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	MHL032-445	A. BUILDING: _____ B. WING _____	10/16/2020

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FAYETTEVILLE STREET COMMUNITY LIVING HOME	111 NORTH MAPLE STREET DURHAM, NC 27703

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V 000	INITIAL COMMENTS A complaint survey was completed on October 16, 2020. The complaint was substantiated (Intake #NC000170195). 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	FSCLH provides the best care possible for residents with developmental disability needs. FSCLH goal has always been to enhance the lives of residents by providing a strong support system including Natural Supports, Community Supports and Community Resources that would strengthen their provision of hope to live as independently as possible. Our hope is to continue to maintain and promote stability, safety, self-confidence, self esteem and Motivation through encouragement and care. FSCLH services to each resident is carried out with quality, respect, commitment, and integrity for each and every resident.	V112
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; (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.	V 112		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin Williams — TITLE: CEO / Administrator — (X6) DATE: 11-11-2020

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on interview and record review, the facility management failed to assure that goals/strategies/interventions were developed and implemented to address client's needs and behaviors, including substance abuse affecting 1 of 1 former client (FC #1). The findings are: Review on 10/8/20 and 10/9/20 of FC #1's record revealed the following information: -- 52 year old female. -- Admitted to the facility on 4/16/20 from a state psychiatric hospital where she had been in continuous treatment for almost 2 years. -- Discharged on 10/5/20 due to starting a fire within the facility. -- Resided in the facility almost 6 months. -- Diagnoses include: Schizoaffective DO (disorder)-Bipolar Type, Personality DO with Antisocial and Borderline Traits, Substance Abuse DO (Alcohol, Cocaine and Marijuana), Mild IDD (Intellectual Developmental Disability), Pre-Diabetes, HTN (Hypertension-high blood pressure), GERD (Gastroesophageal Reflux disorder), History of MRSA (Methicillin-Resistant Staphylococcus Aureus-a serious staff infection), Constipation, Post Menopausal and History of Sexual Abuse. -- Has a county appointed DSS (Department of Social Services) legal Guardian. -- Psychological testing done on 1/17/19 resulted in an IQ (Intelligence Quotient) of 61. -- No goals/interventions developed to address substance abuse issues.	V 112	Measures IN Place to Correct the deficient Area of Practice Preventive Tools IN Place. F-SCLH will immediately increase the supervision and monitoring of each resident to ensure Safety and Accountability. FSCLH will ensure that each resident is properly supervised appropriately with a daily Check off Supervision log, this will include/document Morning to Evening activities and will Note any behaviors that could entice an elopement. FSCLH will immediately contact the authorities and will thoroughly document event and Contact entities. FSCLH will ensure that Monthly Supervisions are Conducted More Frequently with →	V 112

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V 112	Continued From page 2 Review on 10/14/20 of a Treatment Progress Review Summary dated 3/10/20 written by FC #1's Psychiatrist while she was still hospitalized prior to placement at the facility revealed the following information; -- "This is the 61st state psychiatric admission... to [name of state psychiatric hospital] on 7/11/18 under IVC (involuntary commitment) from [name of regional hospital], where she has been held for approximately 1 month after reportedly engaging in threatening behavior at her group home..." -- "She apparently made threats at her group home with a knife and was nude in public there, and said she would burn down the group home. She has a hx (history) of burning down a group home in the past and has had extensive legal charges (arson)..." -- "On 12/5/19, renewed LOO (level of observation) 1:1E for sexual acting out and aggression (allowed Q (every) 15 minute checks when in room with staff staying just outside the door, to give her some privacy)... Patient (FC #1) has been on 1:1E when out of her room and a staff member by her door when in room to ensure safe environment..." -- FC #1 was placed on a behavior intervention plan on 12/12/18 and remained on it through out the rest of this hospitalization. Continued review on 10/8/20 of FC #1's record revealed a "Behavior Support Plan" dated 6/22/20 written by a Psychologist including the following information: -- This plan was signed by the Psychologist, the legal Guardian and the facility QP (Qualified Professional) on 6/23/20. -- Input on this plan was provided by the client's treatment team including the legal Guardian and the facility QP. -- "[FC #1] has been in and out of placements	V 112	Unexpected Visits. This is to ensure that people are where they are suppose to be and that actions are carry out as expected. FSCLH will Communicate with each resident and assess their social, emotional status in hopes of improving their problem-solving skills (talking it out) when it comes to regulating their feelings and behaviors to prevent them from running away (elopement). FSCLH will keep open communication ongoing that residents can freely come and discuss any negative feels or behaviors in effort to prevent them walking away from the group home.	V11

