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V 000	INITIAL COMMENTS A complaint survey was completed on 3/9/21. The complaint was substantiated (intake #NC00173960). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability Sister facilities are identified in this report. The sister facilities will be identified as sister facility A and sister facility B. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000		
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	V 112		

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V 112	Continued From page 1 obtained. This Rule is not met as evidenced by: Based on record review, observations and interviews the facility failed to implement strategies for 2 of 2 current clients (#1, #2) and 1 of 1 former client (FC#3). The findings are: Review on 2/3/21 of client #1's record revealed: - Admission Date: 7/10/15 - Diagnoses: Impulse Control Disorder; Schizophrenia and Moderate IDD (Intellectual and Developmental Disabilities) - Review of Client #1's PCP (Person Centered Profile) dated 6/25/20 revealed: "[Client #1] requires 24-hour awake staff for her safety and others ...can be impatient and when she wants something, she will try to get it if she has to attempt to elope, steal, or be physically and/or verbally aggressive ...should be closely monitored to ensure that she doesn't engage in physical aggression ...should always be transported the furthest away from driver to alleviate the possibility of her attacking the driver ...behaviors are unpredictable she has attacked even when she has presented herself as calm. [Client #1's] 2-1 staffing is very imperative for the sake of her safety and others." Review on 2/3/21 of client #2's record revealed: - Admission Date: 9/18/18 - Diagnoses: ADHD (Attention Deficit	V 112		

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Hyperactivity Disorder); PTSD (Post-Traumatic Stress Disorder); Intermittent Explosive Disorder; and Oppositional Defiant Disorder
- Review of Client #2's PCP dated 9/17/20 revealed: "[Client #2] often acts out if she does not get her way however her behaviors can be manageable with 1:1 staff or when working with certain males ...continues to display aggressive behaviors when she does not get what she wants ...On several occasions [client #2] has gotten into fights on the van which has required for staff to stop the van and pull over."

Review on 2/3/21 of former client (FC) #3's record revealed:
- Admission Date: 7/9/19
- Discharge Date: 1/23/21
- Diagnoses: Severe IDD and Adjustment Disorder
- Review of FC #3's goals in the PCP dated 10/1/19 revealed: "He should be monitored closely when he is directly interacting with younger peers in order to redirect or block as needed. [FC #3] doesn't like for others to get in his personal space or touching his belongings. [FC #3] requires extensive support with prevention of emotional outburst. He will curse, scream, holler, cry, void on himself, and pound on tables...requires extensive support with prevention of property destruction (e.g., fire setting, breaking furniture). He will break things such as glasses, radios, television, and he has broken a dresser ... requires extensive support with prevention of stealing...requires extensive support with prevention of self-injury. He will punch and slap his face and head ...requires extensive support with prevention of non-aggressive but inappropriate sexual behavior (e.g. exposes self in public, exhibitionism, inappropriate touching or gesturing). He will

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V 112	Continued From page 3 disrobe in public and he has a history of inappropriately touching children ...requires extensive support with prevention of sexual aggression. He has a history of sexual aggression which includes oral sex with a child ...requires extensive support with prevention of wondering. He has a history of running off and requires very close supervision and activities to keep him busy and appropriately engaged." Finding #1 Review of photographs and interview on 2/4/21 with FC #3's Legal Guardian revealed: - She resides out of state. On 1/23/21 after not being able to get in contact with FC #3 because staff did not answer the phone, she asked her mother to pick up FC #3. - When her mother arrived at the group home she noticed that FC #3's left eye was tearing, and his right eye was swollen. Her mother also noticed scratches to his face and neck. - FC #3 would tell on himself if he self-harmed. FC #3 told her mother he did not put the marks on himself. FC #3 reported that someone with a name that sounded like client A2 jumped on him and beat him up. Note: client A2's name sounds a lot like client A1's name. - Soon after her mother picked up FC #3 and brought him to her home, she was unable to manage his behaviors and he went to the hospital. - "[FC #3's] (left eye) was running; tearing and his right eye it was swollen. [FC #3] kept saying his eye hurt and he kept rubbing it. On top of his right eye lid there were scratches. His neck was covered in clawing scratches on the front side neck and the back of his neck." - Reviewed pictures provided by the legal guardian. The legal guardian indicated the	V 112		

