Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040-006	A. BUILDING: ______ B. WING ______	R 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWELL	292 DOGWOOD LANE SNOW HILL, NC 28580

(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 and follow up survey was completed on February 9, 2021. The complaint was unsubstantiated (intake # NC00173388). 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	Ambleside, Inc. views this as a very serious matter, and has worked diligently to ensure that an incident such as this does not happen again while this young man is in our residential program To prevent another incident such as this moving forward, Ambleside has retrained all Hopewell house staff members on the appropriate storage practices for the Ambleside vehicle, and staff's personal keys, procedure while they are working at the Hopewell House. Furthermore, to ensure that staff members are abiding by the appropriate key storage procedures, Hopewell's QP is completing no less than bi-weekly spot checks at the Hopewell house to ensure that the keys are stored appropriately per policy and procedure. The QP is documenting these spot checks on an Ambleside agency created form, and submitting a copy of the filled-out form to the Director of Operations no later than Friday at 5:00pm, weekly. With these improved safety verifications, we	
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		2/22/21

DHSR - Mental Health
FEB 2 [illegible]
Lic. & Cert. Section

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement strategies based on assessment for 1 of 2 audited clients (client #2). The findings are: Review on 1/27/21 of client #2's record revealed: - 25 year old male admitted 8/26/19. - Diagnoses included Bipolar Disorder, Pervasive Developmental Disorder, Intellectual/Developmental Disability, moderate, Attention Deficit Hyperactivity Disorder. - Admission Assessment dated 8/28/19 included ". . . Risk Assessment: [Client #2] has a history of eloping from his residence, and has stolen vehicles in the past when keys were left in the car. It is recommended that keys to automobiles are stored on staff's person at all times, and never left sitting out in the house. It is recommended that all staff be made aware of Policy and procedure as it pertains to elopement incidents to ensure [client #2's] safety in the community. [Client #2] should not be left unattended in the community, as he does not have peripheral awareness to detect danger from cars or from strangers." - "Individual Support Plan Short Range Goals SP (Support Plan) Meeting Date: 7.23.2020 Implementation Date: 11/01/2020" included short range goal and strategies to address elopement, but no goals or strategies to address client #2's history of stealing vehicles. - "Risk/Support Needs Assessment" completed 7/23/20 included " . . . Positive Behavior Support . . . Requires support to prevent, manage or	V 112	are confident that the keys are being stored appropriately, and the member involved in this incident does not have an opportunity to steal the house's vehicle keys again. In addition to staff re-training and verification that the keys are being stored correctly through on-site visits, the member's treatment plan has been updated and implemented. The following goal was written into the member's plan, and was effective 2/8/2021; "Member will independently maintain his health and safety within his home by having zero incidents of stealing the Ambleside company vehicle keys, and not attempting to steal the agency vehicle day and night throughout the plan year." This goal was approved by the member's guardian verbally and in writing, and staff member's view and record this goal on a daily basis. This goal is monitored by Hopewells QP on a daily basis through note review.	

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provide therapy for behaviors or conditions that can potentially cause physical harm to self or others or that may be a misdemeanor . . . " with "Yes" checked.
- "Support Intensity Scale" dated 6/14/18 included ". . . Other Pertinent Information . . . [client #2] does not have a driver license but has driven vehicles previously across town which resulted in a minor accident. . . . Section 1B: Exceptional Behavioral Support Needs . . . 11. Prevention of wandering 2-Extensive Support [client #2] needs support in prevention and response to eloping. these incidences occur several times a year. Police supports have been utilized. . . 4. Prevention of stealing 1-Some Support . . Support in prevention of stealing from stores, library, others property esp. (especially) car keys needs to be provided. . . . "
- "After Visit Summary" from a local acute care hospital dated 1/4/2021 included ". . . Reason for visit Motor Vehicle Crash . . . " with care instructions for "Scrapes (Abrasions)."

Review on 1/26/21 of North Carolina Incident Response Improvement System (IRIS) reports for client #2 revealed:
- Level III incident report "Last Submitted 1/08/2021" for incident of 1/04/2021.
- ". . . Staff member did not follow Ambleside (Licensee) protocol and left the key to the van inside of the van. When the member (client #2) went to retrieve a cup out of the van, he noticed the key, and drove the car off Ambleside property. This resulted in the member being pursued by law enforcement, and ultimately forced off the road. . . "
- Attached to the incident report was an "Investigation Report . . . January 4, 2021" completed and signed by the Director of Operations 1/8/21.

