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V 000	INITIAL COMMENTS A complaint survey was completed on 10/30/2020. The complaint was unsubstantiated (intake #NC170524). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.	V 000		
V 368	G.S. 122C-63 Assurance for continuity of care § 122C-63 ASSURANCE FOR CONTINUITY OF CARE FOR INDIVIDUALS WITH MENTAL RETARDATION (a) Any individual with mental retardation admitted for residential care or treatment for other than respite or emergency care to any residential facility operated under the authority of this Chapter and supported all or in part by state-appropriated funds has the right to residential placement in an alternative facility if the client is in need of placement and if the original facility can no longer provide the necessary care or treatment. (b) The operator of a residential facility providing residential care or treatment, for other than respite or emergency care, for individuals with mental retardation shall notify the area authority serving the client's county of residence of his intent to close a facility or to discharge a client who may be in need of continuing care at least 60 days prior to the closing or discharge. The operator's notification to the area authority of intent to close a facility or to discharge a client who may be in need of continuing care constitutes the operator's acknowledgement of the obligation to continue to serve the client until: (1) The area authority determines that the client is not in need of continuing care; (2) The client is moved to an alternative	V 368		

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residential placement; or
(3) Sixty days have elapsed;
whichever occurs first.
In cases in which the safety of the client who may be in need of continuing care, of other clients, of the staff of the residential facility, or of the general public, is concerned, this 60- day notification period may be waived by securing an emergency placement in a more secure and safe facility. The operator of the residential facility shall notify the area authority that an emergency placement has been arranged within 24 hours of the placement. The area authority and the Secretary shall retain their respective responsibilities upon receipt of this notice.
(c) An individual who may be in need of continuing care may be discharged from a residential facility without further claim for continuing care against the area authority or the State if:
(1) After the parent or guardian, if the client is a minor or an adjudicated incompetent adult, or the client, if an adult not adjudicated incompetent, has entered into a contract with the operator upon the client's admission to the original residential facility the parent, guardian, or client who entered into the contract refuses to carry out the contract, or
(2) After an alternative placement for a client in need of continuing care is located, the parent or guardian who admitted the client to the residential facility, if the client is a minor or an adjudicated incompetent adult, or the client if an adult not adjudicated incompetent, refuses the alternative placement.
(d) Decisions made by the area authority regarding the need for continued placement or regarding the availability of an alternative placement of a client may be appealed pursuant

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to the appeals process of the area authority and subsequently to the Secretary or the Commission under their rules. If the appeal process extends beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange a temporary placement in a State facility for the mentally retarded pending the outcome of the appeal.

(e) The area authority that serves the county of residence of the client is responsible for assessing the need for continuity of care and for the coordination of the placement among available public and private facilities whenever the authority is notified that a client may be in need of continuing care. If an alternative placement is not available beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange for a temporary placement in a State facility for the mentally retarded. The area authority shall retain responsibility for coordination of placement during a temporary placement in a State facility.

(f) The Secretary is responsible for coordinative and financial assistance to the area authority in the performing of its duties to coordinate placement so as to assure continuity of care and for assuring a continuity of care placement beyond the operator's 60-day obligation period.

(g) The area authority's financial responsibility, through local and allocated State resources, is limited to:

(1) Costs relating to the identification and coordination of alternative placements;

(2) If the original facility is an area facility, maintenance of the client in the original facility for up to 60 days; and

(3) Release of allocated categorical State funds used to support the care or treatment of the

