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V 000	INITIAL COMMENTS A complaint survey was completed on February 23, 2021. The complaint was substantiated (Intake #NC00174049). 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		
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		

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This Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to develop and implement strategies to address client needs and behaviors affecting 4 of 4 clients (#1 #2 #3 #4). The findings are:

A. Review on 2/6/21 of Client #1's record revealed the following information;
-- 42 year old male.
-- Date of admission 6/15/20.
-- Diagnoses include Open TBI (Traumatic Brain Injury) with Depressed Skull Fracture with loss of consciousness, Past Surgery - Craniotomy, Unspecified Mood Disorder, Depressed Mood, Impulse Control Disorder, Adjustment Disorder with Mixed Anxiety Disorder, Right Eye Blindness, Generalized Anxiety Disorder, Insomnia, Hypersexual Behavior, Right Side Weakness, Repeated Falls, Hyperlipidemia and Obesity.
-- Has a court appointed Guardian (his Mother).
-- Uses a wheelchair/walker/cane for assistance with movement.

Observation of Client #1 on 2/6/21 from 10:30 am through 1:30 pm revealed the following information;
-- He rolls himself throughout the facility in his wheelchair that he propels with his left hand/arm and his feet. The wheelchair does not have footrests or leg supports on it, so the client slightly drags his feet, or is able to barely lift his feet up enough to propel it.
-- His movements are at a slowed pace.
-- He had an unsteady, shuffling gait and appears

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able to take a few steps by himself while holding on to a stationary object (couch, chair) to transfer himself from his wheelchair to a different area (such as sitting on the couch).
-- His right arm/hand had severe contractures which makes it curl up and rest close to his body on the right side of his chest. This arm appears to be nonfunctional.
-- His speech is severely affected by the TBI and is slurred/soft and slow, thereby making it very difficult for others to understand what he is trying to communicate. His speech at that time was garbled and hard to understand. He generally communicated with 1 to 4 word phrases and had to be asked to repeat himself by staff, peers and Surveyor frequently.
-- He had very short patchy areas of hair on his head with multiple scars on many portions caused by severe trauma and/or injury.
-- He appeared quite frail.

Review on 2/6/21 an admission assessment titled "Type Services" completed by the former House Manager (HM) dated 6/15/20 identified the following information regarding Client #1;
-- He has a history of at "risk behaviors" including "fighting if provoked persistently."
-- He has a history of "Inapropriate sexual interactions with others and needs constant reminding of inappropriate comments, gestures or asking for hugs."

Review on 2/6/21 of Client #1's treatment plan completed by the Qualified Professional (QP) dated 6/15/20 (the date of his admission to the facility) revealed the following information;
-- A "Safety Plan/Risk Identification Results" assessment completed on 7/13/20 by the Program Director (PD) with the following "Risk Categories" identified: choking, falls, verbal

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aggression ("towards anyone around him, especially towards the person he's targeting"), physical aggression, AWOL (absent without leave - walking away from the property/supervision), theft of food/drinks, medication refusal and/or cheeking and hiding medication and "rude or inapropriate comments in the sexual nature with others." Also identified are supports required of reminders needed "not to open the vehicle door while the vehicle door should remain closed. [Client #1] in the past grab another person in front of him, as such, he should not sit directly behind another person or the driver (while in a vehicle)."
-- No documentation of any goals, strategies or interventions related to the above identified areas.
-- No documentation of any goals, strategies or interventions related to protecting his safety (peers harming or abusing him).
-- No documentation of any goals, strategies or interventions related to the frequency or reason for numerous calls made to 911.

