your plans to make sure the above happens. These action items will be monitored and reviewed weekly on each Monday via [video conference] by the Director of Operations and/or Regional Vice President for ongoing compliance and completion." Client #1 was a medically complex 42-year-old client with diagnoses of Spastic Quadriplegic Cerebral Palsy, Chronic static encephalopathy, partial epilepsy, blindness, diabetes, and 11 additional diagnoses. She was non-verbal and was bed bound with total care. Client #1 did not have a current signed treatment plan.	V 289		

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V 289	Continued From page 28 Client #1 had an injury of unknown origin noticed on 6/18/20 and the resulting lack of coordination of treatment resulted in the wound becoming infected by the time she attended her first medical appointment on 6/25/20. Subsequently, the wound then required multiple trips to Urgent Care due to an infected abscess. The guardians of Client #1 were not notified on the wound for 6 days and upon seeing it for the first time on 6/25/20, insisted that Client #1 be taken to the Emergency Room immediately. The facility declined this level of care, choosing instead to take Client #1 to Urgent Care 5 days later on 6/30/20, at which time the wound had to be lanced, drained, packed with gauze and wick placed to drain the infection. Documentation from both the facility and in Urgent Care Encounter notes report Client #1 was experiencing pain and discomfort due to the wound. The lack of a June MAR and lack of correct documentation on the July MAR resulted in not being able to ascertain if medications were administered as ordered for Client #1. There was missing documentation completed by the Licensed Practical Nurse (LPN) to document calls from staff seeking guidance on wound care and there was no documentation to evidence wound care and follow up exams by the nurse occurred as ordered. Client #1 had also not received a pureed diet as ordered. The guardians reported that Qualified Professional (QP) #1's response to their question on why the pureed diet had not been received was due to QP #1's fear that Client #1 "would choke death." When the guardians brought the issue to the facility's contracted Physician Assistant (PA) for review, the guardians reported the PA stated the order for a pureed diet should not have been changed/discontinued and that QP #1's response to the PA and guardians was that	V 289		

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V 289	Continued From page 29 staff had stopped doing the pureed diet. Staff interviews consistently reported that there wasn't enough staff working on each shift to manage all the individualized needs for clients, to include preparing a pureed diet and even getting Client #1 out of bed for pressure release or to socialize in the house. The Guardians for Client #1 report having seen only 1 staff working in the facility at times and they reported a long-standing client rights concern that there was not staff available to answer the phone, thus restricting calls to Client #1. QP #1 was aware of the lack of staff answering the phone but was unable to support staff in answering the phone at a designated time each day for Client #1's guardians to call their daughter. QP #1 was also unable to coordinate Client #1 receiving her personal Hoyer lift since her admission in September of 2019 so that it could be utilized in the guardians' home for visits. Client #2 was age 28 with diagnoses of Autistic Disorder, Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Severe Intellectual Disabilities and physical health conditions of Dysmenorrhea (painful menstruation), chronic constipation, and allergic rhinitis. Per her treatment plan, Client #2 was to be receiving 1:1 personal care services during the day which was authorized for additional payment to the facility but was not evidenced as being implemented. Client #2 was also to be receiving an ICF level care per her treatment plan and her admission assessment reported she had just moved from her mother's home into a sister facility on 8/24/16 that was an ICF level of care. Hillpark Group Home reported Client #2 was admitted to their facility on 8/24/16, which is a non-ICF 5600C level of care.	V 289		

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V 289	Continued From page 30 Client #2 did not have the additional 1:1 staff supervision to ensure hers and others safety coordinated for her and this resulted in her leaving the group home naked for an unspecified period of time in which staff did not notice her absence. A neighbor came to the group home to notify staff that Client #2 had left the group home and destroyed his mail. Client #2 had returned to the group home on her own and unnoticed. Client #2 was the subject of a previous complaint at the facility in May 2020 and the facility Administrator reported an intention to get a 3rd staff person to meet the needs for Client #2 at that time. This additional 1:1 staff for Client #2 did not occur from May 2019 through approximately July 2020 according to staff interviews. Staff report there was not enough staff scheduled on each shift to get all the residents out of the group home during an emergency, as 3 residents required a Hoyer lift and the remaining 3 also required assistance to exit. Per a construction survey on 2/27/20, the group home was not to have more than 3 residents who could not evacuate themselves and the current census had 6 clients that required assistance to evacuate. Three of four staff interviews reported an overall lack of supervision and oversight by QP #1 and they reported they had not seen QP #1 in the house for 2 years. Supervision/training was reported to be 5 minutes in length and consisted of a piece of paper passed around for staff to sign. Staff described the home environment as unsafe, disorganized and a "circus." Residential services for the purpose of care, habilitation or rehabilitation were not provided for clients audited and this caused serious neglect to	V 289		

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V 289	Continued From page 31 occur at the facility. There was an overall lack of coordination of care, a lack of staffing to meet the individual needs of clients, and a lack of on-site supervision to ensure client care and treatment needs were being met. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor	V 290	See next page	

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V 290	Continued From page 32 clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide enough staff to respond to the individualized client needs for 2 of 2 audited clients (Client #1, #2). The findings are: Finding #1: Client #1 was medically complex and required additional staff to meet her individualized needs. Review on 9/8/20 of emails sent by the surveyor between 8/26/20 and 9/8/20 to QP #1 requesting documentation to include the treatment plan revealed:	V 290	Staffing patterns and staff to client ratios are based on census and client specific needs. The Director of Operations, Regional Vice President of Operations, or Quality Assurance Specialist will provide weekly supervision of the Administrator and QP/Program Specialist. The supervision is documented weekly and includes: Need of people supported in the home (Behavioral, Adaptive Equipment and Medical and ensuring appropriate staff ratio, and any other operational needs for the home. Supervision of staffing and staffing ratio will be monitored through weekly supervision meetings for the next 60 days and then on a routine basis. The Director of Operations or Regional Vice President will monitor Hours Reports to ensure the group home is compliance with appropriate staffing to meet client needs. In the future the Administrator will ensure the staff ratio is appropriate to respond to client needs. By: 10/10/20	

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V 290	Continued From page 33 -Documentation was requested on 8/26/20, 8/28/20, 9/4/20, and 9/8/20. As of 5PM on 9/8/20, the following were not submitted for Client #1: treatment plan, client assessments, June MAR, daily/shift notes, team meeting notes, and all pages of Urgent Care Discharge summaries (submitted with missing pages). Review on 9/15/20 of medical records emailed from the guardians of Client #1 to the surveyor on 9/7/20 and 9/15/20 revealed: -Date of Admission: 9/3/19. -Age 42. -Diagnoses: Spastic Quadriplegic Cerebral Palsy, Chronic static encephalopathy, partial epilepsy, chronic pain, flexion contractures, neurogenic bladder, chronic constipation, spasticity, gastroesophageal reflux disease (GERD, gastrointestinal tube (G tube) developmental delay, blindness, diabetes, c difficile enterocolitis, dysphagia, anxiety, non-verbal, bed bound with total care and is bed bound with total. -History and physical dated 8/8/19: "continued g tube feeding at night and is on a pureed diet with thin liquids during the day" and "the patient is at high risk for complications due to multiple comorbidities." -Musculoskeletal: "Total care. Non-ambulatory. The patient is bed bound. Contractures. Review on 9/9/20 of the 2/27/20 biennial Construction Survey revealed: - "On September 16, 2016 the facility was approved for six residents with up to three non-ambulatory residents. Based on this information we are requiring the home to maintain compliance with the following: the 2006 Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services (10A NCAC 27G) and the applicable portions of the	V 290		