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pictures were of FC #3 and taken by her mother on the same day her mother picked up FC #3 at the group home (1/23/21). Multiple scratches on the front of FC #3's neck and some scratches on the back of his neck. A scratch above his right eye (just below his eyebrow) and a scratch below his right eye. A swollen area under his right eye.

Review on 2/12/21 of FC #3's hospital record revealed:
- Date: 2/8/21
- "SW (Social Worker) spoke with [Licensee #1], manager of the former group home. She stated that pts (patient's) sister became his guardian in December 2020 when mom relinquished guardianship due to the difficulties managing [FC #3's] care. Pts sister visited [FC #3] in the GH (group home) and abruptly removed him when she noticed scratches and a black eye. Sister reportedly did not ask about the injuries which [Licensee #1] explained. She stated that [FC #3] became violent while riding in a transport van. Other consumers in the van intervened in order to protect the driver who was driving the bus when the incident occurred. [Licensee #1] explained that [FC #3] often exhibits self-injurious and violent behaviors so scratches and bruises are common. This type of aggressive behavior has been documented while pt has been here (hospital) ..."

Interview on 2/9/21 with FC #3 revealed:
- He did not scratch his neck while riding the van.
- "[Client A1] scratched my neck (on the van). Yes, [client A1] went to my day program. [Client A1] did not live in my group home."
- "[Client A1] jumped on me and beat me up, he scratched my neck and punched me in the eye and scratched my eye."
- Client A1 told him not to hit client A3 while they

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were on the van.
- He indicated that only client A1 hurt him and he was beat up by client A1 "12 days" before he left.
- FC #3 began talking off topic and was unable to provide more details about what occurred.

Interviews on 2/10/21 and 2/11/21 with client A1 revealed:
- He is 17 years old and resides in sister facility A. He rode the van with FC #3 to and from the day program.
- Staff #5 was the driver for the van that transported to and from the day program. Staff #5 was the only staff on the van.
- There had been an incident about one month ago with him and FC #3.
- On the day of the incident it was time to leave the day program and prior to getting on the van FC #3 attacked staff #5. Staff #5 escorted FC #3 to the van and FC #3 tried to hit other clients on the van. He was sitting next to FC #3 in the very back of the van.
- Prior to the van leaving FC #3 tried to rip his (FC #3's) shirt off and was restrained by Staff #5.
- During the ride to the group homes FC #3 tried to bite him, and he punched FC #3 in the mouth. He scratched FC #3 on the face and neck during the van ride. FC #3 also banged his head on the window during the van ride. He was scratched on his arm by FC #3.
- Staff #5 who was driving the van did not see anything because he and FC #3 were in the very back of the van.
- "[FC #3] was destroying the van. I got upset. [FC #6] tried to break the window too. Then [FC #3] went to sleep and we arrived at the group home."

Interviews on 2/9/21 and 2/11/21 with staff #5 revealed:

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- On 1/22/21 FC #3 did not want to get on the van at the day program to go back to the group home because he thought he was going home with his sister.
- FC #3 had extreme behaviors on the van on 1/22/21. FC #3 took his clothes off and defecated in the van seat. He became violent and hit the van.
- Prior to leaving the day program he and staff B #4 had to restrain FC #3 in the van.
- While driving the van on 1/22/21 he heard someone say FC #3 had attacked client A1 and client A3. He told FC #3 to calm down. Client A1 and FC #3 were sitting on the same row in the very back of the van (4th row) and client A3 was sitting in front of FC #3 on the van.
- Due to FC #3's behaviors on the van he dropped FC #3 off first.
- He later received a phone call from staff #2 who asked him about the scratches on FC #3's neck.
- He told staff #2 he did not see any scratches on FC #3 when he dropped him off at the group home. He could not see what was going on because FC #3 was sitting in the very back of the van on the 4th row.
- He drove 12 clients from 5 different group homes to and from the Day Program by himself.
- "I am new, and no one offered to help. I thought I was supposed to manage the situation as best as possible. It was 2nd or 3rd time transporting [FC #3]. It was becoming overwhelming."