1. Review on 2/8/21 of Police call logs from 1/17/20 through 1/25/21 (1 year and 8 days) revealed the following information regarding Client #1;
-- 26 calls were made/received by the local county Sheriff's Department.
-- 8 of these calls also required EMS (emergency medical services) response and intervention.
-- Client #1 made 10 of these calls.
-- 3 of these calls were made about Client #1.
Content of Police calls:
-- 1/25/21 (Two calls made by Client #1) - Flu like symptoms, headache and domestic disturbance - reports someone is bothering him. EMS (Emergency Medical Services) responded to the facility.
-- 1/11/21 (Two calls made by Client #1) - Called asking for an ambulance and Police. EMS

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responded to the facility transporting him to the ER (emergency room), Client #1 was "stating that he is not getting his right amount of medication and it is affecting his sleep."
-- 1/6/21 - Wants someone to "pick him up and take him to jail." Check well being of the caller.
-- 12/28/20 - "Another person who lives at the group home is threatening him (no identified client)". Requesting Police.
-- 12/11/20 - Staff called reporting that Client #1 fell and has a serious bleeding injury to the back of his head. EMS responded to the facility and transported him to the ER for evaluation and treatment.
-- 10/27/20 - Staff called reporting Client #1 and Client #2 were creating a disturbance "two resd (residents) got into it."
-- 9/24/20 - 911 hang up call "unable to understand caller (Client #1)."
-- 8/2/20 - "Caller is handicapped and was frustrated and thought he was being threatened from another conversation going on..."
-- 7/23/20 (Two calls were made by Client #1) - Reported suspicious person, "there may be 2 people there he doesn't know." "Female (staff) advised that the male accidentally called 911/Then another male was in the BG (background) screaming who was she talking to then TC (unknown abbreviation) could hear someone fighting over the phone."

2. Review on 2/12/21 of documentation in a binder titled "Body Checks" revealed the following information regarding Client #1;
-- 2/10/21 - (8:50 am) Fell out of wheelchair in bedroom. Swollen red area on upper right back.
-- 1/25/21 - Was hit in the middle of his head by Client #2, "red areas, excoriation."
-- 1/15/21 - Found on the floor by staff in his bedroom, "red marks on the back of neck from

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necklace."
-- 1/13/21 - (12:23 pm) Staff heard Client #1 fall, "no injury."
-- 1/11/21 - (7:25 am) Staff heard Client #1 fall, "fell backwards out of wheelchair, no injury."
-- 12/27/20 - (9:54 am) Fell against the wall in his room, "minor scrapes on back right shoulder blade and redness on right shoulder."
-- 12/23/20 - Was walking back to his chair, fell into the corner of the wall in the bathroom, "scraped his arm and right hand and middle of his back."
-- 12/11/20 - "Went down face forward and hit brick (a brick fireplace hearth in his bedroom) and opened up his head." EMS was called and responded and transported the client to the emergency room. "Staff observed a big gash in his scalp that had to be stapled closed (13 staples). There is also bruising on the bridge of his nose where it had been broken/fractured."
-- 12/10/20 - Got hit in the nose by another resident (Client #4). Had a bloody nose.
-- 12/9/20 - (3:50 pm) Slipped when getting into facility van. "Has a cut on his right elbow with a little blood, no other injuries."
-- 12/9/20 - Head check "red in the area (top) no swelling or bleeding. Staff asked what happened to hand. Said he hit it on his wheelchair. Red and bruised. No blood or swelling."
-- 12/9/20 - "Red spot on head is gone now. Noticed right hand bruised and right pinky finger is cut."
-- 12/8/20 - Red area on top of his head midsection, no cuts/bruising. Fell yesterday.
-- 12/7/20 - (10:15 pm) "Cut on right pinky, elbow broken skin, redness on neck and forearm and left hand. And he hit his right side of his head (this fall required EMS transport to the ER where he was diagnosed with a head Concussion)."
-- 12/6/20 - Using bathroom, fell back into his