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V 290	Continued From page 34 2012 North Carolina State Building Code - Section 425.3 - Small Residential Care Facilities." -The 2012 North Carolina State Building Code - Section 425.3 Small Residential Care Facilities reported: "Residential care facilities keeping no more than six adults or six unrestrained children with no more than three who are unable to respond and evacuate without assistance." Interview on 9/2/20 with Staff #1 revealed: -Worked at the group home 10-12 years. - "Feels like there is enough staff now ...they are trying to do 3 people this year during the day." - 3 clients require full care like Client #1, 2 clients need partial assistance and 1 needs no assistance. Interview on 9/8/20 with Staff #2 revealed: -Resigned during the survey on 9/2/20. Worked there "2 years this last time." - "It's supposed to be a DDA (Developmental Disabilities-Adult) home, but 5 clients are 100% total care. Too much client needs for what staff they have." - "It's unsafe there. No safety system, no sprinkler. It's licensed for 1 person in wheel chair, we have 3 wheelchairs." - "The safety of getting everyone out in emergency is an issue. There were 3 in wheel chairs and clients who required Hoyer lift." - "Worked 70-80-90 hrs. week, we all worked so many days straight, I usually worked 6 days straight 13 hours a day, I got burned out." - "This unit has gone downhill drastically after [former house manager] left, it went to hell ...staff issues are lack of communication with administrative staff and the clientele are not matched with the house-they are just putting whomever in there to fill the beds." - "There was still only 1 staff on 3rd shift. There's	V 290		

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V 290	Continued From page 35 no way staff can get everyone out if house is on-fire because 3 clients require Hoyer lift." - "All staff have complained to [QP #1] and "it was brushed under the rug." - "There was no one in charge of daily house needs" after the former house manager left in February 2020. - Dinner was between 6:30PM and 8:00PM. There was not enough staff to feed everyone. After dinner, there was no time left for anything else (showers). -Client #1 was not bathed daily, maybe 2 times per week. Interview on 9/17/20 with Former Staff (FS) #3 revealed: -Worked there 13 years, 11 as the house manager (HM). - "2 staff is not enough." Everyone in the house is total care except 1 client." - "I don't know how they get away with 1 staff on overnight shift. One person can't get out all the wheelchairs. [Client #1] would take all the time for that 1 staff person." - If there was an emergency, staff could not get all the clients out. - 3 clients are in wheel chairs and require Hoyer lift. - "The clients at Hillpark need higher level of care. They [QP #1 and administrator] did not match the houses up to level of client needs. Hillpark needs to do better at matching clients with other clients and not accept just anyone. If you have 5 calm clients without behaviors and add 1 new client with behaviors, it disrupts the house. I communicated this to the QP [#1] and Administrator, but nothing got done." - "I knew something would happen and DHSR (Division of Health Service Regulation) would be contacted."	V 290		

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V 290	Continued From page 36 Interview on 9/16/20 with FS #4 revealed: -Worked there 7 years. Left 7/6/20. - "All the client needs can absolutely not be managed. There's not enough staff for all the clients in wheel chairs. They need 3 staff." "On day shifts, there's normally 2 staff, but they need 3. There's only 1 staff at night with 3 wheel chairs." - "We requested more staff on the schedule all the time with [QP #1], she'd say 'I'll get back with you' ...and then never get back with you." - "My concern for [Client #1] was that she was not gotten up out of bed. She wasn't with other clients in the home, she was by herself in her room. This was a daily occurrence except when I got her out of bed." - "Client bathing was not done daily- usually every other day." - "There was no oversight at all. Seriously. None. Staff was self-contained. No one came out there." Interviews between 8/26/20 and 9/15/20 with the guardian (step-mother) for Client #1 revealed: -Had seen only 1 staff working with 4-5 clients at times before Covid-19 (prior to March 2020). Now they can only see through the windows as family is not allowed in the group home to visit. -Had been asked 2-3 times by QP #1 to move Client #1 to a different group home as the facility "did not have enough staff to meet [Client #1's] needs for full care." -Was told by QP #1 the facility "did not have money to afford to hire additional staff to meet [Client #1's] needs." -QP #1 wanted to move Client #1 to an ICF (intermediate Care Facility) as the current non-ICF 5600C level care could not meet her needs. -Guardians refused to move Client #1 as the	V 290		

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V 290	Continued From page 37 facility "should not have accepted her if they couldn't care for [Client #1]." -Did not want to move Client #1 as she had only been there a year but was now "concerned about retaliation" from facility staff and might be open to considering other housing options now. Interview on 9/18/20 with the Director of Operations revealed: -QP #1 had asked the family to move Client #1 to an ICF level of care that could better meet her needs and the family would not move Client #1. Finding #2: Client #2 had individualized safety needs that required a 1:1 staff to ensure her safety and the safety of others. Review of the record on 9/8/20 for Client #2 revealed: -Date of Admission: 8/24/16. -Age: 28. -Diagnoses: Autistic Disorder, Disruptive Mood Dysregulation Disorder, Severe Intellectual Disabilities, Attention Deficit Hyperactivity Disorder, Dysmenorrhea (painful menstruation), chronic constipation, allergic rhinitis. -Treatment plan dated 4/1/20 reported the following: -- "The individual continues to require ICF-ICC level of care." --There was no update to the plan to indicate a step-down to a non-ICF 5600C level of care (Hillpark Group Home) had occurred/was appropriate. -- "Needs 1:1 services through-out her day for behavioral supports and being at risk to self ... She is at risk of harm to self/others." --"The team agrees that having 1:1 supervision in	V 290		

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V 290	Continued From page 38 the home has been most effective for redirection and completion of ADLs in the home." -Treatment plan dated 2/24/20 reported the following needs: "1:1 assistance compiled with a positive outgoing attitude can cause [Client #2] to fully engage and complete tasks or activities assigned to her." -There was no update to the treatment plan in June/July 2020 to address the 1:1 supervision needs to prevent Client #2 from going Absent Without Leave (AWOL). Review on 8/26/20 of the Statement of Deficiencies dated 5/23/19 revealed: -The issue of Client #2 receiving 1:1 staffing was previously cited. The facility was to add a 3rd staff at that time to address the additional supervision needs of Client #2. Interview on 9/8/20 with Staff #2 revealed: -Can't do personal care while others are tearing up the house (Client #2). -Only 1 person can get out by themselves in an emergency and they would still need staff guidance (Client #2). - "[QP #1] started running 3 staff right after [Client #3] moved in June. Prior to that, we only had 2 staff on the day shift ...3 when we could ...staff can't have day off with 2 staff only." - "They [QP #1 and Administrator] tried to get by on 2 staff, then a resident went AWOL - [Client #2]. She left the property, she's the only one who could walk in the house ...and she went all the way to end of driveway, crossed street, went to a neighbor's house and took their mail. She brought it back home and ripped it up in her room. She came back on her own. The neighbor alerted staff. Staff didn't know she was gone. The mail that got ripped up was a check and car papers. We started to get 3 staff after that incident." No	V 290		

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V 290	Continued From page 39 one knew how long Client #2 was gone from the home." Interview on 9/17/20 with Former Staff (FS) #3 revealed: - "After the complaint last year that [Client #2] was involved in, we were supposed to get a 3rd staff for [Client #2] and that never occurred from 5/23/19 until I left in February 2020. I was always told 'we are working on that' when I asked about the 3rd staff being hired." - "[Client #2] required 1:1 for stealing, she was a choking hazard, she was physically aggressive ...It was really bad for a while. She needs all the attention." - "I know of two long term clients whose guardians took them out of the home because of [Client #2]." - "Clients aren't happy there-no one wants to eat in the dining room with [Client #2], so they just stay in their rooms." Interview on 9/16/20 with FS #4 revealed: - "[Client #2] went AWOL in June or July. She came out of the house naked, crossed the street, got mail and then shredded the mail. Staff didn't notice until neighbor came by who was missing their mail. The Incident was reported to the QP [#1], whether she did anything about it, I don't know." - "[Client #2 and #5] are not in wheel chairs, but [Client #2] freezes with the fire alarm, so you have to get her out. She won't go by herself." -The house was "disorganized. It's a circus out there. Someone is going to get hurt." Interview on 8/26/20 with QP #1 revealed: - "There are 6 residents in the house and 3 staff on 1st and 2nd shift."	V 290		