Interview on 2/9/21 with staff #2 revealed:
- FC #3 had come into the group home sometime in December 2020 or January 2021 with scratches on his neck and cheek area. She never noticed that FC #3 had a swollen area around his eye. She treated it with Neosporin.
- FC #3 told her that he got into a fight and got scratched up. FC #3 never provided the name of

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the person he got into a fight with.
- The transportation staff, staff #5, also said that FC #3 got into an altercation on the van but never told her who FC #3 got into an altercation with.

Interview 2/11/21 with the Licensee #1 revealed:
- She was only aware that FC #3 had scratches to his face and neck area. She was not aware FC #3 had swelling below his eye.
- She had talked to staff #5 about the incident that caused FC #3 to get scratched.
- FC #3 was scratched on the van on 1/22/21.
- On 1/22/21 FC #3 was going home from the day program on the van. FC #3 stripped off his clothes and defecated on the van. FC #3 had attacked client A1 and client A3 on the van as well. Client A1 fought back and FC #3 got scratched.
- She was aware that the treatment plans for FC #3 and other clients who rode the van needed one on one care, but she indicated the clients did not "get one on one care during transport."

Finding #2

Observation and interview on 2/2/21 at 12:19 pm with client #1 revealed:
- There was a recent physical fight that involved her and client #2. She thought the fight occurred sometime last week (1/25/21-1/29/21)
- On the day of the physical fight she wanted hot dogs and french fries for dinner and client #2 did not want hotdogs and french fries.
- Client #2 came into her bedroom upset over the dinner plans and hit her in the head with a broom. She picked up a fan and hit client #2 on the hand "so that [client #2] would let go of the broom."
- Then client #2 bit her left arm. Client #2 then pushed her down the hall to the kitchen. While in the kitchen client #2 hit her in the head and

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punched her in the nose which caused it to bleed.
- Client #2 then bit her on her left breast. Client #1 ran outside and ran down the street and called the police from at a neighbor's home.
- She and client #2 were the only clients present during the fight.
- The police arrived at the group home and she was charged with assault.
- Her court date for the assault is 3/24/21.
- At approximately 12:19 pm, observed a circular bruise to the inside of her left upper arm. Also observed a bruising pattern to her left upper breast area with a semi-circle of bruise at the top.

Interview 2/2/21 with client #2 revealed:
- She and client #1 got into a physical altercation "last week."
- She was upset with client #1 because client #1 "was saying the thing I was saying."
- Client #1 hit her with a fan but she could not remember why client #1 hit her with a fan.
- She hit client #1 back with a broom. This occurred in the hallway near their bedrooms.
- At some point she and client #1 ended up in the kitchen.
- Client #1 started pulling her hair and she started punching client #1 in the nose.
- There were no other clients present.
- Staff #8 was the only staff there and he was outside smoking a cigarette. Staff #5 was doing transportation and they were waiting for him to arrive at the group home.
- She recalled the police and paramedics had come to the group home. She and client #1 were not taken to the hospital. She had a court date of 3/24/21 due to the fight.
- "I probably bit her to get her off of me."
- "I was just hitting her and blacked out."