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V 112	Continued From page 3 such as hospitals and group homes since the age of 9, was hospitalized over 60 times, and has been discharged from multiple group homes due to behavior issues." -- "She also has an extensive legal history that began when she was 17 years old. A recent psychological evaluation indicated that she has been convicted over 10 times for crimes such as damage to property, breaking and entering, arson, injury to person/property, assault with a deadly weapon on an officer, and unauthorized use of a motor vehicle." -- "The most recent of these was a conviction of arson at the group home where she lived. She reportedly set the bed on fire. She then alerted staff of what she had done and helped them get the other residents out of the group home. She was convicted and incarcerated for six years for this." -- "Upon her release from jail [FC #1] was placed at a group home in [name of nearby county]. She was only here for a few days before being discharged due to assaulting a staff member. She was involuntarily committed to [name of the above county hospital] and then transferred to [name of state psychiatric hospital] in July 2018. She remained there until her current placement (Fayetteville Street Community Living Home)..." -- "She has a history of being in special ed (education) classes when she was in school but was home schooled after fifth grade. It is unknown if she graduated." -- "She has received disability for some time and has never had any type of employment. Her records also indicate that she has been tested over the years resulting in a diagnoses of Mild Intellectual Disability most of the times. She also has an extensive mental health treatment history..." -- "She has a history of auditory hallucinations	V 112	FSCLH will interview each resident upon schedule and unscheduled visit. The interview will be enhanced with open end question to ensure that the resident is feeling well, not suicidal or wanting to leave (run away). Should a crisis occur a crisis unit will be called. FSCLH will prevent lag time between activities by keeping residents busy in effort to provide fewer opportunities to plan elopements. FSCLH will provide high-interest tasks of each resident choice to keep them busy to eliminate elopements. FSCLH will reduce potentially perceived threats that could trigger an elopement.	

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V 112	Continued From page 4 and delusions." -- "Fire setting was also a behavior that she typically engaged in when she was either placed in a group home or hospital so that she would be discharged back to her Mother." -- "She has a history of hypersexual/sexually inapropriate behavior... there were issues reported with physical aggression as well." -- "As stated previously, [FC #1] lives in a group home setting (Fayetteville Street Community Living Home) with three other male residents and two other female residents. [FC #1] reports she does not like living at this group home and wants to move to a nursing home instead..." -- "The staff who work with her currently report issues with physical aggression, elopement, verbal aggression, false accusations, inapropriate sexual comments, and other attention seeking behaviors." -- "[FC #1] does have a one on one staff currently. However this individual is not there at all waking times. The team did agree that this will be a requirement for keeping [FC #1] safe..." -- "She (FC #1) takes the following medications: ...Lorazepam (Ativan) for agitation, anxiety and impulsivity. Olanzapine (Zyprexa) for psychosis. Valproic Acid (Depakote) for mood stabilization. And Chlorpromazine (Thorazine) for aggression, impulsivity, psychosis and mood instability." -- "There is a significant history of trauma for [FC #1] including reports of verbal, physical, and sexual abuse as a young child. She also has the extensive history of instability with regards to living arrangements ..." -- "[FC #1] needs constant visual monitoring and supervision due to a history of behaviors such as running away and fire setting. Staff should always have their eyes on her except when privacy is needed such as going to the bathroom or showering. Even in these situations, staff	V 112	FSCLH will do everything possible to Safe guard each resident. FSCLH will ensure the safety and security of each resident by any means necessary and will document any/all Changes necessary with additional training to ensure knowledge of each employee. FSCLH will closely monitor each resident during wake hours and during bed Checks (2 hour). # Measures in Place For prevention and who will monitor.	V112

