STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-329	A. BUILDING: _____ B. WING _____	C 12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCTAVISH HOME	236 MCTAVISH LANE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 12/15/20. The complaints were substantiated. (NC00170847 and NC00171111). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Development Disabilities.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court	V 291		

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V 291	Continued From page 1 or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on interviews and records review the facility failed to coordinate with other professionals in the care and treatment of a client (Client #1). The findings are: Review on 11/16/20 of Client #1's record revealed: - Admission: 7/30/18 - Diagnoses: Mild Intellectual Disability, Tourette's Disorder, Oppositional Disorder, Reactive Attachment disorder, Post Traumatic Stress Syndrome, conduct Disorder and Mood Disorder - Person Centered Plan goals: work on increasing social skills by learning to appropriate interact with pers/other people within the community, learn about his medication, attend all medical appointments, participate in physical activities three times a week. Review on 11/25/20 of police report dated 10/27/20 at 7:06 pm revealed: - Police respond to the McTavish Home - Client #1 reports to police he is mad and did not want to stay at the group home. Client #1 stated he would leave the group home after police left - Police asked Client #1 if he wanted to go the hospital and would he go voluntarily. - Client #1 said he would go hospital but that he wasn't taking his medications. - Police transport Client #1 to hospital. - Police stay with Client #1 until he is assigned a bed. Hospital staff reported they did not need further assistance.	V 291		

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V 291	Continued From page 2 Review on Review on 11/19/20 of medical record dated 10/27/20 and 10/28/20 for Client #1 revealed: - patient arrives at hospital ED (emergency department) at 8:19 PM Chief Compliant: Psychiatric Evaluation, Client#1 (pt.) refused to go inside residence and take his medications - sent to emergency department by group home staff - '20-year-old male pt., presenting today with police for psychiatric evaluation. Pt resides at a group home. Pt was apparently was outside this afternoon, was directed to go inside and decide he didn't want to. He refused to go back inside as well as take his medications' No SI or HI. He has no complaints - 'Psychiatric Evaluation: no aggressive behaviors, no agitation, no bizarre behavior, no delusions, no disorganized speech, no disorganized thought process, no hallucinations, no paranoid behavior, no self-multination, no suicidal thoughts, no suicide threats and not suicide attempt - Physical Exam: does not appear distressed, no respiratory distress, alert and oriented, normal mood and affect, speech is normal behavior is normal, thought content normal' Continued review of hospital medical record for Client #1 revealed: - 9:30 PM Call placed to group home and Staff #4 stated that the manger must be called at (number given). Call placed to her (House Manager) and there was not answer. Left voice mail requesting a call back. - 9:39 PM left message with Wes Care (number given) to please contact hospital - Left a message with Qualified Professional (QP) (number given). Social worker was transferred to on call staff (number given), Social Worker left a message	V 291		

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V 291	Continued From page 3 - Social Worker reached out to Wes Care Afterhours hotline and spoke to Licensee who stated, 'pt. will have to wait until the morning when they have staff who will be able to pick [pt.] up.' - Social Worker attempted to explain this is an ED and pt. is medically stable and ready for discharge - Social Worker received a call back from the QP stating '[pt.] could be picked up in the morning.' Social Worker reminded the QP that 'this is an ED and [pt.] is medically stable.' The QP stated she 'would attempt to reach [Staff #1] and would call Social Worker back.' - Social Worker reached out to on call supervisor (Hospital Supervisor) who stated, 'due to the Covid we don't want [pt.] just sitting in the ED and to arrange transportation for [pt.] to be transported via ambulance.' - Social Worker reached out to Life Star (ambulance service), Social Worker arranged for transport at 2:30 AM (10/28/20) for ambulance to transport pt. back to group home - Social Worker reached back out to Group Home to let them know pt. will be discharge at 2:30 am. Social Worker spoke with Staff #4 who stated that would be fine to transport pt. back to group home. Interview on 11/16/20 with Client #1 revealed: - "I was playing basketball and it was getting late and I didn't want to come back inside. She (Staff #1) said I had to come in. I told her I wasn't going in and I didn't." - Staff #1 called the police to assist with getting Client #1 inside the group home. - "The police came, and I went inside. The (the police) asked me if I was going to listen and stay inside. I said no. I wanted to leave, and I wasn't going to take my meds (medication)." - The police asked Client #1 if he would	V 291		