Interview 2/9/21 with staff #8 revealed:

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V 112	Continued From page 9 - On 1/26/21 he was the only staff on duty when client #1 and client #2 got into a fight. - He normally did not work at this group home and worked on 1/26/21 as a "fill in." - On 1/26/21, client #1 and client #2 had come home from the day program and went to their bedrooms. - Client #1 had come out of her bedroom and asked if they could have hot dogs for dinner. He told her yes it was fine to have hot dogs for dinner. - When client #1 told client #2 they were having hot dogs for dinner "that is when everything went downhill." - Client #2 got upset and started screaming because she did not want hot dogs for dinner. - He asked client #1 to go back to her bedroom. - Client #2 walked outside and stated she wanted to wait for the other staff to come on shift. - He stood out on the porch with client #2 to make sure she did not walk away. - Client #2 indicated client #1 had been bothering her all day at the day program. He asked client #2 to go to her bedroom to calm down. Client #2 continued to bring up the day program and stated she was going to beat client #1's "a*s." - Client #2 went back inside and banged on client #1's bedroom door and walked into the kitchen and sat down. - Client #1 had come out of her room and stated she felt threatened. He told her to go back into her bedroom. Client #2 picked up a metal paper towel holder and threw it at client #1. Client #1 closed her bedroom door and he closed the front door. As he closed the front door, client #2 ran into client #1's bedroom. - Client #2 started to attack client #1. Client #1 and client #2 moved out of client #1's bedroom quickly. He pulled client #2 off client #1. - Client #1 ended up going outside and he	V 112		

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followed her. He followed client #1 two houses down and client #2 was outside making threats to fight.
- The police arrived but he was unsure who called the police.
- When the police arrived they called the paramedics.
- He denied that he left the clients alone.
- He denied that he smoked until the police arrived.
- Client #2 had a cut on one of her fingers.
- He was the only staff working when the fight occurred. There was supposed to be two staff working.
- "[Client #1] had a bloody nose and a bite mark on her arm. I am guessing the bite mark and bloody nose occurred while they were in the bedroom. I am guessing it occurred when I closed the front door and [client #2] ran into [client #1's] room."

Interview 2/9/21 with staff #5 revealed:
- By the time he arrived to the group home on 1/26/21 the police were there.
- "[Staff #8] was the only staff there at the time. It would have been better if I had been there just so that two staff could have been present because the clients feel if one staff is present the clients do not listen."

Interview on 2/10/21 with the police officer revealed:
- He had been called to the group home on 1/26/21 for an altercation between client #1 and client #2.
- Both clients had injuries.
- When the fight occurred client #2 had a broomstick and client #1 had a fan.
- "[Client #2] was being aggressive towards [client #1]. [Client #2] went into [client #1's] room."

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V 112	Continued From page 11 - "[Client #1] had injuries to her face and was bleeding from her nose and her face was swollen. I believe [client #2] bit [client #1] on the shoulder. [Client #2] had a scratch on one of her hands. Paramedics were called but neither client went to the hospital." Review on 2/10/21 of the Level 1 Incident Report dated 1/26/21 revealed: - Date of Incident: 1/26/21 - Date submitted: 1/26/21 - Name of person who signed the form: staff #5 and the Qualified Professional (QP): "On 1/26 at 1316 Calvert Dr around 3:15, [Client #1] commented about food and [client #2] got upset in a disagreement. [Client #2] was asked to go to her room but refused and went outside for a cigarette. [Client #2] came back inside asking [client #1] if she wanted to fight and went into her room and attacked her." Interview 2/11/21 with the Licensee #1 revealed: - She was aware that the treatment plans indicated the clients needed one on one supervision and normally there were 2-3 staff on each shift. - On 1/26/21 the other staff who was supposed to be working was not present because he was transporting clients on the van. This deficiency is cross referenced into 10A NCAC 27G .5602 Staff (V290) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d)	V 290		

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of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.
(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 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.
(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:
(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
(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.
(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:
(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
(2) the services of a certified substance

