| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| INDEPENDENT LIVING GROUP HOME AT OLD SALISI | 2415 OLD SALISBURY ROAD WINSTON-SALEM, NC 27127 |

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| V 000 | INITIAL COMMENTS<br><br>A complaint survey was completed on 11/6/2020. The complaint was substantiated (intake #NC170449). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability | V 000 | | |
| V 132 | G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection<br><br>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY<br>(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:<br>a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.<br>b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.<br>c. Misappropriation of the property of a healthcare facility.<br>d. Diversion of drugs belonging to a health care facility or to a patient or client.<br>e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).<br>Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the | V 132 | | |

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| V 132 | Continued From page 1<br>investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure that all allegations against health care personnel were reported to the HCPR within required time frames affecting 1 of 1 surveyed staff (#1). The findings are:<br><br>(Refer to citation in 10A NCAC 27D .0304 Protection From Harm, Abuse, Neglect or Exploitation (V512) for additional background information.)<br><br>Review on 10/14/2020 of Client #1's record revealed:<br>- Admission date: 10/15/2017<br>- Diagnoses: Mild Intellectual Development Disabilities; Schizoaffective Disorder (D/O), unspecified; Other Schizoaffective D/O; Impulse Control D/O unspecified; Type 2 Diabetes, High blood pressure; Low sodium<br>- A "Behavior Support Program" (BSP) treatment plan dated 3/18/2020 and developed by a Licensed Psychologist (LP) that revealed: target behaviors of physical aggression, verbal | V 132 | | |

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| V 132 | Continued From page 2 | V 132 | | |

aggression, property destruction, elopement, threats to self-harm, and improper use of the telephone.
- The BSP specified " ... [Client #1] must be visually monitored at all times when he is outside his home. This is important to prevent contact with minors, AWOL (absent without leave), and it prevents [Client #1] from embellishing stories that could result in larger issues ... As per BSP in regards to Elopement: a) If [Client #1] goes outside the home and meets criteria for the definition of elopement, he must be monitored visually, and staff should attempt to direct him back inside. B) If [Client #1] leaves the property, staff must ensure proper staff to client ratio. If there is only one staff on shift and there are more than 1 individuals in the group home; the staff person can't go after [Client #1]. If staff is in this situation, they must call the police and follow company and state regulations on missing individual. C) If there is enough staff for someone to follow [Client #1] after he leaves the premises, then staff should follow him and attempt to continue to redirect him back to the group home and follow company policies about this type of incident ..."

Review on 10/14/2020 of Staff #1's employee record revealed:
- Hire date: 2/6/2020 as a paraprofessional;
- Client-specific training for Client #1 on 2/10/2020 and 5/3/2020;
- Training in NCI+ (the facility's training curriculum for seclusion, physical restraint and isolation time out) on 2/7/2020;
- Training on Client Rights on 2/6/2020;
- Training on abuse and neglect/code of conduct on 2/6/2020;
- Training on Special Populations on 2/6/2020;
- No documentation of previous allegations of

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| V 132 | Continued From page 3<br>client abuse, neglect or exploitation against Staff #1.<br><br>Review on 10/14/2020 of the Incident Response Improvement System (IRIS) revealed:<br>- There was no incident report for Client #1's 10/11/2020 incident in IRIS;<br>- There was no documentation of notification to HCPR of an allegation against Staff #1.<br><br>Review on 10/14/2020 of LME-MCO (Local Management Entity-Managed Care Organization) Communication Bulletin #J272 dated 11/15/2017 revealed:<br>- " ... If the staff member is unlicensed, the Health Care Personnel Registry (HCPR) section in IRIS must be completed for the initial allegation within 24 hours and for the results of investigations of these allegations within 5 working days of the initial notification as defined in North Carolina General Statue 131E-256(b) and 10A NCAC 13O ..."<br><br>Review on 10/16/2020 of the Incident Response Improvement System (IRIS) revealed:<br>- An incident report dated 10/11/2020 at 5:30PM was submitted for Client #1;<br>- The report was originally submitted by the Director on 10/14/2020;<br>- The report included an allegation of resident abuse by Staff #1;<br>- Client #1 sustained a "thyroid cartilage fracture" as a result of the incident.<br><br>Review on 10/16/2020 of Client #1's records from a local hospital revealed:<br>- On 10/11/2020, Client #1 was admitted to the Emergency Department (ED) for evaluation of neck and throat pain;<br>- Examination by the ED Physician revealed: " ... | V 132 | | |