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V 290	Continued From page 40 This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 290		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.	V 291	The following in-services/training were completed by the clinical team to address client #1 coordination of care : Regional RN and Administrator- Wound Care and Frist Aid , LPN – Thick-It, comfort bites for client #1, documentation of BM chart, feeding client #1, feeding a visual impaired person, RTL – Meal/Fluid Intake Record and Toileting/Changing Record. RHA confirmed there was never a Hoyer Lift ordered for client #1 from her previous provider. The clinical team will coordinate with client #1 new Primary Care Physician to secure a Hoyer Lift. The Regional RN will monitor each client's coordination of care in the bi-weekly nursing supervision meeting for the next 60 days. Coordination of care for clients will be monitored weekly on supervision calls for 60 days then on a routine basis through Corporate QA Assessments, routine chart reviews, and observations conducted by the Director of Operations, Regional Vice President of Operations, or Quality Assurance Specialist. In the future the Administrator will ensure service coordination between disciplines occurs to provide treatment/habilitation. By: 10-10-20	

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V 291	Continued From page 41 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to maintain service coordination for treatment/habilitation or case management for 2 of 2 audited clients (Client #1 and #2). The findings are: Finding #1: The facility failed to coordinate wound care for Client #1 as ordered for an injury that occurred 6/18/20. Review on 9/8/20 of emails sent by the surveyor between 8/26/20 and 9/8/20 to QP #1 requesting documentation revealed: -Documentation was requested on 8/26/20, 8/28/20, 9/4/20, and 9/8/20. As of 5PM on 9/8/20, the following were not submitted for Client #1: treatment plan, client assessments, June MAR, daily/shift notes, team meeting notes, and all pages of Urgent Care Discharge summaries (submitted with missing pages). Note: Because these Urgent Care Discharge Summaries were missing multiple pages, it was difficult to ascertain what had occurred at the visits and the official Urgent Care Encounter Summaries had to be requested directly from the hospital to be faxed to the surveyor to complete the record review. These same Encounter Notes were emailed to the surveyor on 9/8/20 by QP #1 and the documents had a fax transmission notice at the top of each page indicating the facility received these Encounter Notes via fax from the hospital on 9/8/20, indicating the facility did not have these records detailing medical orders for medications and wound care prior to 9/8/20. Review on 9/15/20 of medical records emailed from the guardians of Client #1to the surveyor on	V 291		

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V 291	Continued From page 42 9/7/20 and 9/15/20 revealed: -Date of Admission: 9/3/19. -Age 42. -Diagnoses: Spastic Quadriplegic Cerebral Palsy, Chronic static encephalopathy, partial epilepsy, chronic pain, flexion contractures, neurogenic bladder, chronic constipation, spasticity, gastroesophageal reflux disease (GERD, gastrointestinal tube (G tube) developmental delay, blindness, diabetes, c difficile enterocolitis, dysphagia, anxiety, non-verbal, bed bound with total care. Review and interview on 8/31/20 of images of the wound taken by the guardian of Client #1 revealed: -Guardian took the first cell phone picture of the wound on 6/25/20. -Wound was raised from the skin in a "knot" protruding from the right shoulder, it appeared yellow and white with a flaky scab over it, and the area around the wound was a deep red color. Review on 9/8/20 of the Incident Report (IR) for Client #1 revealed: -IR dated 6/18/20 and completed by Staff #2. -Description of Injury: "Went to change [Client #1] and noticed a bite of some kind on her upper arm/shoulder area, took a picture and called nurse. It didn't appear flared up." Staff #1 was a witness of the incident. -Nursing was notified 6/18/20, The Qualified Professional (QP #1) was notified 6/25/20 and the date the legal representative (guardian) was notified is illegible (date written over). -The Licensed Practical Nurse (LPN) signed the IR on 6/29/20 and reported "Bite with redness 4cm x 2 cm. Staff cleaned, applied Benadryl cream and cool compress. On 6/25 area was swollen, raised and she was seen by [Physician's	V 291		

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V 291	Continued From page 43 Assistant], new RX (prescription) Clindamycin for infection. On 6/29. Redness, fluid felt in raised area. Sent to Urgent Care. Abscess lanced and drained. Continue Clindamycin." -QP #1 follow up was reported as "Seen in clinic 6/25, antibiotic started. Staff will agree to reporting to nursing daily on healing as encouraged by physician. Topical antibiotic to be started." - "Action to prevent reoccurrence: Staff in-serviced to clarify reporting process. Follow up with Urgent Care and doctor will review on 7/7/20." -QP #1 and Administrator signed IR on 6/26/20 and the LPN signed the IR on 6/29/20. Review on 8/28/20 of an email dated 7/7/20 from QP #1 to the facility's administrator and Director of Operations revealed: -Timeline of Client #1's treatment was provided as follows: - "6/18/20: Staff note a red mark, raised area with a pin point center ...nursing called but not QP [#1]. Nurse advised to apply Benadryl cream and a warm compress as needed." - "6/19 to 6/22: No further report from Hillpark staff. During this time, staff note the area looked less red, no oozing or discomfort indicated .... Benadryl cream only applied 6/18." - "6/23: ... [Client #1] seems to be in some discomfort, as indicated by her hitting at that area. The spot was more red than before, nursing notified." - "6/24: Staff noted the area continues to be red and swollen, nursing notified and [Client #1] added to the list for clinic on 6/25." - "6/25: ...seen in clinic, an antibiotic was ordered and started that evening. Guidance to staff was to send nursing a daily photo, have the area cultured if it produced fluid, continue to monitor.	V 291		

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V 291	Continued From page 44 QP [#1] and guardian are notified. Guardian asked to speak to QP [#1] and nursing in person the next day." - "6/26: ...Guardian expressed his frustration at not being notified sooner, feels [Client #1's] rights have been infringed upon. Apology offered and group received notification preferences. [Guardian] then insists that 1. [Client #1] be seen immediately in the emergency department 2. A nurse sees [Client #1] at the group home in person every day 3. That [Guardian] be permitted to see [Client #1's] injury/area of concern in person that day 4. [Guardian] receive a copy of the Incident Report 5. That HRC (Human Rights Committee) be notified of the issue. Note that during this meeting, [Guardian], brought up additional concerns, feeling that [Client #1's] rights are being violated because staff don't answer the phone when he calls. The previous day, QP [#1] and [Guardian] had already been in communication to establish a set time for [Client #1] to receive a phone call. A new phone and answering machine was also purchased." - "[Guardian] was told that the team would need guidance from the COVID hotline regarding a daily nurse visit, as well as how to proceed sharing the details of the incident report." - "Resolution was that staff send nursing a daily picture. Daily photo was (and continues to be) also sent to guardian with any updates. [Guardian] was asked to submit his request in writing. Summary of concern noted for HRC (Human Rights Committee) agenda. Additionally, the house was sprayed for spiders. Hillpark staff were in serviced on timely notification, as well as the ..." -Page 2 of email timeline was not provided for the survey. -No evidence was reported in the timeline that in person or virtual medical care was coordinated	V 291		

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V 291	Continued From page 45 for Client #1 as a result of the 6/23/20 and 6/24/20 staff phone calls to nursing or after the initial discovery of the wound between 6/19/20 to 6/22/20. Review on 6/28/20 of an email dated 6/26/20 at 9:46AM to the facility's Covid-19 hotline revealed: - Request reported the guardians wanted Client #1 seen in the ER on that date. - No response from the Hotline regarding the request was provided for the surveyor to determine what coordination of care was recommended and when. Review on 8/28/20 of nursing notes for Client #1 revealed: -There are 4 total nursing notes completed by the LPN related to Client #1's wound. ---Note #1: 6/25/20: "Client seen at med (medication) clinic to check what appeared to be an infected insect bite ...new order Clindamycin 150 mg 3x daily for ten days." ---Note #2: 6/29/20: "Insect area dry and flaky. Call to [the physician assistant]. New order Bactroban twice daily for 5 days." ---Note #3: 7/2/20: Insect bite, still swollen, warm. Taken to Urgent Care for evaluation. Lanced, drained, large amount purulent drainage. Continue antibiotic, warm compresses, daily dressing changes." ---Note #4: 7/7/20: Client seen by Physician Assistant [PA] at med clinic. Improvement noted. Clindamycin extended additional 7 days." ---No note for 6/30/20 Urgent Care visit attended by the LPN. ---No note for the LPN's call to the guardians at 7:00PM on 6/24/20 to notify of the injury per the guardians' interview on 8/26/20. ---No nursing notes documented further follow up care was completed as ordered by a physician on	V 291		