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V 112	Continued From page 5 should be monitoring the door to ensure she is where she is supposed to be." -- "The group home should have a plan in place for visits with her Sister if this is something she desires to do." -- "The group home will need to have alarms on all doors and windows to ensure staff is alerted if [FC #1] tries to elope." -- "Targeted Maladaptive Behaviors: Inappropriate sexual comments, elopement, verbal aggression, false allegations, physical aggression." -- "Procedures for Elopement: Step One - If [FC #1] leaves the group home or designated area without permission, staff will follow her and attempt to bring her back to the designated area. While following her, staff will immediately contact the first responder listed in the crisis plan in the ISP. Step Two - If she refuses to come back to the group home, or becomes confrontational, staff should call 911 and ask for a CST (Crisis Support Team) officer to assist with getting her safely back to the group home." -- "[FC #1] will participate in a reward system in which she can earn extra cigarettes for not leaving the group home without permission she will be given a yellow card at the end of each day if she has not left the group home without permission. Once [FC #1] accumulates four yellow cards, she can trade them all in for an extra cigarette." -- This document was also signed by FC #1's legal Guardian and the QP on 6/23/20. Review of FC #1's record on 10/9/20 revealed the following information; -- On 7/1/20 behavior logs tracking the clients target behaviors every hour from 7:00 am to 9:00 pm by staff were initiated. -- The behaviors monitored were "Physical	V 112	FSCLH will ensure that each employee is thoroughly trained before working with the residents with and/all additional training provided as needed and as often as needed. FSCLH has alarm systems on all doors, windows that will sound upon each entry. FSCLH employees will sign documentation after training that they understands each expectation and they are able to perform the job expected. FSCLH will ensure that additional training is completed satisfactory before employee	V112 V289

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V 112	Continued From page 6 Aggression, Verbal Aggression, Inapropriate Sexual Comments, Elopement and False Allegations." -- During the week of 9/28/20 - 10/4/20 (the week prior to 10/5/20 when she set the fire) she had only earned reward cards 3 out of 7 days. Review on 10/12/20 of FC #1's Admission Assessment completed by the QP on 4/2/20 revealed the following information; -- "[FC #1] has been in the hospital 61 times for mental condition." -- "Has history of alcohol and cocaine abuse." -- "Immediate Needs/Interventions: Need to keep all Doctors appointment administer all medication & observe her taking them. Need placement, observe her closing if smoking." -- "Planned Follow Up/Recommendations: 1. Continue medications as ordered 2. She is to have no matches or lighter 3. Observe her closely when smoking to prevent her from starting fires." Review on 10/9/20 of FC #1's Treatment Plan short term goals revealed the following information; -- "ISP (Individual Support Plan) meeting date: 7/7/20." -- Goal: "[FC #1] will independently socialize with others appropriately and will reframe from crossing boundaries for 6 out of 7 days throughout the duration of the plan year. What are the prerequisite skills needed for the goal? ...[FC #1] needs guidance when engaging with others safely as it relates to ensuring that [FC #1] is not exposing to contrabands to bring in the home. When socializing ensure that [FC #1] is "NOT" given matches, lighters, knives or phones. [FC #1] must be monitored at all times for the safety and security of her and others ..." -- Goal: "[FC #1] will maintain safety skills at	V 112	is released to work with residents. Should the CEO recommend additional training for a staff member but that member disagree. That staff member will NOT be released to work at the group home until their status is satisfactory, meet all requirements, acknowledgement has been completed with satisfaction of administrator. FSLLH will train each staff ON problem solving skills and crisis intervention skills. FSLLH will continue to have special training ON preventive strategies to reduce the likelihood that elopement will occur by ensuring Monitoring and Supervision.	V112 V284

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V 112	Continued From page 7 home and community including all drills 7 out of 7 days throughout the duration of the plan year. What are the prerequisite skills needed for the goal? ...[FC #1] requires the assistance of FSCLH (Fayetteville Street Community Living Home) to keep her safe at all times. By history [FC #1] can become confrontational towards others and will become defiant, especially when she can't have her way or when she wants something and can't get it. [FC #1] will walk away from the area rather at home or in the community away from staff. [FC #1] requires full attention from staff therefore requires one on one staffing at all times ... [FC #1]: will not elope or leave the premises without escort by staff. Staff: will Monitor at all times." -- Goal: "[FC #1] will follow her behavioral plan and will alert staff when she becomes aggravated or frustrated 7 out of 7 days throughout the duration of the plan year. What are the prerequisite skills needed for the goal? ...Staff should monitor [FC #1] closely at all times. Staff should search for contrabands should [FC #1] elopes (two female staff members) and report any discoveries to Administrator (Administrator/Licensee (A/L)) immediately. Staff: will monitor at all times. Staff: will ensure that she feels safe at all times." -- This treatment plan was signed by the legal Guardian, the QP and the A/L on 8/21/20. Review on 10/13/20 of FC #1's ISP developed on 7/22/20 written by her IDD Care Coordinator with the LME (Local Management Entity) revealed the following information; -- "What is not working? ...[FC #1] has occasional crying spells, and may not understand what is going on around her. ...Eloping to purchase alcohol or obtain cigarettes."	V 112	FSCLH will conduct additional Monthly Meeting to decrease any opportunities of a safety risk. Should a risk be discoovered/identified it will be address immediately. FSCLH will train each Staff Member on incident writing as well as incident reporting. FSCLH will ensure that all supporting documentation is available for review. FSCLH will ensure a stronger documentation system by adding a daily ledger of daily activities. This ledger will be check off ledger of each resident and will be mark by their initial and by staff working.	V112 V284