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V 291	Continued From page 4	V 291		

voluntarily go to the emergency room department and Client #1 left with police.
- "I was ok I just didn't want to come inside (the group home). Staff couldn't pick me up at the hospital. I came home in an ambulance in the morning."

Interview on 11/16/20 Staff #1 revealed:
- Staff #1 works from (9:00AM to 7:00 pm
- "[Client#1] refused to come in and it was getting dark. He eventually came back into the yard, but then refused to come in the house. I called the police at that point. I was the only one working."
- Police arrived at the group home. Client #1 was directed by police to come inside and he did.
- Police asked Client #1 would remain in the home and take his medications. Client #1 said 'no' he wasn't staying inside, and he wasn't taking his medications.
- Police then asked Client #1 if he would voluntarily go to the emergency room department.
- Client #1 reported "yes'.
- Client #1 was transported via police to the emergency room.
- "I gave the police my number. I explained to him (the officer) that my ringer is messed up. I saw the next morning (10/28/20) they (hospital staff) tried to contact me (for the purpose of transporting Client #1 back to the group home).
- There was only one staff working after I left my shift (approximately 7:30 - 7:45 pm on 10/27/20). The hospital was calling to have someone pick up [Client #1]. I think the hospital talked with the [QP].
- Staff#1 reported that "I haven't been here that long, I don't know procedures (for picking up clients at the hospital) but I'm pretty sure they (staff) have to pick them (clients) up."

Interview on 11/23/20 with Staff #4 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-329	A. BUILDING: _____ B. WING _____	C 12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCTAVISH HOME	236 MCTAVISH LANE WINSTON SALEM, NC 27103

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V 291	Continued From page 5 - "I arrived just as [Staff #1] was asking [Client #1] to come inside. It was getting dark and [Client #1] didn't want to follow direction. - Police were called and basically, they took him to the emergency room for evaluation. He wouldn't take his medications for [Staff #1] either." - The hospital social worker calls the group home and request transportation for Client #1. Staff #4 is unable to transport since he is the only staff present in the group home. -Staff #4 request that social Worker contact the lead staff (Staff #1 or the QP). - The hospital social worker calls the group home and informs Staff #4 that Client #1 will be transported back via ambulance. Interview on 11/23/20 with the QP revealed: - The QP spoke with the hospital Social Worker and reported that the group home only had 1 overnight staff and he could not transport without waking up the clients. - The QP had no access to a vehicle to transport Client #1. - "Typically, we (staff) exhaust all available staff to transport a client. However, currently there just aren't enough staff. - Its very inconvenient to release a client from observation at night. - With Covid it hard to have more staff and more on call staff."	V 291		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-329	A. BUILDING: _____ B. WING _____	C 12/15/2020

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V 367	Continued From page 6	V 367		

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:
(1) hospital records including confidential information;
(2) reports by other authorities; and

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V 367	Continued From page 7 (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		

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	MHL034-329	A. BUILDING: _____ B. WING _____	C 12/15/2020