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V 291	Continued From page 46 the following dates: 1) 6/25/20: "Nurse will check her frequently." 2) 7/7/20: "Nurse will monitor it closely." 3) 7/16/20: Urgent Care order to "watch wound for the next couple days looking for increased redness fever or chills." 4) 7/28/20 "Continue to monitor insect bite." ---There were three calls to nursing by staff requesting guidance on wound care per QP #1's email dated 7/7/20 and these calls were not documented in nursing notes. Medical intervention per phone calls occurred on: 6/18/20, 6/23/20, and 6/24/20. ---Note dated 7/2/20 incorrectly reported Client #1's wound was lanced on 7/2/20. ---No notes to indicate "daily check-ins with staff occurred per QP #1's email dated 7/2/20." Review on 8/26/20 of an email sent by QP #1 dated 7/2/20 revealed: - "Nursing has continued daily check-ins with staff." Review on 8/28/20 of an email dated 7/7/20 from QP #1 to the facility's Administrator and Director of Operations revealed: - "6/18/20: " ...Nurse advised to apply Benadryl cream and a warm compress as needed." Review on 9/8/20 of the medical records for Client #1 revealed: -Client #1 had an injury of unknown origin that required treatment by a licensed health professional on nine dates as follows: 6/18/20,6/23/20, 6/24/20, 6/25/20, 6/30/20, 7/2/20, 7/7/20, 7/16/20, and 7/28/20. -There was no facility documentation to evidence wound care was coordinated/occurred as ordered (Benadryl cream, compresses, bandage changes, monitoring for fever) or that nursing	V 291		

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V 291	Continued From page 47 completed daily check-ins/follow up care as ordered. Review on 9/8/20 of the PA progress note for Client #1's first in-person medical exam on 6/25/20 revealed: - "Is seen today due to an infected area on her right shoulder consistent with an insect bite, although no bite was witnessed. The area is red and inflamed and has a nodular area in the center of it. However, the patient does have a history of hitting herself in that area and it may be that the insect bite was inflamed by her beating on the area and it has caused it to become more pronounced." -Ordered: Clindamycin 150 mg TID (3 times daily) x 10 days and "We will monitor very closely. The nurse will check her frequently and call [PA] with any concerns." Review on 9/8/20 of the Urgent Care Encounter Note for Client #1's second in-person medical exam on 6/30/20 revealed: -Was seen for an abscess. - "Caretakers first noticed a wound pop up on the right anterior shoulder 2 weeks ago and they state it has gotten progressively more and more red and elevated and now there is active fluctuance (pus which has accumulated beneath the epidermis). The patient was put on Clindamycin 4 days ago which they described helped the surrounding erythema (reddening of the skin from injury) but the fluctuant still remain." - "Patient had a 3 x 4-centimeter (cm) area of fluctuance and erythema" and "5 x 5 cm of erythema." -Local anesthetic was used and the area was lanced with "about 10 cc (cubic centimeters) of purulence (pus) was expressed." -Drainage: "copious" amount and "purulent and	V 291		

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V 291	Continued From page 48 bloody." - "Culture of purulence was obtained and 4cm (centimeters) of 1-inch gauze packing was placed (in the wound). Non-adhesive bandage and 4 x 4 dressing was applied to the site of the wound." -Ordered: "Caretakers were told to continue the Clindamycin which has 5 days left and to follow-up in 2 to 3 days for wound recheck. In the meantime, they were told to change bandages daily and to seek medical care for any new or worsening symptoms." Review on 9/8/20 of the Urgent Care Encounter Note for Client #1's third in-person medical exam on 7/2/20 revealed: - "Erythema surrounding wound is much improved after I&D (Incision and drainage) and Clindamycin. Patient does have what seems to be a fatty nodule protruding from the incision but no pus drainage and scant blood drainage from the site." -Patient "has been hitting herself like she does when she is in pain." -Ordered: "Continue Clindamycin and daily bandage changes along with warm compresses. Patient has an appointment coming up with her primary care doctor in next couple of days for which caretaker said they will follow-up with primary care for future wound checks." Review on 9/8/20 of the PA progress note for Client #1's fourth in-person medical exam on 7/7/20 revealed: -"Seen today in follow up of an abscess on her right shoulder ...the area was red, swollen but was not draining ...started her on Clindamycin and warm compresses ...the area seemed to get a little worse before it got better ...they took her to Urgent Care, where it was I&D'd and a wick (material that absorbs liquids) was placed, and	V 291		

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V 291	Continued From page 49 since then it has drastically improved." - "There is no swelling or drainage but there is an area about the size of a golf ball that is slightly red. The area also has a small piece of tissue sticking out of where the I&D occurred. That should resolve on its own. However, the nurse will monitor it closely and call me if it fails to resolve in 5-6 days." -Ordered: Extended Clindamycin 150 mg per pgt (percutaneous gastrostomy tube) tube TID for an additional 7 days. "Nurses will monitor it very closely and if it does fail to improve over the next 5-6 days, they will call me immediately. See back at next clinic, and the nurse will monitor closely until then." Review on 9/8/20 of the Urgent Care Encounter note for Client #1's fifth in-person medical exam on 7/16/20 revealed: -Seen for a wound recheck. "Caretaker states that the skin was getting back to its normal color but yesterday looked like it would have been more red and inflamed but now today it seems to have improved from yesterday." - "Upon exam patient mainly has post inflammatory hyperpigmentation with a little bit of serosanguinous (both blood and the liquid part of blood called serum) fluid weepage and healing cavity. Expressed serosanguinous fluid from the wound cavity." - "The redness has worsened. The swelling has worsened." -Ordered: "Again, the patient caretaker was told to watch wound for the next couple days looking for increased redness fever or chills and if she develops any of that, did not bring her back to the clinic." Review on 9/8/20 of the PA progress note for Client #1's sixth in-person medical exam on	V 291		

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V 291	Continued From page 50 7/28/20 revealed: - "Follow up for right shoulder lesion ...staff states area has improved. Will continue to monitor insect bite." Review on 8/26/20 and 9/29/20 of the Incident Response Improvement System (IRIS) revealed: -There was no IRIS report completed for Client #1's injury on 6/18/20 that required medical care by a licensed healthcare professional 9 times. Review on 9/8/20 of the Inservice Training for facility staff on Client #1's injury revealed: -Training date 6/30/20 (no time/place reported) entitled "Incident Reporting and Documentation." -Purpose of the training was outlined in one paragraph reviewing what is an incident (Absence Without Leave and aggressive clients) and how to fill out an incident report. - Client #1's injury or how it was to be managed was not covered in the training, nor was contacting the QP when any incident occurred. - Four staff signed the training form (Staff #1, #2, #3, and #4). Interviews between 8/26/20 and 9/15/20 with the guardians (father and step-mother) for Client #1 revealed: -Was first notified of the wound at 7:00PM on 6/24/20 by the LPN and they were told that Client #1 had a mosquito bite that occurred on 6/18/20 and it had gotten red and bigger and that Client #1 should be seen by the doctor the following day (6/25/20). - Were upset about the late notification (6 days) of the wound by staff and the lack of subsequent follow up caused them to worry and fear for Client #1's safety in the home. "We didn't know if [Client #1] was dead or alive." -Went to the 6/25/20 appointment with the	V 291		