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V 112	Continued From page 3 - The internal investigation included interviews with the House Lead, staff #5, former staff #8, and former staff #9. - During their interviews with the Director of Operations, former staff #8 and another staff not listed on the client census form stated they routinely left the van key in the van cupholder; former staff #8 stated he ". . . was not the only one that has left the key on the van;" the staff not listed on the client census form stated ". . . I leave it in the cupholder on the van. . . they key has been in the cup holder pretty much since June/July. . . every staff . . . typically . . " left the key in the van. - When interviewed by the Director of Operations, the House Lead, former staff #8, and former staff #9 recalled being informed of client #2's history of stealing vehicles during client specific training; staff #5 did not recall being informed of client #2's history of stealing vehicles, but stated she did receive client specific training. - Level II incident report dated 7/11/19 submitted from client #2's previous placement included client #2 took a facility owned van and drove it into oncoming traffic on a very busy highway hitting four cars; client #2 was taken to the hospital by law enforcement and was admitted. Review on 2/03/21 of a "Claim Summary Report" dated 1/27/21 from the Licensee's vehicle insurance carrier revealed the van was a "Total Loss." During interview on 1/26/21 client #2 stated: - He "wanted to take the van for a spin." - He knew where staff put the van key, "in the cup holder in the van." - He waited until staff were occupied and then he asked if he could get his cup out of the van. - When he went to the van he "jumped in, locked	V 112		

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the door, started the van and threw it in gear and took off."
- He was driving 75 miles per hour on the highway to a nearby town.
- The Police "couldn't catch" him.
- At one point he "stopped, got out of the van and then saw the police so I jumped back in and kept going."
- "The Police used that thing and popped the tires and I hit a pole then."
- "The Police busted out the window and drug me out and handcuffed" him.
- He "thought it would be fun, but it wasn't" because he "got dragged out of the car."
- He was going to the mall in a nearby town.

During interview on 2/05/21 client #2's guardian stated:
- He was notified a staff left the van keys in the cup holder and client #2 took the van.
- Client #2 "is good about noticing things like that and he wanted to go joy riding."
- "They (the Facility) were pre-warned about this. This is the third time he's done it."
- "They were told, I told them and they knew about it from the group home he came from. And the people who work there knew it."

During interview on 2/08/21 an officer with the North Carolina Highway Patrol stated:
- 5 law enforcement vehicles were involved in the pursuit of a van driven by client #2 on 1/04/21.
- The van was being driven recklessly on a heavily traveled highway.
- A Highway Patrol Trooper used a pursuit intervention technique to force the van off the road to end the pursuit.
- The pursuit ended 9 1/2 miles from the town where the facility was located.
- Although the van was forced off the road and hit

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an embankment causing extensive damage to the van, an accident report was not done.
- No criminal charges were brought against client #2.

Review on 2/03/21 of staff #5's personnel record revealed:
- Hire date 4/20/20.
- Title of paraprofessional.
- Client #2 "Client Specific Training" dated 9/21/20, included "Behavior Concerns;" specific "behavior concerns" were not documented.

Attempted interviews with staff #5 on 2/03/21 and 2/04/21 were unsuccessful; staff #5 did not return the surveyor's telephone call.

Review on 2/03/21 of former staff #8's personnel record revealed:
- Hire date 8/31/20; separation date 1/05/21.
- Title of paraprofessional.
- Client #2 "Client Specific Training" dated 9/08/20 included "Behavior Concerns;" specific "behavior concerns" were not documented.

Attempted interviews with former staff #8 on 2/03/21 was unsuccessful; the telephone number provided by the Director of Operations was "not in service."

Review on 2/03/21 of former staff #9's personnel record revealed:
- Hire date of 5/07/20, separation date of 1/08/21.
- Title of paraprofessional.
- Client #2 "Client Specific Training" dated 5/12/20 included "Behavior Concerns;"specific "behavior concerns" were not documented.