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V 290	Continued From page 13 abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure staff-client ratios enabled staff to respond to individualized client needs affecting for 2 of 2 current clients (#1, #2) and 1 of 1 former client (FC#3). The findings are: Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review, observations and interviews the facility failed to implement strategies for 2 of 2 current clients (#1, #2) and 1 of 1 former client (FC#3). Review on 2/24/21 of the Plan of Protection dated 2/24/21 written by the Licensee #1 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Effective today agency will staff according to the client's ISP (Individual Support Plan)/PCP. The agency will do everything possible to recruit, train and retain staff. The agency will continue to offer incentives for staff in an effort according to the guidelines in the ISP/PCP and ensure that if they have time during the day allocated to fade enhanced hour needs it's included in the plan as well. The agency will reach out to the Care Coordinators and ensure that anyone not requiring 1:1 during transport is clearly stated in their ISP/PCP. The agency will ensure that there is adequate staffing in the van and in the home to ensure that the safety needs of the people we serve are met by making sure that the staff those	V 290		

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V 290	Continued From page 14 who require extra staffing during transport is present. Describe your plans to make sure the above happens. The agency director and the agency QP will ensure that this happens." The facility served two current female clients and one former male client with various diagnoses not limited to: Impulse Control Disorder; Schizophrenia; Moderate IDD; ADHD; PTSD; Intermittent Explosive Disorder; Oppositional Defiant Disorder; Adjustment Disorder; and Severe IDD. Their treatment plans indicated that they needed one on one staffing and close monitoring due to histories of aggressive behaviors and inappropriate sexualized behaviors. On two occasions physical altercations occurred when there was only one staff present. The first physical altercation, occurred when one staff was driving a van and supervising 12 clients which included the 3 clients at the facility. This altercation resulted in FC #3's receiving multiple neck scratches, face scratches along with swelling under his right eye. During another physical altercation between client #1 and client #2 with one staff present, client #1 sustained a bloody nose and bite marks. This deficiency constitutes a Type A1 rule violation for serious neglect 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 290		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities	V 364		

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V 364	Continued From page 15 § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as	V 364		

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the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;
b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or
c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;
A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision;
(5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;
(6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;
(7) Participate in religious worship;
(8) Keep and spend a reasonable sum of his own money;
(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and
(10) Have access to individual storage space for his private use.
(c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically,

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V 364	Continued From page 17 emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive	V 364		

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V 364	Continued From page 18 visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in	V 364		

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V 364	Continued From page 19 the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on interviews and record review the facility failed to ensure privacy during telephone calls and failed to allow communication with guardians affecting for 2 of 2 current clients (#1, #2) and 1 of 1 former client (FC#3). The findings are: Interview on 2/2/21 with client #1 revealed: - She is only allowed to make phone calls at her day program on Tuesday and Thursday. Interview on 2/2/21 with client #2 revealed: - She is only allowed to make phone calls on Wednesday and Friday and "sometimes" on the weekends. Staff listened in on her phone calls. - She was unsure if she could call her legal guardian any time. - "All of my calls were on speaker phone and staff listened in." Interview on 2/4/21 with former client (FC) #3's	V 364		

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V 364	Continued From page 20 Legal Guardian revealed: - When she talked to FC #3 on the phone in the group home her phone calls were on speaker phone and the staff listened in. Interview on 2/9/21 with staff #2 revealed: - The clients have "certain phone days" to make phone calls. - The clients usually make their calls from the day program because they were using the group home phone to call the police. - Denied that she monitored client phone calls. - The group home phone does not work. Interview on 2/9/21 with staff #2 revealed: - Client #2's telephone call days were Wednesday and Friday. - Client #1's telephone call days were Tuesday and Thursday. - Client #1 preferred to make her phone calls at the day program. - She monitored the telephone calls of client #1 and client #2. - "When I am there, (the group home) I monitor phone calls. I don't recall anyone (staff, administration) telling me to do that." - The group home phone does not work. Interview on 2/9/21 with staff #8 revealed: - He only worked as a "fill in" and did not recall which days clients could make phone calls. - He had been told by the House Manager (staff #3) to monitor client's telephone calls. - "I would listen to what the clients would say (on the phone) because [client #1] and [client #2] lie about everything." Interview on 2/9/21 with staff #7 revealed: - He allowed clients to make phone calls whenever they wanted to make calls.	V 364		