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V 291	Continued From page 51 facility's Physician Assistant (PA) to see the wound in person. - "The wound was huge, swollen, and the skin was broken ...looked like someone poured acid on her arm ...it was not covered with a bandage or anything under her shirt." -Staff #2 told the guardians it looked that way because Client #1 hit it and Staff #1 and the LPN "nonchalantly" stated "That's what happens when you live in the woods (mosquito bites)." -Requested an immediate meeting with QP #1 and the LPN that was set for 6/26/20 and at that meeting, requested Client #1 be taken to the Emergency Room (ER) that day for care by a medical doctor. -Left the 6/26/20 meeting believing Client #1 would be taken to Urgent Care that day. -Client #1's visit to Urgent Care was not coordinated until 6/30/20, at which time the wound was lanced, bandaged and a follow up appointment set. -Wound is healing now but still "looks discolored." - "This wound should not have gone this far-it should never have gotten infected." - "I just want the lives of the clients in the facility to be cared for." Interview on 9/2/20 with Staff #1 revealed: -Worked there 10-12 years. -Saw Client #1's injury on 6/18/20. "It looked like a bug bite, a hive with a rash, called the nurse who said to ice it, swelling went down, don't know how many days later it was red and swollen again." - "A week later, maybe a few days later, [Client #1] went to Urgent Care, we were told to come back again on a day the same day doctor was there-he (the doctor) said it (the wound) looked good, but it looked funky to us. He (the doctor) said it was normal the 2nd time [client #1] went	V 291		

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V 291	Continued From page 52 back ...it was healing nicely." -Between 6/18/20 and 6/24/20 "it looked like a mosquito bite and went down and looked normal, it came back and then she [Client #1] saw the doctor (PA) the next day. I checked it every day. It was pink and red and didn't need anything." - "I put a cool cloth on it and Benadryl cream on 6/18 and it looked better." Was not sure if it was to be applied more than that one time. Was not directed to do this more than one time by the nurse. -Protocol for wound care was to "go to the doctor, inform people who need to know." -Did not administer any basic first aid (cleaning wound, bandaging wound)- "There's sometimes you don't put a bandage on." - "Doctor said it (the wound) was [Client #1] hitting on herself and she scratched herself with a fingernail." - "With spastic, she [Client #1] hits herself ...if it was itching, she could've hit it more so that made it red, overnight it got raised up." - "With Covid, no one could come in the house for a visit ...[guardians] had to visit outside with much social distancing and they visited under a tree in the back yard...something in the tree got on her [Client #1]." Interview on 9/8/20 with Staff #2 revealed: -Resigned during the survey on 9/2/20. Worked there "2 years this last time." - "Was there when the wound still first appeared. We reported it the day we noticed it, it appeared to be mosquito bite, [Staff #1] took picture." - "Over 4-5 days, it had swelled up and appeared to be infected, then [Client #1] saw the RHA doctors. I feel it was treated and did start to heal up." -IR Policy "is to call nurse [the LPN] and QP [#1], we were in habit of just calling the nurse as she	V 291		

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V 291	Continued From page 53 usually calls QP ...we were probably wrong on that point." - "Clients are not bathed daily, maybe 2 times a week, dates bathed are not documented anywhere". Interview on 8/26/20 with QP #1 revealed: - "Spider bite occurred on 6/18/20. Bite was almost in client's armpit-shoulder area." - Wound was "a lump, really red around it, size of a small tangerine or small child's hand. As it was healing it looked really gross, stayed pink and crusted up." -Not sure if was red because Client #1 "smacked it because it bothered her or if it was just irritated." -Nurse was called on 6/18 who prescribed Benadryl cream and cold compresses." - "Staff put Benadryl cream on the area one time and did a cold compress one time." - "There was no change in the area, so it was considered a non-issue." -Staff did not call QP #1 between 6/18/20 and 6/24/20. QP #1 was made aware of the wound on 6/25/20. Staff said they didn't call QP #1 because the wound didn't get any worse. -Guardians came to the facility on 6/25/20 for a scheduled "clinic" meeting with the PA which occurs two times per month. Client #1 saw the PA on 6/25/20 who prescribed an antibiotic and continued cold compresses. -Guardians were upset they had not been notified immediately and they wanted Client #1 to go to urgent care that day (6/25/20). -Couldn't take Client #1 to urgent care without notifying administration due to Covid-19 precautions and the need to "weigh potential exposure to the virus with the spider bite urgency." -Guardian wanted daily nurse visits but that could	V 291		

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V 291	Continued From page 54 not be accommodated due to Covid-19 restrictions. Nurses were not allowed in the group homes, only in the main office building. -There was a delay in getting approval to take Client #1 to Urgent Care due to the need to go through the Covid-19 policy to get approval for any off-site visit to the community. -QP #1 offered to send guardian daily pictures of the wound which she did. - "It was determined on 6/26/20 or 6/29/20 that client could go to urgent care. Urgent care directed to continue antibiotics and no new care instructions were prescribed." - "On 7/3/20, [Client #1] was taken to Urgent care again as the bite really did worse after the guardian saw it. Urgent Care lanced the wound and cultured it. No specific infection was determined, just that it was infected." -The PA reviewed the Urgent Care notes on 7/7/20 and observed the wound to be "healing nicely." -Guardians were to receive a daily call starting 6/25/20 from facility staff to update on Client #1. -Thought this was happening until guardians called her to report ongoing issue of the house phone was still not being answered Interview on 9/8/20 with the facility's contracted PA revealed: -Had worked there since 6/1/20 and went to facility main office every other Thursday. - "Doesn't remember" his reaction to seeing Client #1's wound for the first time on 6/25/20. -Guardians were "pleased with the game plan ...what exactly are they complaining about now?" -Read progress notes for 6/25/20, 7/2/20 and 7/7/20 verbatim in response to all surveyor questions. -When asked for his professional opinion regarding wound care for Client #1 he stated	V 291		

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V 291	Continued From page 55 "That's a loaded question-do you want to hand me a bear trap to stick my hand into next? I have no opinion about that ...that's the safest way I can answer that". Finding #2: The facility failed to coordinate a pureed diet as ordered for Client #1. Review on 9/24/20 of medical reports faxed from a local hospital to the surveyor for Client #1 revealed: --3/11/20: Was seen for a follow-up on her feeding tube. -The "very attendant caregiver" asked the doctor whether or not Client #1 could eat normally by mouth. -The doctor replied "I explained to him I have no way to determine this without access to old available records or a modified barium swallow test through speech therapy as I do not know whether the tube was placed for feeding and/or medication administration ..." -The Encounter Note reported need for further assessment before a recommendation could be made for oral feeding. Note: No further follow up on the 3/11/19 recommendation for a barium swallow test until 9/1/20. --10/3/19: Was seen with a group home caregiver who reported Client #1 recently moved to the group home and they (staff) were interested in having her feeding tube changed to a different type of low-profile feeding tube. The doctor reported in the encounter note that he was not provided client records/medical history as to what type of feeding tube Client #1 had or where it was placed and by whom. "Her past surgical history is only known as gastrostomy tube placement with no other details noted" and "Since we have absolutely no idea what we are dealing with, I	V 291		

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V 291	Continued From page 56 have recommended obtaining both a plain abdominal x-ray as well as a feeding tube study with oral contrast to determine the location and type of feeding tube." ---No coordination of care between medical providers had occurred by QP #1 in preparation for the facility's request to change the type of feeding tube Client #1 had. Review on 9/15/20 of medical records emailed from the guardians of Client #1 to the surveyor on 9/7/20 and 9/15/20 revealed: -History and physical dated 8/8/19: Document was from previous facility and completed prior to admission at Hillpark Group Home on 9/3/19. Reported Client #1 "continued g tube feeding at night and is on a pureed diet with thin liquids during the day." -Barium Swallow test and Speech Pathology report dated 9/1/20: "Findings ...Barium was administered in multiple consistencies in puree, thick liquid, liquid and solid. The was no penetration or aspiration of barium during the study." -Penetration Aspiration Score: "1-Material does not enter airway." -Assessment: "The patient managed all trials with no airway compromise ...recommend puree diet and NTL (Nectar-thick liquids. Patient has PEG (Percutaneous endoscopic gastrostomy) for nutritional support. Recommend oral feeding for comfort when desired by patient." -Treatment plan dated 6/26/20 Diet: "It is important that [Client #1] maintain as much of her current abilities as possible. She really enjoys eating and should continue to do so orally for as long as it is safe to do so. It may be helpful to talk her through what she will be eating. Starting and ending the meal with sweeter tasting foods can improve her eating."	V 291		