During interview on 2/03/21 former staff #9 stated:

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- Everyone hired to work in the facility was trained on each client's "behaviors, needs, history, all that."
- He was familiar with client #2's history of stealing vehicles.
- At the time of the incident, he was in the facility working on documentation and staff #5 was cooking supper.
- Client #2 "apparently" asked staff #5 if he "could go to the van to get either his jacket or his cup."
- "Another consumer ran in and said [client #2] was in the van and had started it."
- He ran outside and tried to get in the van but the doors were locked.
- He instructed staff #5 to call 911 and the Qualified Professional and then he "got in my car and followed him."
- He followed client #2 and maintained contact with a Sheriff's Deputy to let them know where client #2 was.
- He didn't know if client #2 "lost control or if the police intervened but he wound up hitting a mound of dirt."
- Client #2 was driving "between 60 and 65 miles per hour, no more than 70 and was running red lights."
- Client #2 was transported to a local acute care hospital, was evaluated in the Emergency Department and released.
- Client #2 told said "he saw a prior staff leave the key in the van."
- "We were all told to keep the keys on us, even our personal keys."

During interviews on 2/03/21 and 2/04/21 the Qualified Professional (QP) stated:
- She had worked at the facility since November 2020.
- One of her responsibilities was writing short range goals and strategies based on "individual

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needs, staff input and my observations."
- She was "still learning the individuals" on her caseload.
- If a plan was written before she was hired she updated the plans to meet individuals' needs.
- Client #2's plan was not due and "was not done by me;" his next team meeting was scheduled for October 2021.
- The QP's "who were here before me didn't do everything they were supposed to do" and she was "still cleaning up behind the last QP."
- If needed, a plan could be updated before the due date.
- Client #2 was "not a high behavioral individual" but was "very sneaky."
- She was aware of client #2's history of stealing vehicles; "They mentioned it when I first started" but "he had not done anything until that particular day and he gave no sign that he would."
- She asked client #2 about stealing the van and "he thought it was fun. He bragged about it."
- Client #2 "didn't know" why he took the van.
- "He could've been hurt worse than he was or he could've been killed."
- There was no information in client #2's plan about his history of stealing vehicles.
- She needed to revise the plan to include a goal to address client #2's stealing of the van, but she would first need to get approval from client #2's guardian and Care Coordinator.

During interviews on 1/26/21, 2/04/21 and 2/05/21, the Director of Operations stated:
- He was aware of client #2's history of stealing vehicles.
- It was "hard to say" how he learned of client #2's history; he was "not sure if it was documented."
- The Social Worker at the hospital client #2 was admitted from "probably" told him about client #2's history.

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- The Social Worker told him client #2 had "taken a vehicle once and had wrecked it and that's why he was in the hospital and in need of placement."
- Short range goals and strategies were updated as needed; a team meeting was held and the guardian had to sign off on any changes to the treatment/habilitation plans.
- Prior to admission the "Clinical Team" looked at a client's "historical documentation and needs to determine if we can adequately serve the individual."
- The Clinical Team that assessed client #2 for admission was comprised of 3 former QP's and the former Chief Clinical Officer.
- The former Chief Clinical Officer was a Registered Nurse.
- He could not say "with 100% certainty" that the former Chief Clinical Officer was involved in the assessment of client #2 for admission.

Review on 2/09/21 of the Plan of Protection completed by the Director of Operations dated 2/09/21 revealed:
- "What immediate action will the facility take to ensure the safety of the consumers in your care? Ambleside has taken immediate measures to ensure the protection of the individuals in the home, and prevention of the identified behavior from occurring again. Ambleside has re-trained all Hopewell staff members in appropriate key storage protocol, and verification of understanding has been signed by all staff members. Additionally, Ambleside has received verbal approval from the member's guardian to add a goal into his Short Range strategies designed to highlight this behavior and bring it to the attention of all staff members on a daily basis."
- "Describe your plans to make sure the above happens. The Hopewell House's Service