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V 112	Continued From page 8 -- "What you can do to help me out of difficult situations? Explaining things to [FC #1] and providing alternatives can be helpful for her. Intervening when she begins to get upset or agitated through redirection, paying attention and assisting her to go to her safe space are important. 1:1 staff assist with prevention for challenging behaviors is needed..." -- "How to support me best: ...1:1 staff assistance with prevention of challenging behaviors is needed." Interview on 10/9/20 with the QP revealed the following information regarding FC #1; -- FC #1 was supposed to be attending a day program, however due to COVID-19, the day program had suspended services. -- FC #1 left the facility (eloped) 3 times during her stay at the group home. "She would either go to family's houses or to the store on the corner." -- The first time FC #1 left was shortly after she was first admitted to the facility. She walked away from the facility and went to her Sister's house. Staff did not know when she left. Her Sister called the facility to let them know that FC #1 was with her, and she would bring her back to the facility. She returned the client about 3 hours later. -- She considered the time with her Sister "family visitation time." -- FC #1's Behavior Support Plan did not begin until 7/1/20. -- When FC #1 eloped from the facility her behavior would be "calm and smooth, she would not be mad or cussing, not acting out." She would quietly leave "when she sees an opportunity." -- FC #1's behaviors since April 2020 include: "confrontational, threatening staff, cuss you out, pushing staff (physically), play a client against	V 112	FSLLH will ensure that this ledger is completed throughout the shift and will end at the end of shift daily by signing that each item stated on the form was conducted and completed. The results of the form will be kept in a daily binder. Should there be any issues noted on forms; those issues will be address immediately by Notification of CEO/QP. FSLLH will provide each employee feedback (positive or negative) and will address any/all concerns.	V112 V284

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V 112	Continued From page 9 another client." -- During the daytime shift there would be 2 or 3 staff, FC #1's 1:1 staff would be either the A/L or the House Supervisor (HS). -- On the evening shift (4 pm-9 pm), 2 extra staff worked, the second staff was added to provide supervision for FC #1. -- She was not sure if a staff on the evening shift was designated to be FC #1's 1:1 staff. Interview on 10/9/20 with the QP reported the following information about FC #1 and the fire on 10/5/20; -- The A/L and the HS had just left the facility. The HS had worked the daytime shift. -- Staff #1 and Staff #2 worked the second shift. Staff #1 called the A/L when FC #1 could not be found. -- "She [FC #1] was found at the corner store by the A/L and the HS." -- The A/L said FC #1 smelled like she drank beer. "[FC#1] said she drank beer, she may have had some of someone else's beer." -- After FC #1 returned to the facility "She said she needed to change her tampon, she went in the bathroom and was in there for a while. She came out and went to her room and set the fire. She came out in a rush and sat on the front porch." -- "Staff #2 put out the fire." -- FC #1 was not agitated. -- When questioned the reason for setting the fire, FC #1 said "She wanted to get out of the group home and said nobody would listen to her." Interview on 10/8/20 with Staff #1 revealed that she had only been working at the facility for about a month. Interview on 10/14/20 with Staff #1 revealed the	V 112	FSCLH will ensure that each PCP is carried out to the best of ability and will ensure that all revisions of PCP will be completed or discontinued as needed. All intervention on PCP will be discussed thoroughly. FSCLH will provide staff with protocol list and will ensure that All clinical recommendations are follow. FSCLH will ensure that QM Monitoring will be conducted daily by supervisors ~~bi~~ bi monthly by QP and Monthly by Administrator. * Currently QP is monitoring every other day.	V112 V289