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V 291	Continued From page 57 Review on 9/8/20 of the physicians' orders for Client #1' diet revealed: -Ancillary Orders on MAR dated 9/2/19 report "Puree Diet, Osmolite 1.5 via G-tube (gastrointestinal tube) at 50 milliliters (ML) per hour with water prior to feed and after feed." -Ancillary Orders on MAR dated 9/5/19 and 10/7/19 report "flush PEG (Percutaneous endoscopic gastrostomy) tube with 120 ML of water before and after nocturnal feedings." - Ancillary Orders on MAR dated 9/5/19 report "Every shift flush with 120 ML water before and after medications." Review on 9/8/20 of the June 2020 MAR for Client #1 revealed: -No June 2020 MAR was submitted for review. -Due to the failure to accurately document medication administration, it could not be determined if client #1 received a pureed diet or had her PEG tube flushed before and after feedings and after medications were administered as ordered during June 2020. Review on 9/8/20 of the July 2020 MAR for Client #1 revealed: -The pureed diet was on the July MAR to be administered but was not documented as administered on any date/time for the month of July 2020. -Cleaning and flushing the feeding tube was not documented as completed on the July MAR. -Due to the failure to accurately document medication orders and administration, it could not be determined if client #1 received a pureed diet as ordered or if the feeding tube was cleaned and flushed daily as ordered during July 2020. Review on 9/7/20 of a text message from QP #1	V 291		

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V 291	Continued From page 58 to the guardians of Client #1 dated 9/1/20 at 1:46PM revealed: - "Hey there. [Client #1] had her swallow study today. The physician will review the results at clinic next week (as is protocol) and we will have a clear picture as to whether removal of the feeding tube is realistic or not. Results of swallow study reported that she should not take meals orally, but comfort bites as tolerated are ok." Review on 9/15/20 of an email to the surveyor from the guardians of Client #1 on 9/15/20 revealed: - "Concerning the swallow test. How [QP #1] come up with this when what she said is not what the reports states. As you can see by the study the report indicates that [Client #1] has no problem with swallowing with multiple consistencies including puree, thick liquid, liquid, and solid. The nurse said today 9/07/2020 they have not received the report from the speech pathologists yet. So how did [QP #1] come up with this. What she says in not correct at all." Interviews between 8/26/20 and 9/15/20 with the guardians for Client #1 revealed: -Client #1 was not offered pureed meals that were medically ordered during the day. Staff continually reported only giving Client #1 a few bites of yogurt. -Had numerous conversations with staff about providing the pureed diet that was ordered, but staff continued to report only giving Client #1 a few bites of yogurt. -Always asked staff "what did [Client #1] have for dinner and they'd always say Yogurt." -Had asked staff if they were pureeing meals for Client #1 and they would report they "didn't think she'd like that (meal) pureed." -Had told staff they had to at least offer the same	V 291		

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V 291	Continued From page 59 meal, pureed, that the other residents were having. -When guardians brought this concern to QP #1, she reportedly stated that Client #1 didn't like any of the food options the guardians had suggested and that Client #1 would "choke to death" if offered the options the guardians suggested (ice cream, mashed potatoes). -Guardians insisted the facility get a Barium Swallow Test done as guardians wanted the feeding tube removed and/or a very clear directive/medical order on how the facility is to be feeding Client #1. -Wanted specific medical recommendations regarding oral feeding and pureed diet from the Barium Swallow test added as goal for Client #1's to hold staff accountable for following through with the strategies ordered by medical providers. -Wanted ongoing medical consultation with an independent specialist for Client #1's diet to occur. Review on 9/22/20 of a text from the guardians of Client #1 to surveyor revealed: -They attended a medical appointment with Client #1 on 9/22/20 to discuss Client #1 not getting a pureed diet. -The Physician's Assistant (PA) reported that the pureed diet should not have not been changed (discontinued) and that Client #1 should be left on this diet until there was an order to change it. -QP #1 reported to the guardians and the PA that staff changed/stopped the pureed diet. Interview on 9/2/20 with Staff #1 revealed: -Client #1 was "only one tube fed." Interview on 9/17/20 with Former Staff (FS) #3 revealed: -Was doing pureed meals for Client #1 twice daily	V 291		

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V 291	Continued From page 60 prior to her resignation as House Manager (December 2019). Interview on 9/8/20 with FS #4 revealed: -Worked there 7 years. Left 7/6/20. - "Yogurt was only thing fed to her, staff never pureed food for her." - Client #1 did not get breakfast. - Often fed in her room and not at dinner table with others. Finding #3: The facility failed to coordinate client #1's personal Hoyer lift being delivered to her family for use at their home during visits with Client #1. Review on 9/15/20 of a medical order from the previous facility provided by the guardians of Client #1 revealed: - Report with medical orders was signed and dated 8/8/19 and was from Client #1's previous facility that transferred Client #1 to Hillpark Group Home. -Client #1 was ordered her own Hoyer lift for her personal use upon discharge from this facility. - "Lift ...was being ordered for discharge... She is total assist with total lift due to her disability with significant flexion contractures to both legs." Review on 9/8/20 of an email from QP #1 to the surveyor dated 9/8/20 revealed: - "The nurse was in the process of ordering a new Hoyer. At the in-house clinic on 8/26 (2020), the physician noted that Medicaid was unlikely to pay for a new lift, as one had recently been purchased for [Client #1] and was in use in the group home. The acquisition of a second lift for [Client #1] would need to be purchased by RHA. With this information, I personally called [guardian] to tell her that as RHA property, a	V 291		

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V 291	Continued From page 61 second lift would not likely be authorized to leave the group home, however the process to order it would continue. There is plenty of storage space at the group home. Inadequate storage space is not a reason to stop this process." Review on 9/15/20 of a text from QP #1 sent to the guardians dated 12/12/19 revealed: - "Sorry for the delay. Please know we are still working on it. It's just a matter of cost and space. There is not practically room for a third lift in the house. Medicaid is paying for it and this is a very lengthy process and can take up to a year. RHA is willing to by one but has already purchased 2 lifts this past year." Interview on 9/1/20 with the guardians of Client #1 revealed: -Client #1 had a Hoyer Lift ordered for her personal use by her former facility in August or September of 2019. The guardians had not received the lift as of September 2020 and their continued follow-up with QP #1 had resulted in different reasons given on the status of the Hoyer lift. - "[Client #1] deserves her own Hoyer lift to keep at her [guardians] and we requested RHA reorder one for use at home so we can change her when she visits." - "We documented conversations with [QP #1] about the missing Hoyer lift on December 12, 2019, May 7 and May 14 of 2020 and on August 28, 2020." - Guardians stated they "haven't seen it in a year. [QP #1] told us she cancelled the order as the house already has a lift and there's not enough room to store [Client #1's] personal one. No one asked us about cancelling the order. We insisted [QP #1] re-order one but she said the family might not get one because they (RHA) had	V 291		

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V 291	Continued From page 62 already ordered one." - "On May 7, 2020, [QP #1] said RHA stopped the process of ordering a Hoyer lift for [Client #1] when RHA bought a new one. I told her that Medicaid was going to pay for [Client #1's] anyway. We want to store it at our house so when [Client #1] comes to visit, we have one for her. [QP #1] said she was shooting an email to the right now!" -QP #1 explained that "RHA canceled the Hoyer lift for [Client #1] to own and said they canceled the order because RHA has one that's electric." -Were told by QP #1 that they "could keep no more than 3 Hoyer lifts in the house because they had no storage." - "We asked for evidence they canceled the Hoyer lift and evidence that they re-requested one for the family to use for her at home." - "If we could get the order information, we can track down the date the Hoyer lift was delivered to RHA or when and who canceled the order so we could follow up with getting another one." No documentation was provided. - "At our last visit, I counted 3 in the garage and all had client names on them, and none were labeled as [Client #1's]." Interview on 9/8/20 with Staff #2 revealed: - "[Client #1] was to come with a Hoyer lift, but she didn't come with one. There's an electric one we use for all of them, RHA purchased that." - "We did have 2-3 other ones are in the garage, one belongs to [Client #4], one belongs to [Client #3], and the 3rd is RHA's." Interview on 9/17/20 with Former Staff (FS) #3 revealed: -Was former House manager for 11 years, left in February 2020. - "[Client #1] never had a personal lift. "	V 291		