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V 112	Continued From page 9 Coordinator/QP will conduct no less than 2 on-site checks per week to ensure that the key is being stored in the appropriate location per agency policy and procedure. furthermore, the Service Coordinator/QP will check the notes daily to ensure that staff members have reviewed and noted that the individual did not handle the keys the day prior. Finally, Ambleside will use a 2-person verification to ensure that the goals are added to the plan. [the Director of Operations] will update the member's plan and obtain guardian approval & Service Coordinator/QP [QP] will verify that the goals are implemented in the Note Recording system." Client #2's diagnoses included Pervasive Developmental Disorder, moderate Intellectual/Developmental Disability, Bipolar Disorder and Attention Deficit Hyperactivity Disorder. He was admitted to the facility from the behavioral health unit of a regional acute care hospital following an incident wherein he stole and crashed a facility owned van. His history of stealing keys and vehicles was documented in his Admission Assessment of 8/28/19 and his Supports Intensity Scale of 6/14/18. Although the Licensee and QP were aware, and all of the facility staff were trained on client #2's history of stealing keys and vehicles, no short range goals or strategies were included in his treatment/habilitation plan. On January 4, 2021, client #2 observed former staff #8 leave the van keys in the cup holder in the van. He got into the van, locked the doors, started the van and drove away from the facility. A pursuit involving multiple law enforcement units ensued with client #2 driving recklessly, exceeding the speed limit and running stop lights. The pursuit ended approximately 9 ½ miles from the city limits following the use of a pursuit intervention	V 112		

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V 112	Continued From page 10 technique by the NC Highway Patrol. Although client #2 suffered no serious injury, the van was deemed a total loss. This deficiency constitutes a Type A2 rule violation for substantial risk for serious harm and must be corrected within 23 days. An administrative penalty of $500.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 112		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews the facility was not maintained in a safe, clean attractive, orderly manner and free from offensive odors. The findings are: Observations of the facility at approximately 11:15 am on 1/26/21 revealed: - An overwhelming smell of household cleaner throughout the kitchen and living room. - Painted cabinet faces in the kitchen were scuffed and scratched. - An approximate 10 inch tear in the floor vinyl.	V 736	Ensuring that the members served at the Hopewell house are living in a clean, sanitary, and beautiful home is the mission of Ambleside, Inc., and we will take immediate steps to ensure that the deficiencies noted in this report are corrected within the 30 day period to ensure that our mission is being upheld. The cleanliness deficiencies will be corrected by the Group Home staff members, and the maintenance deficiencies will be corrected by Ambleside's Maintenance Supervisor. Hopewell's QP will verify that all sanitary items have been completed, and the Director of Operations will ensure that all maintenance items have been completed.	3/9/21

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V 736	Continued From page 11 - The handle of the microwave was missing and there were dried food spatters inside the unit. - Onions in the pantry had sprouted. - Kitchen cabinet and drawer pulls missing. - Debris and stains on the molding on the top of the french door in the dining area. - Cob web with dead insect hanging from the ceiling at the french door. - A vinyl recliner with holes in the arms with the stuffing exposed in the living room. - The air return in the hallway had a heavy coating of dust. - A chest of drawers with 5 missing drawer pulls in client #6's bedroom. - Dark staining on the wall at the head of client #6's bed. - Paint peeling from the door frame in bathroom #1. - Bathroom #1 with a missing door pull on the cabinet and a missing drawer pull on the vanity drawer. - A small unfinished repair to the wall above the toilet in bathroom #1. - Dark stains in the bathtub in bathroom #1. - A large unfinished repair to the hallway wall. - Dark staining to the walk-in shower in bathroom #2. - Black, mildew like stains to the shoe molding around the shower in bathroom #2. - Approximately 6 inch unfinished repair to the wall over the toilet in bathroom #2. - Exposed light bulb in the ceiling fixture in client #1's bedroom. - Exposed light bulb in the ceiling fixture in client #5's bedroom. - 5 boxes of incontinent supplies and a vacuum cleaner stored in the back hallway near an emergency exit. - An electrical box with an exposed wire in the hallway ceiling.	V 736		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWELL	**292 DOGWOOD LANE SNOW HILL, NC 28580**

(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 736	Continued From page 12 - Brown spots on the ceiling in client #3's bedroom. - The light fixture cover was hanging loose in client #2 & #4's shared bedroom. - Cobwebs in client #2 & #4's shared bedroom. During interview on 1/26/21 the House Lead stated: - The unfinished repair in the hallway wall had been there approximately 3 months. - Maintenance staff were working to complete repairs and were in the process of re-installing the security cameras. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		