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V 112	Continued From page 10 following information; -- On 10/5/20 there was "no 1:1 staff in the afternoon, [Staff #2] came in and I assumed he was the 1:1." -- "There was always a 1:1 staff on the evening shift, either [the A/L or the HS]." -- The staff followed FC #1's behavior plan. On 10/14/20 during interview Staff #1 responded to Surveyor's questions as follows; -- How did FC #1 elope on 10/5/20? She may have gone outside, "she was approved to go out on the front porch to sit (without staff with her)." -- On 10/5/20 were you the only staff working alone when FC #1 eloped? "At the moment, "[HS] and [A/L] had left to get food." -- Had FC #1 eloped any other times during the month you have worked here? "One time she walked out to the stop sign, but then turned around and came back." Interview on 10/14/20 and 10/15/20 with Staff #2 revealed the following information regarding FC #1; -- The A/L or the HS is always her 1:1 staff. -- "The 1:1 staff comes in the morning." -- "I have never been her 1:1 staff." -- It was "not unusual to not have a 1:1 (on his shift - second shift)." -- "I come in at 4:00 (pm) for my shift." -- FC #1 goes to bed at 9:00 pm. -- There is no alarm on the front door "only on the back door and [FC #1's] room (door) and window." -- On 10/5/20 "I came in at 4:00 (pm)." -- "When I came in [Staff #1] was already there, and she [FC #1] had already been brought back (to the facility by the A/L and the HS)." Interview on 10/14/20 with the A/L revealed the	V 112	FSLH Plans to ensure this occurring again is as Follow; FSLH will conduct unscheduled visits by LEO/AP and will Provide feedback dismissal or provide additional training Should it is seen to be warranted immediately. FSLH will expand Monitoring of each resident at all times. FSLH will provide training and will enhance training necessary with the employee signing that they have completed training Satisfactory. FSLH will Maintain Strong Supervision at all times the Whereabouts by all residents.	V112 V289

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	MHL032-445	A. BUILDING: _____ B. WING _____	10/16/2020

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V 112	Continued From page 11 following information regarding FC #1; -- "[FC #1] had a 1:1 always." The 1:1 staff would either be herself or the HS. -- On 10/5/20 she and the HS left the group home in the late afternoon and had to make another stop as a different client had an appointment to attend. -- Staff #1 "did know" she was to be FC #1's 1:1 staff that evening. -- Staff #2 was there when she and the HS left. -- "We just have extra staff on duty. To be able to monitor her." -- No evening staff is assigned or scheduled to be FC #1's 1:1 staff. -- FC #1 probably had the lighter hid in her vagina. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE, (tag V-289) for a Type A1 rule violation and must be corrected within 23 days.	V 112	FSCLH will continue to Provide Staff training. FSCLH will provide Staff Meeting addressing any/all Concerns and will implement a procedure of how addressing the concerns will be carried out. Such as time frame of completing a task etc). FSCLH will ensure that each Person Centered Plan is carried out to the best of ability. And will ensure that all revisions of PLP will be completed or discontinued as needed. Each PLP will be monitored and follow with updates.	V112 V289
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.	V 289		

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V 289	Continued From page 12 (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .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)	V 289	FSCLH will report any/all finding to the proper entity and will follow all recommendation / protocol and procedures to the maximum expectation to ensure the safety and supervision of all residents. FSCLH will provide each employee feedback (positive or negative) and will address any/all concerns. FSCLH will dismiss any employee that is not performing as needed.	V112 V289

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V 289	Continued From page 13 (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observation, interview and record review, the facility management failed to assure that residential services were provided 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 affecting 1 of 1 former client (FC #1). The findings are: Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN, Tag V-112. Based on interview and record review, the facility management failed to assure that goals/strategies/interventions were developed and implemented to address client's needs and behaviors, including substance abuse affecting 1 of 1 former client (FC #1). Review on 10/8/20 and 10/9/20 of FC #1's record revealed the following information: -- 52 year old female. -- Admitted to the facility on 4/16/20 from a state psychiatric hospital where she had been in continuous treatment for almost 2 years. -- Discharged on 10/5/20 due to starting a fire	V 289	FSCLH for best practice will continue to utilize the PCP as the driving document and will update with strong details of monitoring/supervising as needed and will follow all guidelines. V112 V289 FSCLH will ensure that close Monitoring/Supervisions are Conducted throughout each shift with additional staff as needed to ensure the safety and security of all residents 12/1. FSCLH will ensure that all Policy and procedures are updated with Changes of Group home.	