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V 368	Continued From page 3 specific client at the time of alternative placement if the Secretary requires the release. (h) In accordance with G.S. 143B-147(a)(1) the Commission shall develop programmatic rules to implement this section, and, in accordance with G.S. 122C-112(a)(6), the Secretary shall adopt budgetary rules to implement this section. (1981, c. 1012; 1985, c. 589, s. 2.) This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the area authority (the Local Management Entity / Managed Care Organization (LME/MCO)) was notified 60 days in advance of the intent to discharge a client affecting 1 of 1 former clients (FC #1). The findings are: Reviews on 10/22/2020 and 10/23/2020 of FC #1's record revealed: - Admission date: 9/29/2020 - Discharge date: 10/7/2020 - Diagnoses: Attention Deficit-Hyperactivity Disorder; Autism Spectrum Disorder; Moderate Intellectual Disabilities; Vitamin D Deficiency; Constipation; History of abdominal trauma (2016); History of colostomy (2016); Extensive physical and emotional abuse; multiple transitions and changes in placement; geographical distance from natural supports; limited contact with natural supports. - An assessment dated 9/11/2020 and completed	V 368		

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by the Qualified Professional/Clinical Director (QP/CD) revealed:
- FC #1 used very few words and mostly communicated with grunts and gestures.
- "There is very little medical information on [FC #1]. She does not like to go to doctor's appointment as it trigger for inappropriate behaviors. It was reported that she went for an appointment and required several staff to intervene with her aggressive behaviors ..."
- An interdisciplinary team from the facility met on 9/23/2020 and approved FC #1's admission effective 9/29/2020 " ... under the following conditions: If the team determine that [FC #1's] health and safety needs cannot be met she will be discharged within 90 days. It was discussed with [FC #1's home LME/MCO], the guardian that it is a trial placement for [FC #1]."
- Referrals were recommended for evaluation and Behavior Support Plan (BSP) development by a Licensed Psychologist (LP), psychiatric services for medication management, and primary medical care services.
- An "Initial Behavioral Support Recommendations" plan developed by the LP and dated 9/29/2020 revealed:
- Target behaviors of aggression, self-injurious behaviors, and disruptive behaviors.
- Documentation of notes from a hospital in another area of the state revealed:
- FC #1 had been discharged from her previous group home and went to her Mother/Guardian's home on 8/31/2020.
- While at an urgent care office to have a TB skin test read on 9/3/2020, FC #1 bit the end of a nurse's finger off and attacked her Mother and Aunt.
- On 9/6/2020, FC #1 had another aggressive episode at home and was subsequently admitted for an "emergency hold" to the hospital's

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emergency department (ED) on 9/6/2020.
- FC #1 remained in the ED until admission to the facility on 9/29/2020.
- During the hospital ED stay, FC #1 had intermittent episodes of "acting out" and attempting to bite hospital staff, required PRN (as needed) medication for aggression, and required physical restraint by security staff and four-point locking restraints.

Review on 10/22/2020 of the facility's incident reports revealed:
- FC #1 had incidents of aggression twice on 9/30/2020, 10/5/2020, 10/6/2020, and twice on 10/7/2020.
- Each incident occurred suddenly with no identified precipitant.
- Each incident required the use of physical interventions to release hair pulls, release bites, or physically restrain FC #1 to prevent her from hitting staff or banging her head against the wall.
- Multiple facility staff were required during the interventions.
- At 3:30PM on 10/7/2020, FC #1 was dancing and then "suddenly physically attacked" the Group Home Manager (GHM);
- FC #1 began biting the GHM and "attacked" backup staff (#2);
- Law Enforcement Officers (LEO) were called to assist when FC #1 would not calm down;
- FC #1 was physically aggressive with LEO and was then transported to the local hospital emergency department (ED).

Review on 10/29/2020 of Coordination of Care Logs dated 9/17/2020 to 10/7/2020 and completed by the CEO/ED revealed:
- FC #1 was admitted to the facility of a 90-day trial placement;
- FC #1 was "strapped to a stretcher" when she

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was transported by emergency medical services (EMS) on her admission date;
- FC #1 had multiple incidents of aggressive behavior while at the facility;
- On 10/7/2020, FC #1 had been so aggressive that she required the intervention of three LEO to physically restrain her and transport her to the hospital ED;
- The CEO/ED and the QAC spoke with the LME/MCO to discuss emergency discharge of FC #1;
- The facility management was concerned about the safety of FC #1, other clients and staff;
- FC #1 was in dire need of support that could not be provided in a community setting;
- Concerns had been raised that FC #1 had medical issues that may have contributed to her behaviors, but that could not be addressed because FC #1 refused to leave the facility.