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| V 132 | Continued From page 4<br><br>This is a 36-year-old male with a history as above who presented to the emergency department for evaluation of anterior neck pain and hoarse voice after a strangulation injury from a security guard (Staff #1) at his group home ... CT (computerized tomography) imaging of the neck is indicated to evaluate for injuries to the airway.<br>Reassessment: CT imaging was reviewed myself and significant for cricoid and thyroid cartilage fractures with asymmetry of the vocal cords ...<br>Clinical impression: 1. Neck pain, 2. Assault by manual strangulation, 3. Closed fracture of thyroid cartilage, initial encounter (HCC) ...<br>Current plan is as follows: Patient with fractured thyroid and cricoid cartilages, consistent with choke injury ..."<br><br>Interview on 10/14/2020 with Client #1 revealed:<br>- On 10/11/2020, at approximately 4:30-5:00pm, Client #1 had been "mad because we didn't have no cigarettes ...";<br>- He ran away from the facility;<br>- He had been minding his own business and walking beside the road when Staff #1 "ran up on me and did a choke slam on me ... He (Staff #1) just jumped on my back and took me down ..."<br>- After Staff #1 had Client #1 on the ground, Staff #1 said: "You didn't know I could take your big a*s down, did you?"<br>- The neighbors heard Client #1 screaming for help and Law Enforcement was called;<br>- Client #1 was taken to a local hospital;<br>- Client #1's "Adam's apple" was fractured, his trachea was bruised, and he had a cut on his scalp.<br><br>Interview on 10/16/2020 with Staff #1 revealed:<br>-On 10/11/2020, Client #1 had run away from the facility after becoming upset about not having any cigarettes; | V 132 | | |

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- He had run after Client #1 and placed him in a restraint hold that was not "textbook" according to his NCI training;
- Client #1 was taken to a local hospital ED following the incident;
- He found out about the allegation that he had choked Client #1 on 10/12/2020 when the Director called him;
- The Director had interviewed him about the incident;
- Part of the facility's protocol following allegations made against staff was that the staff could not have contact with the client;
- He had not been working at the facility since the incident.

Interviews on 10/14/2020 and 11/6/2020 with the Qualified Professional (QP) revealed:
- Staff #1 had informed the QP that he had been attempting to execute a therapeutic hold using NCI techniques during the 10/11/2020 incident with Client #1;
- The therapeutic hold used was not a proper NCI hold, but the QP did not believe that Staff #1 was trying to hurt Client #1;
- Staff #1 had been taken off the work schedule following the allegation that he choked Client #1.

Interviews from 10/14/2020 to 11/6/2020 with the Director revealed:
- Staff #1 usually worked at a sister facility, but did have client-specific training in order to work with Client #1;
- There had never been any issues or concerns about Staff #1's interactions with clients before;
- On 10/11/2020, Client #1 had walked away from the facility while Staff #1 was inside the facility cooking dinner;
- Staff #1 had run after Client #1 and restrained Client #1;

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| V 132 | Continued From page 6<br>- Client #1 was taken to the ED;<br>- She received a call from a Doctor at the ED the next morning (on 11/12/2020) and told the Director that Client #1 had sustained injuries during the incident;<br>- She had not been aware of any injuries at the time;<br>- She initially thought that Client #1 had made up a false allegation of abuse against Staff #1 in order to stay at the ED;<br>- Staff #1 had been removed from the schedule following the allegation that Staff #1 had choked Client #1, and an investigation was completed;<br>- As of 11/14/2020, she had not yet written or submitted an incident report in IRIS with the included initial notification to HCPR;<br>- The initial report to HCPR of an allegation that Staff #1 abused Client #1 was not made within 24 hours as required by LME-MCO Bulletin #J272 because she thought that the hospital ED staff would have made the report;<br>- She also thought that she had 72 hours to complete the IRIS report with the HCPR notification. | V 132 | | |
| V 290 | 27G .5602 Supervised Living - Staff<br><br>10A NCAC 27G .5602 STAFF<br>(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.<br>(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 | V 290 | | |