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V 289	Continued From page 14 within the facility. -- Resided in the facility almost 6 months. -- Diagnoses include: Schizoaffective DO (disorder)-Bipolar Type, Personality DO with Antisocial and Borderline Traits, Substance Abuse DO (Alcohol, Cocaine and Marijuana), Mild IDD (Intellectual Developmental Disability), Pre-Diabetes, HTN (Hypertension-high blood pressure), GERD (Gastroesophageal Reflux disorder), History of MRSA (Methicillin-Resistant Staphylococcus Aureus-a serious staff infection), Constipation, Post Menopausal and History of Sexual Abuse. -- Has a county appointed DSS (Department of Social Services) legal Guardian. -- Psychological testing done on 1/17/19 resulted in an IQ (Intelligence Quotient) of 61. Review on 10/16/20 of the Plan Of Protection dated 10/16/20 written by the Qualified Professional (QP) and the Administrator/Licensee revealed the following information; "What immediate action will the facility take to ensure the safety of the consumer in your care? Fayetteville Street Community Living Home is a residential facility that we believe provides the best care possible for residents with a developmental disability. Fayetteville Street Community Living Home goal is to enhance the lives of residents by providing a strong support system that would strengthen their provision of hope to live as independently as possible. Our hope is to maintain and promote stability, safety, self-confidence, self-esteem and motivation through encouragement and care. Fayetteville Street Community Living Home helps residents from all ethical background to become independent in many settings such as habilitations, training, Innovation Wavier, vocational and instructions as well as developing	V 289	FSCLH will ensure supervision is done closely while residents are out in Community. FSCLH will ensure that all supervisions are completed daily, by supervisor, QP and administrator (Supervised Visits) Staff's supervision Bi-Weekly / Monthly by QP. Administrator will continue to monitor daily, bi weekly and Monthly to oversee the overall program to ensure that all expectations are met and all residents are properly supervised.	V11 V28

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V 289	Continued From page 15 moral ethics, supporting the desire to positively engaging in a healthy lifestyle while in the residential home and/or in the community as a productive citizen. Fayetteville Street Community Living Home services are carried out with quality, respect, commitment, and integrity for each and every resident. Fayetteville Street Community Living Home has a reputation of providing excellent care for their residents and without a doubt we are truly devastated of the decision that was made that could possibly soil our great reputation. The immediate action the facility is currently implementing to ensure the supervision of each resident in our care will be as follow: Preventive Tools: -- Fayetteville Street Community Living Home will immediately increase the supervision and monitoring of each resident to ensure safety and accountability. -- Fayetteville Street Community Living Home will ensure that each resident is properly supervised appropriately with a daily check off supervision log (this log will document their morning to evening activities daily and will note any behaviors that could entice an elopement). -- Fayetteville Street Community Living Home will immediately contact the authorities and will thoroughly document event and contact entities. -- Fayetteville Street Community Living Home will ensure that monthly supervisions are conducted more frequently with unexpected visits. -- Fayetteville Street Community Living Home will communicate with each resident and assess their social, emotional status in hopes of improving their problem-solving skills (talking it out) when it comes to regulating their feelings and behaviors to prevent them from running away (elopement). -- Fayetteville Street Community Living Home, will	V 289		

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V 289	Continued From page 16 keep open communication ongoing that residents can freely come and discuss any negative feels or behaviors in effort to prevent them walking away from the group home. -- Fayetteville Street Community Living Home will interview each resident upon schedule and unscheduled visit (this is already done, however, the interview will be enhance with open end question to ensure that the resident is feeling well, not suicidal or wanting to leave (run away). -- Should a resident elope the administrator, QP or Residential Manage should conduct a search and siege (same sex staff members 2x) searching for any form of contrabands. Please note it will be no invasion of privacy, external review only. -- Fayetteville Street Community Living Home will prevent lag time between activities (keep residents busy) to provide fewer opportunities to plan elopements. -- Fayetteville Street Community Living Home will provide high-interest tasks of the resident choice to keep them busy to eliminate elopements. -- Fayetteville Street Community Living Home will reduce potentially perceived threats that could trigger an elopement. -- Fayetteville Street Community Living Home will do everything possible to safe guard each resident. -- Fayetteville Street Community Living Home will ensure the safety and security of each resident by any means necessary and will document any/all changes necessary with additional training to ensure knowledge of each employee. -- Fayetteville Street Community Living Home will monitor each resident during wake hours and during bed checks. Staff Training: -- Fayetteville Street Community Living Home will ensure that each employee is thoroughly trained	V 289		