Review on 10/29/2020 of an "Emergency Discharge Notification" dated 10/7/2020 completed by the Chief Executive Officer/Executive Director (CEO/ED) revealed:
- The notification was addressed to FC #1's Care Coordinator (CC) at the LME/MCO;
- An "immediate emergency placement discharge effective October 07, 2020 ..."
- Despite preadmission meetings to discuss FC #1's needs, and agency training, the facility did not have sufficient information or supports to meet FC #1's continuum of care requirements;
- FC #1 had physically assaulted facility staff on multiple occasions;
- FC #1's aggressive outbursts required no less than 4 to 5 staff;
- Aggressive outbursts occurred with no precursor;
- The facility had also been unable to obtain medical treatment for FC #1: " ... We were

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informed that she was afraid of medical offices and doctors; however, we did not realize that even prn (as needed) medication is not effective in calming her to complete assessments ..."
- FC #1's mother had informed facility staff on the evening of 10/6/2020 that FC #1 had sustained a broken bone in her back and had experience several episodes of pneumonia during the past year;
- The facility was unable to rule out medical issues contributing to FC #1's behaviors;
- As a community provider, the facility did not have the resources to provide services to meet all of FC #1's needs.

No interview was completed with FC #1 due to FC #1 being non-verbal and functionally unable to answer questions related to her care.

Interview on 10/29/2020 with FC #1's Guardian revealed:
- The Guardian did not think that facility staff had completed the training or contacted FC #1's Community-based Crisis Provider (CCP) to assist with her behaviors;
- Before FC #1 had been admitted to the facility, the Guardian was told that the admission was on a 90-day trial basis;
- FC #1 had only been at the facility for one week before she was discharged;
- On 10/7/2020, the facility had called the police on FC #1 and the police took her to the hospital ED;
- No facility staff went with FC #1 to the hospital;
- The facility had used the hospital as a "dumping ground" for FC #1;
- FC #1 remained at the hospital ED as of 10/29/2020;
- The facility had not assisted in locating another residential placement for FC #1;

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V 368	Continued From page 8 - The LME/MCO attempted to get the facility to keep FC #1, but the facility refused. Interview on 10/23/2020 with the LP revealed: - When FC #1 was admitted to the facility, the LP had provided behavior support guidelines that were "fairly general" as the LP had not yet met with FC #1 face-to-face; - Because of the severity of FC #1's behaviors, the LP was not aware of a community-based residential program that could successfully work with FC #1. Interview on 10/23/2020 with FC #1's CCP revealed: - The CCP had been told that FC #1 would be admitted to the facility on a 90-day trial period; - FC #1 required a lot of transition time due to her sever trauma history; - The CCP had provided training to the facility staff prior to FC #1's admission; - Following FC #1's admission, the QP/CD had informed the CCP that FC #1 had a couple of "rough days." - The facility did not contact the CCP's crisis line when FC #1 was in crisis; - After FC #1 was admitted to the hospital ED on 10/7/2020, the CCP received a letter from the LME/MCO informing the CCP that there would be an emergency discharge for FC #1. Interview on 10/30/2020 with FC #1's CC from the LME/MCO revealed: - FC #1 had severe aggressive behaviors; - FC #1 was transported to the hospital ED on 10/7/2020; - Notification of FC #1's discharge from the facility was sent to the LME/MCO on 10/7/2020; - The only problem the CC had experienced with the facility was the abruptness of FC #1's	V 368		