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| V 290 | Continued From page 7<br>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.<br>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:<br>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor 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<br>(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.<br>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:<br>(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<br>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure that staff-client ratios enabled staff to respond to individualized clients' | V 290 | | |

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| V 290 | Continued From page 8 | V 290 | | |

needs affecting 2 of 2 clients (#1 & #2). The findings are:

Review on 10/14/2020 of Client #1's record revealed:
- Admission date: 10/15/2017
- Diagnoses: Mild Intellectual Development Disabilities; Schizoaffective Disorder (D/O), unspecified; Other Schizoaffective D/O; Impulse Control D/O unspecified; Type 2 Diabetes, High blood pressure; Low sodium
- A "Behavior Support Program" (BSP) treatment plan dated 3/18/2020 and developed by a Licensed Psychologist (LP) that revealed: target behaviors of physical aggression, verbal aggression, property destruction, elopement, threats to self-harm, and improper use of the telephone.
- The BSP specified " ... [Client #1] must be visually monitored at all times when he is outside his home. This is important to prevent contact with minors, AWOL (absent without leave), and it prevents [Client #1] from embellishing stories that could result in larger issues ...

Review on 10/14/2020 of client #2's record revealed:
- Admission date: 7/13/2017
- Diagnoses: Major Depressive Disorder; Post-Traumatic Stress Disorder; Cocaine Abuse; Moderate Intellectual Disability; and Epilepsy
- A treatment plan dated 11/1/2020 that revealed: " ... [Client #2] has ongoing behaviors that require constant supervision and monitoring, such as physical aggressive, verbal aggressions, property destruction, elopement and socially inappropriate behaviors ..."
- A BSP treatment plan dated 10/26/2019 and developed by an LP that revealed: target behaviors of physical aggression, verbal

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aggression, self-injurious behavior (scratching self, cutting self and/or other means of harming self), property destruction, elopement, threats to self-harm, inappropriate social behavior (invading personal space and/or lying/making false statements).

Reviews on 10/15/2020 and 10/21/2020 of the facility's level 1 incident reports dated 6/3/2020 to 10/21/2020 revealed:
- A total of 9 incidents occurred which involved Clients #1 and #2 being transported to the local hospital emergency department (ED);
- Only one staff was working at the time of each incident.
- On 6/27/2020 at 7:30pm, Client #1 called 911, said he wanted to kill himself, and was transported to the ED;
- On 7/5/2020 at 8:45pm, Client #2 stated that she wanted to kill herself and began damaging property;
- Client #1 came out of his room and stated that he also wanted to go to the hospital, and began damaging property;
- both clients were transported to the ED;
- On 7/20/2020 at 8:00am, Client #2 was agitated, non-compliant, refused to go to the day program, and wanted to go to the hospital;
- Client #2 attempted to elope from the facility, and was transported to the ED;
- On 7/25/2020 at 6:15pm, Client #2 called 911 reporting that she wanted to kill herself;
- When emergency medical services (EMS) arrived, Client #1 told EMS that he wanted to kill himself also;
- Both clients were transported to the ED;
- On 8/7/20200 at 7:30pm, Client #1 eloped from the facility;
- Client #1 rode to the ED via EMS, but was not admitted;

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| V 290 | Continued From page 10<br>- On 8/13/2020 at 8:00am, Client #2 was given her medications, put them down to get water, and then picked up the wrong medications;<br>- Client #2 was transported to the ED to have her stomach pumped;<br>- On 9/8/2020 at 6:45pm, Clients #1 and #2 asked to step outside of the facility for fresh air, then proceeded to elope;<br>- Clients #1 and #2 were transported to a local hospital ED, but were not evaluated or admitted;<br>- On 9/20/2020 at 9:16pm, Client #2 stated that she wanted to go to the hospital, and when asked what was wrong, she reported that she wanted to smoke a cigarette;<br>- Client #2 later reported that she drank bathroom cleaner and was transported to the ED by EMS;<br>- On 10/11/2020 at 5:00pm, Client #1 eloped from the facility, and was restrained using a non-approved technique causing fractures to Client #1's trachea.<br><br>Interviews from 10/14/2020 to 11/6/2020 with the Director revealed:<br>- Clients #1 and #2 had histories of eloping from the facility and going to a local hospital ED;<br>- Because of the frequency that clients #1 and #2 went to the ED, the hospital ED staff would not always evaluate them;<br>- The behavior was manipulative in nature rather than true emergencies;<br>- The facility did not receive an "enhanced rate" for providing services to Clients #1 and #2;<br>- It was difficult to maintain staffing supports above the minimum of one staff when facility clients did not receive the enhanced rate;<br>- When facility clients received the enhanced rate, they did well with fewer behavioral incidents. | V 290 | | |