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V 289	Continued From page 17 before working with the resident with any/all additional training provided as needed and as often as needed. -- Fayetteville Street Community Living Home employee's will sign documentation after training that they understands each process and they are able to perform the job expected (this process has been in place, however moving forward, we will ensure that additional training is completed before employee is released to work with residents. Should administrated recommend that employee receives more training but the employee disagree, that employee will not be release to work within the group home until all requirement, acknowledgement has been completed with satisfaction of administrator. -- Fayetteville Street Community Living Home will train each staff on problem solving skills and crisis intervention skills. -- Fayetteville Street Community Living Home will closely monitor all residents. -- Fayetteville Street Community Living Home will be trained on preventive strategies to reduce the likelihood that elopement will occur. -- Fayetteville Street Community Living Home will conduct additional monthly meeting to decrease any opportunities of a safety risk. Please note that should a risk be discover/identified it will be address immediately. -- Fayetteville Street Community Living Home will train each staff member on incident writing as well as incident reporting. -- Fayetteville Street Community Living Home will ensure that all supporting documentation is available for review. -- Fayetteville Street Community Living Home will ensure a stronger documentation system by adding a daily ledger of daily activities. This ledger will be a check off ledger of each resident and will be mark (by their initial) by staff member	V 289		

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V 289	Continued From page 18 working. This ledger will be completed throughout the shift and will end at the end of the shift daily by them signing that each item stated on the form was conducted and completed. The results of the form will be kept in a daily binder. Should there be any issues stated on forms, those issues will be address immediately by notification of the administrator and/or QP. -- Fayetteville Street Community Living Home will provide each employee feedback (positive or negative) and will address any/all concerns. -- Fayetteville Street Community Living Home will ensure that each Personal Centered Plan (PCP) is carried out to the best of ability and will ensure that all revisions of PCP will be completed or discontinued as needed. All intervention on PCP will be discussed thoroughly. -- Fayetteville Street Community Living Home will provide staff with protocol list and will ensure that all clinical recommendations are follow. Ensuring Home Safety: -- Fayetteville Street Community Living Home will update alarm system on doors and windows to alert staff better. -- Fayetteville Street Community Living Home will have staff available for coverage at all times and each staff's job task will be identified to eliminate confusion. -- Fayetteville Street Community Living Home will train staff on any/all new devices. -- Fayetteville Street Community Living Home will remove all contrabands and anything that may cause harm." "Describe your plans to make sure the above happens: -- Fayetteville Street Community Living Home will conduct unscheduled visits and will provide feedback, dismissal or provide additional training should it is seen to be warranted immediately.	V 289		

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V 289	Continued From page 19 -- Fayetteville Street Community Living Home will ask open end questions to each resident to ensure safety is being provided and they are secure and safe. -- Fayetteville Street Community Living Home will continue to provide training and will enhance any training necessary with the employee signing that they have completed training satisfactory. -- Fayetteville Street Community Living Home will provide continuing staff meeting addressing any/all concerns if found and will implement a procedure of how addressing the concerns will be carried out (such as time frame of completion of course is needed, additional training is conducted by a certain time frame, better time management in completing a task etc). -- Fayetteville Street Community Living Home will ensure that each Personal Centered Plan is carried out to the best of ability and will ensure that all revisions of PCP will be completed or discontinued as needed. -- Fayetteville Street Community Living Home will report any/all finding to the property entity and will follow all recommendation / protocol and procedures to the maximum expectation to ensure safety of residents. -- Fayetteville Street Community Living Home will provide each employee feedback (positive or negative) and will address any/all concerns. Fayetteville Street Community Living Home will dismiss any employee that is not performing as needed. -- Fayetteville Street Community Living Home will ensure that each Personal Centered Plan is carried out to the best of ability and will ensure that all revisions of PCP will be completed or discontinued as needed. For best practice Fayetteville Street Community Living Home will continue to utilize the PCP as the driving document and will update with strong details as	V 289		

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V 289	Continued From page 20 needed and will follow all guidelines. -- Fayetteville Street Community Living Home ensure that close monitoring/supervisions are conducted throughout the shift with additional staff as needed to ensure the safety and security of all residents 24/7/" FC#1 had a diagnoses of Schizoaffective DO (disorder)-Bipolar Type, Personality DO with Antisocial and Borderline Traits, Substance Abuse DO (Alcohol, Cocaine and Marijuana), Mild IDD (Intellectual Developmental Disability). FC#1 had a past and recent history of maladaptive behaviors going back to her late childhood which included physical and verbal aggression, elopement, inappropriate sexual comments, fire setting and making false allegations. She had a previous placement where she set the facility on fire and served time in prison for that act of arson. The facility failed to follow goals and strategies in FC# 1's treatment and behavior plan that addressed these specific behaviors, including having 1:1 supervision. This provided FC #1 with the opportunity to elope on at least 3 occasions, drink alcohol and start a fire in her bedroom. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289	FSCLH will provide staffs training report writing and incident training. FSCLH have conducted additional training on Supervision, elopements, incident reporting, incident reporting writing and proper protocols. FSCLH conducted training On Completing Incident Reporting Forms. FSCLH has implemented a New Incident Form with the Proper details for reporting.	V367
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367	FSCLH will continue to train staffs on IRIs Reports	