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V 368	Continued From page 9 discharge. Interview on 10/23/2020 with the GHM revealed: - Prior to FC #1's admission, facility staff were provided with refresher training on NCI (the training module used for alternatives to restrictive interventions, physical restraint, seclusion, and isolation time out), met with the LP to discuss FC #1's behavior support plan interventions, and had a virtual training with FC#1's CCP to discuss her behavioral issues; - FC #1 was calm at first, but would have aggressive behaviors suddenly; - There was always more than one staff present to assist with FC #1 if she had behaviors; - On 10/7/2020, FC #1 had two incidents in which she became physically aggressive. - During the second incident on 10/7/2020, FC #1 became aggressive towards a staff that was working with another client; - FC #1 had been so aggressive that LEO were called to assist; - FC #1 was transported to the local hospital ED by LEO; - The GHM followed the LEO to the ED to give them information regarding FC #1; - The QAC informed the GHM that FC #1 had been discharged; - The GHM assumed that the QP/CD made decisions about clients' discharges. Interviews on 10/22/2020 and 10/29/2020 with the QAC revealed: - Prior to admission to the facility, FC #1 had been held at a hospital ED because she could not return to her mother's home or to her previous group home; - FC #1's previous group home placement had not sent information to the facility as requested; - FC #1's treatment team had seemed to be	V 368		

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V 368	Continued From page 10 rushing her admission to the facility; - FC #1 had been admitted to the facility on a trial placement because the facility was concerned about whether FC #1 would be successful at the facility; - The facility had been told that FC #1's placement had been successful at her previous group home; - Facility management had been hopeful that they would be able to obtain FC #1 routine medical treatment as that had been an issue in the past; - When FC #1 was first brought to the facility from the hospital ED, she was restrained with soft mechanical restraints; - After FC #1 was admitted, the Guardian had informed facility staff that FC #1 had pneumonia often and had a broken bone in her back at one point; - The facility was aware that FC #1 had behavioral issues, but not that the behaviors were so extreme; - FC #1 would have behavioral outbursts suddenly and without warning; - On 10/7/2020, FC #1 injured the LP seriously enough that the LP required medical attention; - FC #1 was transported to the local ED by LEO; - The GHM provided the ED with information about FC #1 and her treatment needs; - FC #1's Guardian had expressed concern that FC #1 needed a higher level of care; - The QAC agreed with the Guardian that a higher level of care was needed than the facility could provide; - The QAC and the CEO/ED had spoken with the Guardian and informed her verbally that FC #1 would be discharged from the facility, and that a letter would be sent in order for the Guardian to have written notification of discharge; - The discharge verbal and written notification were both on 10/7/2020.	V 368		

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V 368	Continued From page 11 Interview on 10/30/2020 with the CEO/ED revealed: - The facility had attempted to obtain information about FC #1 from her previous residential provider prior to her admission; - FC #1's needs had not been fully disclosed to the facility; - After FC #1 was admitted to the facility, her mother reported that FC #1 had sustained a broken bone in her back and had pneumonia at an unknown time in the past; - FC #1 would not go to medical providers, so the facility could not obtain medical care for her; - It was unknown whether FC #1 had medical issues that may have contributed to her behaviors; - FC #1's aggressive behaviors endangered staff and other clients at the facility; - The CEO/ED did not believe there had been full disclosure of FC #1's treatment needs prior to her admission to the facility; - Had the facility known all of FC #1's needs, they may not have admitted her to the facility; - The facility had told the LME/MCO that FC #1 needed placement at a state developmental center rather than a community-based setting; - The LME/MCO had to make the referral to the state developmental center because that was the only place the developmental center would accept them from; - After FC #1 was taken to the ED on 10/7/2020, no one from the hospital had informed the facility that other placement could not be found; - FC #1's Guardian seemed happy that since FC #1 had been in the ED, a referral to the state development center had been made; - Facility staff had done everything they could to keep FC #1 safe.	V 368		