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| V 512 | Continued From page 11 | V 512 | | |
| V 512 | 27D .0304 Client Rights - Harm, Abuse, Neglect<br><br>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION<br>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.<br>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.<br>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.<br>(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.<br>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interviews, and record reviews, 1 of 1 surveyed staff (#1) neglected 2 of 2 clients (#1 & #2) and failed to protect 1 of 2 clients (#1) from harm. The findings are:<br><br>Review on 10/14/2020 of Client #1's record revealed:<br>- Admission date: 10/15/2017<br>- Diagnoses: Mild Intellectual Development Disabilities; Schizoaffective Disorder (D/O), | V 512 | | |

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| V 512 | Continued From page 12<br><br>unspecified; Other Schizoaffective D/O; Impulse Control D/O unspecified; Type 2 Diabetes, High blood pressure; Low sodium<br>- A "Behavior Support Program" (BSP) treatment plan dated 3/18/2020 and developed by a Licensed Psychologist (LP) that revealed: target behaviors of physical aggression, verbal aggression, property destruction, elopement, threats to self-harm, and improper use of the telephone.<br>- The BSP specified " ... [Client #1] must be visually monitored at all times when he is outside his home. This is important to prevent contact with minors, AWOL (absent without leave), and it prevents [Client #1] from embellishing stories that could result in larger issues ... As per BSP in regards to Elopement: a) If [Client #1] goes outside the home and meets criteria for the definition of elopement, he must be monitored visually, and staff should attempt to direct him back inside. B) If [Client #1] leaves the property, staff must ensure proper staff to client ratio. If there is only one staff on shift and there are more than 1 individuals in the group home; the staff person can't go after [Client #1]. If staff is in this situation, they must call the police and follow company and state regulations on missing individual. C) If there is enough staff for someone to follow [Client #1] after he leaves the premises, then staff should follow him and attempt to continue to redirect him back to the group home and follow company policies about this type of incident ..."<br><br>Review on 10/14/2020 of client #2's record revealed:<br>- Admission date: 7/13/2017<br>- Diagnoses: Major Depressive Disorder; Post-Traumatic Stress Disorder; Cocaine Abuse; Moderate Intellectual Disability; and Epilepsy | V 512 | | |

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| V 512 | Continued From page 13<br>- A treatment plan dated 11/1/2020 that revealed: " ... [Client #2] has ongoing behaviors that require constant supervision and monitoring, such as physical aggressive, verbal aggressions, property destruction, elopement and socially inappropriate behaviors ..."<br>- A BSP treatment plan dated 10/26/2019 and developed by an LP that revealed: target behaviors of physical aggression, verbal aggression, self-injurious behavior (scratching self, cutting self and/or other means of harming self), property destruction, elopement, threats to self-harm, inappropriate social behavior (invading personal space and/or lying/making false statements).<br><br>Review on 10/14/2020 of Staff #1's employee record revealed:<br>- Hire date: 2/6/2020 as a paraprofessional;<br>- Client-specific training for Client #1 on 2/10/2020 and 5/3/2020;<br>- Training in National Crisis Intervention+ (NCI) (the facility's training curriculum for seclusion, physical restraint and isolation time out) on 2/7/2020;<br>- Training on Client Rights on 2/6/2020;<br>- Training on abuse and neglect/code of conduct on 2/6/2020;<br>- Training on Special Populations on 2/6/2020;<br>- No documentation of previous allegations of client abuse, neglect or exploitation against Staff #1.<br><br>Review on 10/14/2020 of a handwritten internal incident report signed by Staff #1 revealed:<br>- On 10/11/2020: - "On Old Salisbury Rd (road) around 5pm, [Client #1] asked to stand on the porch with consumer [Client #2]. Approximately 5:10 [Client #2] reported to staff [#1] that [Client #1] was running away. [Staff #1] immediately | V 512 | | |