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V 364	Continued From page 21 - He monitored client phone calls because they used his personal cell phone as the group home phone was broken. Interviews on 2/10/21 and 2/24/21 with the Qualified Professional (QP) revealed: - Clients could make phone calls on Tuesday and Thursday. - The clients were limited to phone calls on Tuesday and Thursday because they called the police, the ambulance and family members often. - He did not know the group home phone was broken. - "The phone can be a problem." - "The legal guardians, consumers and treatment team understand why there is two days that they can call because they call the police and the ambulance." Review on 2/3/21 of client #1, client #2 and FC #3's Treatment plans revealed: - There were no strategies or goals to address telephone calls being monitored or limited to certain days.	V 364		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified	V 366		

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timeframes not to exceed 45 days;
(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;
(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;
(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's

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services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;

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V 366	Continued From page 24 (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report a Level II incident to the client's legal guardian as required. The findings are: Interview on 2/4/21 with former client (FC) #3's legal guardian revealed: - On 1/23/21, she had not been able to get in contact with staff in over a week. So, she asked her mother to drive to the group home to check on FC #3. - When her mother arrived at the group home, she reported to her that "[FC #3's] (left eye) was running; tearing and his right eye it was swollen. [FC #3] kept saying his eye hurt and he kept rubbing it. On top of his right eye lid there were scratches. His neck was covered in clawing scratches on the front side neck and the back of his neck." - "No one ever reported anything to me about [FC #3] being hurt or injured or even if he had an altercation with another resident." Interview on 2/11/21 with the Licensee #1 revealed: - FC #3 was scratched by client A1 on 1/22/21. She did not know FC #3 had a swollen eye. - "[FC #3] randomly attacked [client A1]. I think [client A1] fought back and that's how he (FC #3)	V 366		

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V 366	Continued From page 25 got the scratches." - She did not have a chance to notify FC #3's legal guardian about the scratches. Review on 2/4/21 of the Incident Response Improvement System (IRIS) revealed: - There was no IRIS report of the 1/22/21 incident that pertained to FC #3 being scratched.	V 366		
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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-308	A. BUILDING: _____ B. WING _____	C 03/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENT LIVING AT CALVERT DRIVE	1316 CALVERT DRIVE WINSTON SALEM, NC 27107

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V 367	Continued From page 26	V 367		

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
(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

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V 367	Continued From page 27 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. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to report all Level II incidents that occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings are: Finding #1 Interview on 2/11/21 with the Licensee #1 revealed: - She had talked to staff #5 recently about the 1/22/21 incident report. - "He said he forgot to write it up." Interview on 2/9/21 with staff #5 revealed: - He worked at the group home and drove the van to and from the day program. - On 1/22/21 he dropped off FC #3 at his group	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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V 367	Continued From page 28	V 367		

home and later received a phone call from staff #2 who questioned him about the scratches on FC #3's neck.
- "I was driving and did not see what was going on behind me."
- "I don't think I ever wrote one (incident report) to be honest."

Review on 2/4/21 of the Incident Response Improvement System (IRIS) revealed:
- There was no IRIS report of the 1/22/21 incident that pertained to FC #3 being scratched.

Finding #2

Review on 2/10/21 of the Police Report revealed:
- Date: 1/26/21 at 16:20
- Crime Incident: Simple Assault
- Victim Name: client #2
- Victim Name: client #1

Interview on 2/10/21 with the police officer revealed:
- He had been called to the group home on 1/26/21 for an altercation between client #1 and client #2.
- Both clients had injuries.
- "[Client #1] had injuries to her face and was bleeding from her nose and her face was swollen. I believe [client #2] bit [client #1] on the shoulder. [Client #2] had a scratch on one of her hands."

Review on 2/10/21 of the IRIS revealed:
- There was no IRIS report of the 1/26/21 incident that pertained to the police being called when client #1 and client #2 got into a fight.