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V 367	Continued From page 21 CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:	V 367	FSCLH will ensure that all supporting documentation is available for review.	V 367

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V 367	Continued From page 22 (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-445	A. BUILDING: _____ B. WING _____	10/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 23	V 367		

This Rule is not met as evidenced by:
Based on interview and record review, the facility management failed to assure all level II incidents were reported to the LME within 72 hours of becoming aware of the incident affecting 1 of 1 former client (FC #1). The findings are:

Review on 10/8/20 and 10/9/20 of FC #1's record revealed the following information:
-- 52 year old female.
-- Admitted to the facility on 4/16/20 from a state psychiatric hospital where she had been in continuous treatment for almost 2 years.
-- Discharged on 10/5/20 due to starting a fire within the facility.
-- Resided in the facility almost 6 months.
-- Diagnoses include: Schizoaffective DO (disorder)-Bipolar Type, Personality DO with Antisocial and Borderline Traits, Substance Abuse DO (Alcohol, Cocaine and Marijuana), Mild IDD (Intellectual Developmental Disability), Pre-Diabetes, HTN (Hypertension-high blood pressure), GERD (Gastroesophageal Reflux disorder), History of MRSA (Methicillin-Resistant Staphylococcus Aureus-a serious staff infection), Constipation, Post Menopausal and History of Sexual Abuse.
-- Has a county appointed DSS (Department of Social Services) legal Guardian.
-- Psychological testing done on 1/17/19 resulted in an IQ (Intelligence Quotient) of 61.

Review on 10/8/20 the North Carolina Incident

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V 367	Continued From page 24 Response Improvement System (IRIS) revealed an incident report submitted on 10/5/20 by the Administrator/Licensee (A/L) regarding a fire in the facility set by FC #1 on 10/5/20. Additional review on 10/8/20 of IRIS revealed no other incidents submitted about FC #1. Review on 10/10/20 of documents submitted by the Qualified Professional (QP) revealed the following information regarding FC #1; -- "Fayetteville Street Community Living Home Client Incident Log" 5/28/20 5:45 pm signed by the QP and the A/L: "[FC #1] left the group home without permission and walked to her sisters house. Sister called group home and informed them she will bring [FC #1] back. No other problem to report. [FC #1's] Guardian and Care Coordinator was called and informed. [FC #1] was apologetic and agreed to no more negative behavior." -- "Fayetteville Street Community Living Home Client Incident Log" 7/29/20 2:55 pm signed by the House Supervisor (HS) and Staff #2: "[FC #1] wanted to smoke another cigarette at 2:30 pm. [FC #1] was told that she would need to wait until her next schedule time. [FC #1] walked off without permission. [A/L] was called and [FC #1] was found at her Mamas house. Sister brought [FC #1] back to group home. No more problem to report." Interview on 10/12/20 with the QP revealed the following information; -- Either she or the A/L were responsible for completing incident reports. -- She was not aware that if a client walked away from the facility without permission and was not approved for any unsupervised time in the	V 367		

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V 367	Continued From page 25 community, this behavior required a report in IRIS. Interview on 10/9/20 with the QP revealed the following information regarding FC #1; -- FC #1 was supposed to be attending a day program, however due to COVID-19, the day program had suspended services. -- FC #1 left the facility (eloped) 3 times during her stay at the group home. "She would either go to family's houses or to the store on the corner." -- The first time FC #1 left was shortly after she was first admitted to the facility. She walked away from the facility and went to her Sister's house. Staff did not know when she left. Her Sister called the facility to let them know that FC #1 was with her, and she would bring her back to the facility. She returned the client about 3 hours later. -- She did not complete an IRIS incident report because she was with her Sister and we "considered this family visitation time." -- FC #1's Behavior Support Plan did not begin until 7/1/20. -- When FC #1 eloped from the facility her behavior would be "calm and smooth, she would not be mad or cussing, not acting out. She would quietly leave "when she sees an opportunity."	V 367		