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| V 512 | Continued From page 14<br><br>went to retrieve [Client #1] as the street is very busy and a potential hazard. [Staff #1] approached [Client #1] from right side, blocking street and prompted [Client #1] to stop. Consumer [Client #1] did not discontinue walking and [Staff #1] carefully placed [Client #1] in a safe therapeutic hold in order to prevent any hazard. [Client #1] was prompted more than 10 times to come home and that [Staff #1] would help. [Client #1] refused. A pedestrian offered to call for help as [Staff #1] phone was inside."<br>- Injury: Checked: aggressive behavior and trip or fall<br>- "Shift Note: While [Client #1] was lying on the ground refusing to get up, [Staff #1] refused to let go as a security measure to assure [Client #1] would not run. [Client #1], while being held, said 'I'm going to get your black a*s fired.' [Staff #1] explained to [Client #1] that we are all good people regardless of color. (Unclear) behavior does not change that. Immediately following the officer's arrival, [Client #1] asked for a cigarette as he was already (unclear) from not having any for the time of the shift. The officer that (unclear) the incident volunteered to answer any further questions if necessary."<br>- "Behavior: Run away/refusal to go home/[Client #1] had decided to leave premises without permission. Once in the company of staff, and while being asked to return home, [Client #1] refused. It was around 5:00 rush hour and is an extremely potential hazard."<br>- "Intervention: Prompted to return home."<br><br>Review on 10/16/2020 of the Incident Response Improvement System (IRIS) revealed:<br>- An incident report dated 10/11/2020 at 5:30PM was submitted for Client #1;<br>- The report was originally submitted by the Director on 10/14/2020; | V 512 | | |

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| V 512 | Continued From page 15<br>- The report included an allegation of resident abuse by Staff #1;<br>- "[Client #1] asked staff (#1) if he could go outside to get some fresh air. Staff said absolutely and was in the kitchen about to prepare dinner. [Client #1] went outside with the other resident (Client #2) and then told her he was leaving and asked her to go with him and she said no. [Client #1] walked up the driveway and the resident (Client #2) went to tell the staff (#1)."<br>- "Agency (unspecified Licensee management staff) spoke with [Client #1] the next day on 10/12/2020. [Client #1] stated his concerns that staff (#1) had assaulted him. [Client #1] also stated that the staff was attempting to keep him out of the road. [Client #1] also stated that he was okay going back to Group Home and that he didn't feel unsafe. The Guardian called and made me aware of the injuries and the allegations and I told her the staff would immediately be taken off the schedule and I will complete my internal investigation I would notify her of my findings."<br>- "Agency (unspecified Licensee management staff) spoke with the staff and discussed the incident that occurred and injuries that resulted and allegations. Staff (#1) stated that [Client #1] asked to go outside and get some fresh air as I (Staff #1) prepared dinner and I stated absolutely. A few minutes later his housemate (Client #2) made me aware that [Client #1] had walked off and tried to get me to go with him. I immediately went outside and as I walked up the driveway I was verbally trying to get [Client #1] to come back to the group home. He refused and continued to walk at a fast pace. I continued to follow him and continued to talk as I was walking. Staff (#1) stated he panicked and was afraid for [Client #1]'s safety because he was on the side of a busy road. Staff (#1) told the other resident (Client #2) | V 512 | | |