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V 291	Continued From page 63 -Was told by QP #1 that "RHA purchased an electric one at the front office, they brought it to the house for [Client #1]. RHA paid for it and ordered it for use at the center, but no clients at the center needed it for changing and Hillpark was still doing 2 person lifts to change clients. [Client #1] needed one so the maintenance guy brought it over. It was brand new. [QP #1] was going to order [Client #1] one for herself." Interview on 9/16/20 with FS #4 revealed: - "RHA got an electric lift used between [Client #1] and [Client #4]." - "There was an old manual one in garage. The nurse could have taken the lift in the garage to one of the other houses to use." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 291		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse	V 364	The Director of Operations and Administrator in-serviced staff on 9/18/20 on answering the phone and the client's right to daily phone calls. The Maintenance Technician has worked with the telephone provider to fix phone lines. The Administrator and clinician team will monitor the working order of the phones lines through weekly supervision visits to the home. The Residential Team Leader monitors to ensure Client #1 has the right to daily phone calls. In the future the Qualified Professional will ensure all clients have the right to receive and make phone calls. By: 10-10-20	

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V 364	Continued From page 64 professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the	V 364		

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V 364	Continued From page 65 conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10)Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or	V 364		

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V 364	Continued From page 66 guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to	V 364		

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V 364	Continued From page 67 G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10)Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.	V 364		

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V 364	Continued From page 68 This Rule is not met as evidenced by: Based on interviews, the facility failed to ensure the right to make and receive phone calls for 1 of 1 audited clients (Client #1). The findings are: Review on 6/28/20 of emails sent from Qualified Professional (QP) #1 to the Administrator and Director of Operations staff revealed: -6/26/20: " ...my list of action items includes getting an answering machine for the group home. I spoke with the family yesterday and we already established a time for them to call-staff have been notified that they need to anticipate a daily call at 5:30pm." -6/30/20: "Staff will purchase an answering machine-probably a new phone as well. A set time was established for the [guardians] to call each day and staff know to anticipate a call at that time." -7/7/20: 6:26 on timeline in the email reported: "Note that during this meeting, [guardian] brought up an additional concern, feeling that [Client #1's] rights are being violated because staff don't answer the phone when he calls. The previous day, QP [#1] and [the guardians] had already been in communication to establish a set time for [Client #1] to receive a phone call. A new phone and answering machine was also purchased." Interviews between 8/31/20 and 9/15/20 with the Guardians of Client #1 revealed: -Staff did not answer the phone at the facility restricting contact with Client #1. -Believed this was a human rights violation.	V 364		

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V 364	Continued From page 69 -Met with QP #1 on 6/26/20 to discuss concern that they could not get in touch with the facility to talk to/check on Client #1 and they couldn't visit during Covid-19, which made them unaware of Client #1's safety and wellbeing in the home. -They called daily during the week of 6/18/20 to 6/25/20 in an attempt to talk with staff and Client #1 but the phone was not answered. -Was told by QP #1 that the facility had a non-working answering machine. -Agreement was made that the facility staff would have a set time that was convenient for the staff to talk to the guardians at 1:30PM daily. -Staff still did not answer the phone at the set time and the guardians called at 1:30PM and then 3-4 times a day after 1:30PM. -The continued absence of phone calls was reported to QP #1 several times and the response was that QP #1 never had trouble getting her calls answered. -Per Client #1's step-mother, "The week of September 7th, we were out of town camping and couldn't reach the facility again at the scheduled time. On Wednesday the 9th, no one answered the phone at Hillpark. We called every 15 minutes between 1:30PM and 4:00PM, then we called [QP #1] who said she had just spoke to staff and for us to keep calling." -QP #1 said she called Hillpark and told staff that guardians would call back at 7:00PM. The guardians called at 7:00PM and still didn't get an answer. They tried 2 more times that night with no answer to their calls. - "We didn't do anything all day on our vacation to meet the 1:30PM call time, we cut dinner short with our family to accommodate the 7:00PM call time and then we debated on calling the sheriff for well person check." - "We don't trust Hillpark to give us any information and we wasn't sure if [Client #1] was	V 364		

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V 364	Continued From page 70 dead or alive. We will call sheriff next time." Interview on 9/2/20 with Staff #1 revealed: -QP #1 set up a 1:30PM call daily. - "[The guardians] have to understand we can't always answer the phone." - "We didn't have an answering machine. We didn't answer calls from a private number-It's a salesperson and they can wait a minute for a call back. We didn't have [the guardians] phone number. It was in their paperwork and [QP #1] had to get it. We figured it was a phone issue, so we got a new phone." Interview on 9/8/20 with Staff #2 revealed: - "[The Guardians] always called in the middle of dinner at 6:30PM. We didn't have time for calls then, it was one of the issues with having only 2 staff. [QP #1] gave them a time to call at 1:30PM." - "It was a problem that staff can't hear the phone ring. It was a cordless phone and it wasn't holding a charge." - "We couldn't hear the phone ring, or we couldn't leave a client to answer the phone." -Answering machine was not working, so we got a new phone as soon as possible-that week." Interview on 9/8/20 with Former Staff #4 revealed: - "The phone was always dying and there was trouble with the phone line which made the phone not work and the alarm system go down. There was a wiring problem for a while, so no phone calls came in." Interview on 8/26/20 with QP #1 revealed: -Guardians were to receive a daily call starting 6/25/20 from facility staff to update on Client #1. -Thought this was happening until guardians	V 364		

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V 364	Continued From page 71 called her to report the ongoing issue with the house phone not being answered by staff. -No additional measures were taken to ensure staff answered the phone at the group home. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 364		
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.	V 367	The Administrator and Qualified Professional were re-trained on 9/24/20 on the Incident Reporting Requirements by the Regional Quality Assurance Specialist. The Administrator will monitor all Incident Reports to determine if they are a level 2 or level 3 and ensure all reporting requirements are met. The Director of Operations or Regional Vice President will review all Nursing on Call Logs to determine what level of incident occurs and to make sure the unit follows all reporting requirements. In the future the Administrator will ensure all reporting requirements for Incident Reporting are completed. By: 10-10-20	

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V 367	Continued From page 72 (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: (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;	V 367		

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V 367	Continued From page 73 (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. This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to report a Level II incident to the Local Mental Health Managed Care Organization (LME/MCO) within 72 hours for 2 of 2 audited clients (Client #1 and #2). The findings are: Review on 8/28/20 of the facility's Policy and Procedure on the "Internal Incident Report Process" revealed: -Initiate an incident/accident report as soon as possible. -Leave the level of injury section on the Incident Report (IR) for an administrative staff to complete. - "The incident/Injury information must be entered into the Event Tracking System within 72 hours of the event or discovery of the injury."	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL045-067	A. BUILDING: _____ B. WING _____	C 09/18/2020

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V 367	Continued From page 74 Review on 8/28/20 of the facility's Policy and Procedure on the "Internal Incident Report Process" revealed: - "Physician Intervention: ...nursing should ensure that the medical record reflects that the doctor was notified and any recommendations that were made and that the nurse follows up on any consults that were ordered as a result. Examples of documentation could be ER report, consultation report, add or change doctors order, etc ...Reminder: document in nursing notes in the client record." - "Nursing/Medical review or intervention should be within 24 hours of the report" and should include "date and time of the exam." - "Nursing should sign the report as soon as they review the situation." Finding #1: Client #1 evidenced an unknown injury on 6/18/20. Review on 9/8/20 of emails sent to the QP #1, The Administrator and the Chief Executive Officer between 8/26/20 and 9/8/20 from the surveyor requesting the Incident Report (IR) revealed: -Four requests were made to receive the IR for Client #1 on the following dates: 8/36/20, 8/28/20, 9/4/20, and 9/8/20. -General Statute 122C-25 was sent on 8/31/20 to Qualified Professional (QP) #1 after she reported the IR could not be provided due to containing "proprietary" information. Review on 8/28/20 of an email dated 8/28/20 sent by QP #1 to the surveyor revealed: - "I have to wait for Chief Compliance Officer to send the requested "data." - "Our Chief Compliance Officer responded that the incident report form is RHA's proprietary information, providing a summary of the events &	V 367		