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V 367	Continued From page 8 This Rule is not met as evidenced by: Based on records review and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity/Managed Care Organization (LME/MCO) within the 72 hours as required. The findings are: Review on 11/16/20 of Client #1's record revealed: - Admission: 7/30/18 - Diagnoses: Mild Intellectual Disability, Tourette's Disorder, Oppositional Disorder, Reactive Attachment disorder, Post Traumatic Stress Syndrome, conduct Disorder and Mood Disorder Review on 11/25/20 of a police report dated 10/27/20 at 7:06 pm revealed: - Police respond to McTavish Home. - Client #1 reports to police he is mad and did not want to stay at the group home. Client #1 stated he would leave the group home after police left. - Police asked Client #1 if he wanted to go the hospital and would he go voluntarily. - Client #1 said he would go hospital but that he wasn't taking his medications. - Police transport Client #1 to hospital. - Police stay with Client #1 until he is assigned a bed. Hospital staff reported they did not need further assistance. Review on 12/1/20 of Former Client (FC)#3's record revealed: - Admission: 7/8/18 - Diagnoses: Moderate Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyper Activity, Sensory Integration Disorder,	V 367		

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	MHL034-329	A. BUILDING: _____ B. WING _____	C 12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCTAVISH HOME	236 MCTAVISH LANE WINSTON SALEM, NC 27103

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V 367	Continued From page 9 Essential Tremors, Dyslexia, Verbal Apraxia, anxiety disorder, and Post Traumatic Stress Disorder and Polyuria - Discharge: 8/15/20 Review on 11/30/20 of a police report dated 2/26/20 at 8:30 pm revealed: - Police respond to McTavish Home - FC#3 reports he was scared because he believed staff(unnamed) was angry and going to hit him with a table leg. FC#3 stated that he believed the caretake (unnamed staff) was going to hit him with a table leg because he (unnamed staff) was possessed by the devil. - FC#3 wished to be seen by Emergency medial personnel (EMS) so they were contacted and responded out. FC#3's reason for wanting EMS was because he was afraid of unnamed staff. FC#3 did not want to go to hospital via EMS. - Staff # 2 was called and responded to group home and relieved the unnamed staff from shift duty. Staff#2 remained at the group home with FC#3. Review on 11/9/20 of the Incident Response Improvement System (IRIS) from 11/9/20 through 1/1/2020 revealed: - No incident report dated 10/27/20 involving Client #1. - No incident report dated 2/26/20 involving FC#3. Attempted interviews on 12/10/20 and 12/11/20 with Former Qualified Professional #2 and Former Qualified Professional #1 were unsuccessful as telephone calls were never returned. Interview on 11/23/20 with the current QP revealed: - QP had started her job duties on 10/1/20 and	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MCTAVISH HOME	236 MCTAVISH LANE WINSTON SALEM, NC 27103

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V 367	Continued From page 10 was not in the QP at the time of these incidents. - QP did not know why IRIS reports were not completed.	V 367		
V 541	27F .0104 Client Rights - Stor. & Protect of Cloth/Poss 10A NCAC 27F .0104 STORAGE AND PROTECTION OF CLOTHING AND POSSESSIONS Facility employees shall make every effort to protect each client's personal clothing and possessions from theft, damage, destruction, loss, and misplacement. This includes, but is not limited to, assisting the client in developing and maintaining an inventory of clothing and personal possessions if the client or legally responsible person desires. This Rule is not met as evidenced by: Based on interviews and records review the facility failed to make every effort to protect clients personal clothing and possessions from loss and damage affecting 1 of 1 (Former Clients (FC)#3). The findings are: Review on 12/1/20 of FC #3's record revealed: - Admission: 7/8/18 - Diagnoses: Moderate Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyper Activity, Sensory Integration Disorder, Essential Tremors, Dyslexia, Verbal Apraxia, anxiety disorder, and Post Traumatic Stress Disorder and Polyuria - Discharge: 8/15/20 - Individual Support Plan dated revealed: FC#3 requires support in the areas of all appointments,	V 541		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-329	A. BUILDING: _____ B. WING _____	C 12/15/2020