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| V 512 | Continued From page 16<br>to go get his phone so he could call for help. Staff (#1) stated he felt as agitated that [Client #1] was he might dart in front of a car so he went from right side of [Client #1] ensuring that he (staff) was near the road and grabbed [Client #1] across the chest and they went backwards. Staff (#1) stated he held his right arm across [Client #1]'s chest and pulled him backwards away from the street and held his head with his left hand as he sat [Client #1] on the ground"<br>- Client #1 sustained a "thyroid cartilage fracture";<br><br>Review on 10/16/2020 of Client #1's records from a local hospital revealed:<br>- On 10/11/2020, Client #1 was admitted to the Emergency Department (ED) for evaluation of neck and throat pain;<br>- Examination by the ED Physician revealed: " ... This is a 36-year-old male with a history as above who presented to the emergency department for evaluation of anterior neck pain and hoarse voice after a strangulation injury from a security guard (Staff #1) at his group home. The emergency department he is hemodynamically stable and there is no evidence of expanding hematoma. His voice is hoarse and there is evidence of trauma to the anterior neck/thyroid/trachea. Chief complaint was reported as psychiatric evaluation for SI (suicidal ideation) and HI (homicidal ideation) however patient denies any suicidal or homicidal ideation at the time of my exam but does say that while he was being held onto the ground he told the security guard that he was going to kill him and that he would kill himself. He said that he said this in the heat of the moment and has no active SI or HI at this time. I do not feel as though a psychiatric consultation is appropriate at this time. However, CT (computerized tomography) imaging of the neck is indicated to evaluate for injuries to the airway. | V 512 | | |

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| V 512 | Continued From page 17<br><br>Reassessment: CT imaging was reviewed myself and significant for cricoid and thyroid cartilage fractures with asymmetry of the vocal cords ... Clinical impression: 1. Neck pain, 2. Assault by manual strangulation, 3. Closed fracture of thyroid cartilage, initial encounter (HCC) ... Current plan is as follows: Patient with fractured thyroid and cricoid cartilages, consistent with choke injury ..."<br><br>Review on 11/5/2020 of a police report for Client #1 dated 10/11/2020 revealed:<br>- A Law Enforcement Officer (LEO) responded to a call made at 16:56 (4:56PM) on Sunday, 10/11/2020 that was dispatched as a "fight in progress".<br>- The LEO observed Client #1 sitting on the ground with his legs in front of him with staff #1 also on the ground behind Client #1;<br>- Staff #1 had one arm around Client #1's "upper chest area near the neck and the other arm behind the white male's ([Client #1]'s) neck ..."<br>- Staff #1 had reported that Client #1 was running away from the facility.<br><br>Interview on 10/14/2020 with Client #1 revealed:<br>- Staff #1 only worked at the facility "once in a blue moon";<br>- On 10/11/2020, at approximately 4:30-5:00pm, Client #1 had been "mad because we didn't have no cigarettes ...";<br>- He ran away from the facility;<br>- He had been minding his own business and walking beside the road when Staff #1 "ran up on me and did a choke slam on me ...He (Staff #1) just jumped on my back and took me down ..."<br>- After Staff #1 had him on the ground, Staff #1 said: "You didn't know I could take your big a*s down, did you?"<br>- The neighbors heard him screaming for help | V 512 | | |

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and Law Enforcement was called;
- When the LEO arrived, he had a taser out and told Staff #1 to "get off me";
- Staff #1 released him after the LEO told him to for the second time;
- He might have been mistaken about seeing the LEO with a taser;
- He was taken to a local hospital;
- His "Adam's apple" was fractured, his trachea was bruised, and he had a cut on his scalp.

Observation at approximately 1:45PM on 10/14/2020 of Client #1 demonstrating the hold used by Staff #1 revealed:
- He requested to demonstrate the hold Staff #1 used during the incident on 10/11/2020;
- He described his actions as those used by Staff #1;
- He placed his right arm around the Surveyor's neck with the elbow pointing forward and him standing behind the Surveyor;
- His left hand was placed over his own right arm in a pulling motion;
- The hold was tight to the point of preventing any head movement or allow the Surveyor to reach under his arm.

Interview on 10/14/2020 with Client #2 revealed:
- Staff #1 did not usually work at the facility, and was usually only there in order to fill in for other staff;
- On 10/11/2020, Client #1 ran away from the facility;
- Staff #1 followed Client #1 and asked him to return to the facility;
- "[Staff #1] just put him (Client #1) down. He (Staff #1) didn't choke him or nothing."
- Staff #1's arm was around Client #1's neck, "but he (Staff #1) wasn't hurting him (Client #1)";
- The neighbor called the local Law Enforcement

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office;
- She thought that Staff #1 still had Client #1 in a therapeutic hold when the LEO arrived;
- Client #1 had been "fine" and asking for a cigarette while the LEO was at the facility;
- Staff #1 had not said anything inappropriate to Client #1 during the incident.