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V 367	Continued From page 75 response, which I faxed to you, is all I was allowed to do." - "If you were here in person, I'd be allowed to let you review it. However, since I've had to send the documents, I was only authorized to send a summary, which I included in the fax." -In response to General Statute 122C-25: "I'm going to pass this on and see what they think. I know that their first response was that they wanted us to comply fully, and then that they had to pass it on up the chain. I'm going to send this message along to my leadership team and hope for the best. Thanks for your patience!" - "This was considered a level 1 incident, which we did not report via IRIS (Incident Response Improvement System)." Review on 9/2/20 of an email dated 9/2/20 sent by QP #1 to the surveyor revealed: - "I sent the incident report via fax, but I didn't include a cover sheet." Note: IR was not received on this date by fax as indicated. Review on 9/8/20 of emails dated 9/8/20 sent by QP #1 to the surveyor revealed: -9:51AM: "I'll send it within the hour." -11:04AM: At this point, I think that I have sent in everything except for ...evidence of giving [guardians] a copy of the incident report. My recollection is that after our Chief Compliance Officer approved it, I put a copy in an envelope & his wife picked it up from me in person, at our office." -10:04AM: Received the IR attached to an email on this date. Review on 9/8/20 of the Incident Report (IR) for Client #1 dated 6/18/20 revealed: -The section to label the injury as a level 1, 2 or 3	V 367		

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V 367	Continued From page 76 was left blank. -Type of incident labeled as "other." -Qualified Professional (QP #1) and the Administrator signed the incident report on 6/26/20. -Guardians notification date was illegible. -QP #1 Follow up reported as "Seen in clinic 6/25, antibiotic started. Staff will agree to reporting to nursing daily on healing as encouraged by physician. Topical antibiotic to be started." -Need for 24-hour follow-up was checked "yes" in the nursing Review section. -The LPN signed the IR 11 days post incident on 6/29/20 after completing the description of treatment given. Review on 8/26/20 of an email sent by QP #1 dated 7/2/20 revealed: - "Nursing has continued daily check-ins with staff" regarding Client #1's wound. Review on 9/8/20 of the medical records for Client #1 revealed: -Client #1 had an injury of unknown origin that required assessment/treatment by a licensed health professional on 6/18/20, 6/23/20, 6/24/20, 6/25/20, 6/30/20, 7/2/20, 7/7/20, 7/16/20, and 7/28/20 (See V291 for details). Review on 8/26/20 and 9/29/20 of IRIS revealed: -There was no IRIS report completed for this medical injury for Client #1 that was noticed on 6/18/20. Review on 8/28/20 of an email dated 7/7/20 from QP #1 to the facility's administrator and Director of Operations revealed: - "Hillpark staff were in serviced on timely notification" regarding Incident Reports.	V 367		

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V 367	Continued From page 77 Review on 9/8/20 of the Inservice Training for facility staff on Client #1's injury revealed: -Training date 6/30/20 (no time/place reported) entitled "Incident Reporting and Documentation." -Purpose of the training was outlined in one paragraph reviewing what is an incident (Absence Without Leave and aggressive clients) and how to fill out an incident report. - Client #1's injury or how it was to be managed was not covered in the training, nor was notifying the QP on the date an incident occurred. - Four staff signed the training form (Staff #1, #2, #3, and #4). Interviews between 8/26/20 and 9/15/20 with the guardians (father and step-mother) for Client #1 revealed: -Was first notified of the wound at 7:00PM on 6/24/20 by the LPN. Were upset about the late notification (6 days) of the wound and the lack of subsequent follow up by the facility staff. -Saw the wound on 6/25/20 and it "was huge, swollen, and the skin was broken ...looked like someone poured acid on her arm ...it was not covered with a bandage or anything under her shirt." -Guardians requested a copy of the incident report twice by text and email to QP #1 and have not received one to date. Interview on 9/2/20 with Staff #1 revealed: -Had not had an in-service training on Incident Reporting. "Direct care doesn't do incident reports, there's protocol like let the behavior person know." - "Made calls to keep everyone updated." -Did not call QP #1 on Client #1's wound because "Nursing does that. I only call [QP #1] when I'm confused."	V 367		

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V 367	Continued From page 78 Interview on 8/26/20 with QP #1 revealed: - "Spider bite occurred on 6/18/20...the nurse was called on 6/18/20 who prescribed Benadryl cream and cold compresses." - QP #1 was not made aware of wound on 6/25/20. The facility policy was to call the QP and the nurse if there was an incident. - Staff reported they didn't call QP #1 because "There was no change in the area, so it was considered a non-issue." - The wound was "a lump, really red around it, size of a small tangerine or small child's hand. As it was healing it looked really gross, stayed pink and crusted up." - The guardians "picked up a copy of the IR from me in person." -Staff attended an In-Service training on 6/30/20 on Incident Reporting and contacts to be made that included direct care staff contacting QP #1 so that she could then contact a client's guardian. Finding #2: Client #2 was Absent Without Leave (AWOL). Review on 9/8/20 and 9/29/20 of the Incident Response Improvement System (IRIS) for Client #2 revealed: -There was no IRIS report completed for going AWOL on an unknown date in June or July 2020. Interview on 9/8/20 with Staff #2 revealed: - "Client #2 ran away, she went AWOL in June." -Client #2 left the property, walked to end of driveway, crossed street, went to a neighbor's house, took their mail, brought it back home and ripped it up in her room. -The neighbor whose mail was stolen alerted staff, who did not know Client #2 had left the house. - "No one knew for sure how long she was	V 367		

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V 367	Continued From page 79 actually gone." - "We started to get 3 staff after that incident." Interview on 9/16/20 with Former Staff (FS) #4 revealed: - "[Client #2] went AWOL in June or July. She came out of the house naked, crossed street, got mail and then shredded the mail. Staff didn't notice until neighbor came by who was missing their mail. The Incident was reported to the QP [#1], whether she did anything about it, I don't know." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 367		
V 540	27F .0103 Client Rights - Health, Hygiene And Grooming 10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING (a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the: (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to shave at least daily; (3) opportunity to obtain the services of a barber or a beautician; and (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving	V 540	The clinical tem developed and implemented a personal hygiene schedule/routine and checklist and in-serviced the staff on the routine. This was completed by 9/18/20. The Director of Operations and the Administrator met with the Residential Team Leader on 9/18/20 to review the homes staffing schedule to ensure it was appropriate to meet client needs. The Administrator will review and monitor the house schedule weekly with the Residential Team Leader to ensure enough staff are in place to provide appropriate care. The clinical team will monitor the clients health, hygiene, and grooming during their supervision visits at least three times a week for 60 days and then on a routine basis . In the future the Qualified Professional will ensure clients are afforded the opportunity for a daily shower. By:10-10-20	

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V 540	Continued From page 80 utensil. (b) Bathtubs or showers and toilets which ensure individual privacy shall be available. (c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available. This Rule is not met as evidenced by: Based on interviews, the facility failed to provide the opportunity for a daily shower for 2 of 2 audited clients (#1 and #2). The findings are: Interview on 9/8/20 with Staff #2 revealed: - "Clients are not bathed daily, maybe 2 times per week, dates bathed are not documented anywhere. There were too much client needs for what staff they have." - "There was no one in charge of daily house needs" after former house manager left in February 2020. Interview on 9/16/20 with FS #4 revealed: - "All the client needs can absolutely not be managed." - "Client bathing was not done daily- usually every other day." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 540		

RHA
HEALTH SERVICES, INC.

DHSR - Mental Health
NOV 6 2020
Lic. & Cert. Section

October 30, 2020

145 Cane Creek Ind. Park Rd
Suite 250
Fletcher, NC 28732

Phone: 828.684.1940
Fax: 828.684.1553

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Complaint Survey completed September 18, 2020

Dear Ms. Takala:

Please find the enclosed Plan of Correction for the Hillpark Group Home complaint survey. If you have any questions feel free to contact me at john.carithers@rhanet.org or call me at 828-817-9565.

Thank you,

John M. Carithers
Facility Administrator
828-817-9565
john.carithers@rhanet.org