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V 541	Continued From page 11 medications, nutrition, vision, positive behaviors and communication, safety supports in community, and completing daily activities such as financial. FC#3 is able to speak up for himself to express some of his personal preferences, needs and wants. He needs help advocating for himself in all areas of his left and does not have a good understanding that choices a decisions are related to consequences and responsibilities ... FC#3 will pinch, squeeze, punch, slap, choke, pull hair and spit at others this primarily occurs towards his (family member). Behaviors could occur weekly and he has not inured others requiring medical treatment ... FC#3 has history of breaking blinds, setting fires, put holes in dry wall and he will bite on the car door panel, his arm, bang his head, hit his chest, and pinch his nipples. FC#3 always requires close supervision and he must be told the boundaries of where he can and cannot go. Goals include: Will refrain from putting non-food items in his mouth, will thoroughly dry himself before putting on clothes, will practice calming techniques when angered or upset, will learn to take turns with engaging in interactive play with others, will refrain from touching others in appropriately and will participate in an exercise routine. Review on 12/14/20 of discharge inventory list for FC#3 dated 8/15/20 revealed: 25 shirts, 3 pants, 15 shorts, 15, underwear, 6 pillow case, 3 towels, 1 fan, 1 noise maker, 1 chair, 3 blankets, 3 pair shoes, 2 bath cloths 1 clock. Signed and dated by Guardian. Discharge list did not include FC#3's iPad, iPad charger(s), toys that were undamaged, and FC#3's NC ID (North Carolina Identification card) and FC#3's blue suit and shoes, belt and tie.	V 541		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 541	Continued From page 12	V 541		

Review on 11/9/20 of a text message sent to House Manager revealed:
- "where is his ID.?" (FC#3's NCID card)

Review on 11/9/20 of text message sent to House Manager on 6/21/20 revealed:
"Hey please look for [FC#3's] suit. It was in the back closet with his jacket
Review on 11/9/20 of a text message sent to the House Manager and the Qualified Professional (QP) #2 revealed: "what about the iPad chargers? A 2 pk(pack) was sent and both have disappeared."
Further review of text messages revealed no communication back to the Guardian from the QP#2 or the House Manager regarding the iPad, iPad chargers, blue suit, shoes and tie and belt.

Review on 12/10/20 of the facility's policy on safeguarding client personal possessions revealed:
...7. "Each individual shall have safe and adequate storage facilities to protect their clothing and other personal items from theft, damage, destruction, loss and misplacement, including helping the individual develop and maintain an inventory of his possessions."

Interview on 11/17/20 with Staff #1 revealed:
- Staff #1 was not sure of a suit belonging to FC#3.
-There were no toys of FC#3's left. "No more than when he left, he destroyed a lot of his thing things."

Interview on 12/14/20 with Staff #3 revealed:
- "I never used his bankcard. I never saw a blue suit"

Interview on 11/16/20 with the House Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCTAVISH HOME	236 MCTAVISH LANE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 541	Continued From page 13 revealed: - "That blue suit did not fit properly to begin with, it was too small, and he destroyed the pants at the dance." - The blue suit coat was worn outside." Attempted interviews on 12/10/20 and 12/11/20 with Former Qualified Professional #2 and Former Qualified Professional #1 were unsuccessful as telephone calls were never returned. Interview on 12/14/20 with the House Manager revealed: - FC#3's bank card and ID were kept locked in the desk. - The bank card was missing in 2019 and the [Guardian] was made aware of this. - "His NCID was replaced. When I was asked to assist the [Guardian] with [FC#3] after he was already discharged. (9/2020) I had the ID. The Guardian had already replaced it so its still at the group home (NCID card)." Interview on 11/9/20 with the Guardian revealed: - "The staff were aware of the suit, shoes, belt, tie, they were aware of the ipads that came up missing, the NC ID and [FC #3's] bank card. - I would get a call about [FC#3] had destroyed something. But that was usually when I called to see how things were or when there was a visit. - His (FC#3) bank card and ID were never left with him. They (bank card and ID) were always locked up in the desk. Neither came home with him. So how can they come up missing if they are responsible for safeguarding those items."	V 541		