Interview on 11/5/2020 with the local LEO Sergeant revealed:
- LEO who responded to the incident with Client #1 on 10/11/2020 had reported that when he arrived, Staff #1 was holding Client #1 on the ground to keep him from leaving;
- It had been reported to the Sergeant that Client #1 left the facility AWOL (absent without leave) frequently;
- Staff #1 had chased Client #1 down and held him down;
- Staff #1 has said something about there being a restrictive intervention training that facility staff received in order to restrain clients;
- The responding LEO saw Staff #1 restraining Client #1, but not choking him;
- The Sergeant had confirmed with the responding LEO that Staff #1 did not have his hands around Client #1's neck.

Interview on 10/16/2020 with Staff #1 revealed:
- The client-specific training that Staff #1 received for Client #1 included information about medications and conflict resolution;
- He had received training in NCI;
- When Client #1 was upset, he encouraged him to go to his bedroom to "refocus", allow him to step outside or have a cigarette;
- If Client #1 went outside, Staff #1 was usually in the kitchen or right beside the exterior door;
- The kitchen and dining areas were immediately adjacent to the exterior door;

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| V 512 | Continued From page 20<br>- On 10/11/2020, Client #1 did not have any cigarettes;<br>- At approximately 4:45-5:00pm, Client #1 and Client #2 went outside while he remained in the kitchen preparing dinner;<br>- Client #2 returned inside and told him that Client #1 was "running off";<br>- He ran out of the facility and saw Client #1 walking on the side of the busy street that was in front of the facility;<br>- He called to Client #1, but Client #1 kept walking away;<br>- He ran up on the side of Client #1 that was closest to the road in order to physically restrain him;<br>- His right arm went across Client #1's chest, and his left arm was across Client #1's back, "like I was giving him a hug ..."<br>- His arms were around Client #1's biceps;<br>- He told Client #1 that he could not let him go because it was unsafe;<br>- From the restraint position, Client #1 could still freely move his arms;<br>- He did not recall having his arms or hands around Client #1's neck at any time;<br>- When asked about how Client #1 sustained injuries, he replied that there may have been some impact when he initially started the physical restraint;<br>- While Client #1 was trying to pull away from him, Client #1's arms or hands may have been in a position that caused the injuries;<br>- The physical restraint used on Client #1 was not a "textbook" NCI hold;<br>- He had attempted to ensure that he was in a position to keep Client #1 safe;<br>- When the Police Officer arrived, he released Client #1 from the therapeutic hold;<br>- The first thing that Client #1 did was smoke a cigarette, so he did not realize that Client #1 had | V 512 | | |

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been injured at all;
- Client #2 came out of the facility and asked if she could do anything for him;
- He asked Client #1 to bring his cell phone so that he could begin making calls to other facility staff;
- He had always been "very fair" to Client #1.

Interviews on 10/14/2020 and 11/6/2020 with the Qualified Professional (QP) revealed:
- The QP had provided client-specific training to Staff #1 by reviewing each of the clients' treatment plans;
- On 10/11/2020, Staff #1 had been working as a relief staff to cover for Staff #2;
- Staff #1 did not usually work at the facility;
- Staff #1 had been cooking while Clients #1 and #2 were outside on the porch;
- Staff #1 had informed the QP that he had been attempting to execute a therapeutic hold using NCI techniques during the 10/11/2020 incident with Client #1;
- The QP thought that Staff #1 and Client #1 may have fallen during the hold because they were on the side of a hill;
- The therapeutic hold used was not a proper NCI hold, but the QP did not believe that Staff #1 was trying to hurt Client #1;
- Client #1 had told the QP later that Staff #1 had not been trying to hurt him;
- Client #1 wanted to be moved out of the facility and would tell different people different things about incidents;
- If the QP had been aware that Staff #2 could not work his shift and Staff #1 would be at the facility alone, the QP would have arranged for additional staff coverage.

Interviews from 10/14/2020 to 11/6/2020 with the Director revealed:

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| V 512 | Continued From page 22<br>- Staff #1 usually worked at a sister facility, but did have client-specific training in order to work with Clients #1 & #2;<br>- There had never been any issues or concerns about Staff #1's interactions with clients before;<br>- Clients #1 and #2 had histories of eloping from the facility and going to a local hospital ED;<br>- Because of the frequency that clients #1 and #2 went to the ED, the hospital ED staff would not always evaluate them;<br>- The behaviors were manipulative in nature rather than true emergencies;<br>- The facility staff that usually worked at the facility (Staff #2) was a strong staff and 99% of the time did not have any issues with Clients #1 and #2's behaviors;<br>- Clients #1 and #2 were opportunists and took advantage of Staff #1;<br>- On 10/11/2020, Client #1 had walked away from the facility while Staff #1 was inside the facility cooking dinner;<br>- Staff #1 had reported that he was nervous because Client #1 was at the road and could possibly be hit by a car;<br>- Staff #1 may have been more worried about Client #1 eloping because he had heard about a recent incident in which a client at another group home had eloped and jumped off of a bridge;<br>- Staff #1 had been removed from the schedule following the allegation that Staff #1 had choked Client #1;<br>- The facility did substantiate the allegation because Client #1 had sustained an injury during the incident;<br>- There must have been an inappropriate restraint used in order for Client #1 to have sustained fractures to his thyroid cartilage;<br>- The Director did not believe that Staff #1 abused Client #1, rather, he used an inappropriate restraint which caused an accidental injury. | V 512 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL034-288 | A. BUILDING: _____ B. WING _____ | C 11/06/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| INDEPENDENT LIVING GROUP HOME AT OLD SALISI | 2415 OLD SALISBURY ROAD WINSTON-SALEM, NC 27127 |

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|---|---|---|---|---|
| V 512 | Continued From page 23<br><br>Review on 11/6/2020 of the Plan of Protection dated 11/6/2020 written by the Director revealed:<br>- "What immediate action will the facility take to ensure the safety of the consumers in your care? Although the agency ensures that all staff are trained on the clients BSP, the agency will develop and implement an additional sheet to the client specific training to include important information from the behavior support plan and how to handle the clients more specifically during the event of a crisis situation and how to intervene. The agency will retrain all staff on client specific training. The QP will be responsible for creating additional information specifically referencing the behavior support plan with a focus on early intervention strategies. The agency will facilitate additional training with the behavior support specialist to ensure there is a clear understanding of strategies utilized. We will continue to stress the importance of notifying management in the event of a crisis in which the staff can't control. Staff training will be complete 11/11/2020<br>- In the event that staff does not follow the policies they will face disciplinary action. Describe your plans to make sure the above happens.<br>The agency will have mandatory in service to ensure staff is aware of emergency numbers are posted in ALL the facilities in the event of a crisis."<br><br>There were two adult clients residing at the facility. Both clients had such extensive mental health, substance use and intellectual disabilities issues that they required Behavior Support Programs (BSP) developed by Licensed Psychologists in addition to their standard treatment plans. Their histories included physical aggression, verbal aggression, property | V 512 | | |

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| V 512 | Continued From page 24<br>destruction, elopement, threats to self-harm, socially inappropriate behaviors, and improper use of the telephone. Client #1's BSP specified that if Client #1 eloped, facility staff should visually monitor him, attempt to redirect him back to the facility, and if there was only one staff present, the facility staff "can't go after [Client #1] in order to ensure staff to client ratio ..." Client #2's BSP specified that she needed "constant supervision and monitoring ..."<br>On 10/11/2020, Staff #1 allowed Clients #1 and #2 to go outside of the facility without direct supervision while Staff #1 remained in the kitchen cooking dinner. Client #1 subsequently eloped from the facility. When Staff #1 learned that Client #1 had eloped, he left Client #2 alone in the facility and ran after Client #1. Staff #1 caught up to Client #1 on the side of the road and grabbed Client #1, causing them both to fall to the ground. While on the ground, Staff #1 held Client #1 in a manner not taught in staff #1's training in seclusion, physical restraint and isolation time out. During the incident, Client #1 sustained fractures to cartilage in his throat. Client #1's hospital records revealed that Client #1's injuries were "consistent with a choke injury ..."<br>This deficiency constitutes a Type A1 rule violation for serious neglect and failure to protect from serious physical harm 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 512 | | |