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V 112	Continued From page 6 chair. "Stated his back was hurting. Bruise on right back and shoulder red." -- 12/1/20 - (5:14 am) Fell, gash on right side of head, still bleeding. "Scrapes and redness on right arm and hand." -- 11/23/20 - "Fell backwards trying to use his walker, cut left eye (eyebrow area)." -- 11/19/20 - "Right knee swollen and very red with minor abrasions. He complains of pain in back." -- 10/27/20 - "Heard resident fall. Was in kitchen by stove. 9:30 pm bruising on back of upper left arm. Scratch on back and head." -- 10/15/21 - (7:30 am) Fell backwards and hit back and head on wall. -- 10/13/20 - Body check. "Scrapes/scratches on left outer thigh, scrape left elbow (from fall the previous day)." -- 10/12/20 - (9:44pm) Fell in his room while changing his DVD (digital video disc). -- 10/8/20 - Fell trying to get into wheelchair. "Wheels weren't locked." -- 10/4/20 - "Fell over wheelchair." -- 9/27/20 - Fell outside past the basketball area twice (many areas on the body illustration picture on this form are circled). "Told to get back in wheelchair." -- 9/18/20 - (5:20 am) Fell in room getting out of bed. -- 9/16/20 - Fell getting into bed. Review on 2/12/21 of Client #1's record revealed the following Physician's visit summary's documenting the following information; -- 12/11/20 - Seen in the ER for a head injury and scalp laceration and nasal bone fracture. -- 12/7/20 - Seen in the ER for a head injury. Documentation on this summary included "(use) concussion precautions until December 15 (2020)."	V 112		

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V 112	Continued From page 7 -- 12/1/20 - Seen in the ER for a head injury and sustained a head concussion. This document had a handwritten note from the Physician "Please use extra precautions for 1 week! Patient cannot have another fall!" Interview on 2/16/21 with the HM revealed the following information; -- When Client #1 sits down in his wheelchair he tends to "flop" down on to the seat with all of his weight, thus causing it to become off balance and leading to falling back and/or out of it. -- The only thing staff have done to alleviate his falling is to redirect him to sit back down in the wheelchair if he is trying to walk around in the facility, and she has placed some padding around the edge of the fireplace hearth in his bedroom. -- She is not aware of any kind of referral to a Physician for assistance or treatment for the client related to his falling. -- She is not aware if there has been any discussion within the facility or by the management company as to Client #1 needing a higher level of care to keep him safer. -- She stated that the concussion precautions consisted of additional monitoring of Client #1. 3. Review on 2/12/21 of the "Behavior Log" from August 2020 through date of review revealed the following information regarding Client #1; FEBRUARY 2020: -- 2/11/21 - "Four behaviors" Stole food from the kitchen, cursing, yelling, lying, spitting, scratching others and noncompliant. -- 2/9/21 - "Two behaviors" Stealing and cursing. -- 2/8/21 - Yelling. -- 2/4/21 - Yelling lying and trying to steal food from the kitchen. -- 2/1/21 - Yelling JANUARY 2021:	V 112		

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V 112	Continued From page 8 -- 1/25/21 - Yelling and swearing (the Police were called - he was hit in the head by Client #2). -- 120/21 - Yelling. -- 1/15/21 - Noncompliance. -- 1/3/21 - Yelling and stealing. DECEMBER 2020: -- 12/30/20 - Stealing food. -- 12/28/20 - Yelling. -- 12/23/20 - Begging for food. -- 12/21/20 - Cursing. -- 12/17/20 - Stealing food. -- 12/16/20 - "Two behaviors" Cursing, yelling and lying. -- 12/9/20 - Lying and stealing. -- 12/8/20 - Stealing. -- 12/7/20 - False accusations and lying. -- 12/3/20 - "Two behaviors" Stole food from kitchen, lying and false accusations. NOVEMBER 2020: -- 11/23/20 - Lying stealing and cursing. -- 11/20/20 - Stealing. -- 11/19/20 - Lying, swearing and spitting at others. -- 11/17/20 - Lying, swearing and spitting at others. -- 11/16/20 - Cursing. -- 11/9/20 - Lying, swearing and stealing. -- 11/4/20 - Stealing. -- 11/2/20 - Stealing. OCTOBER 2020: -- 10/29/20 - Stole (Client #3's) ice cream and ate it. -- 10/28/20 - Swearing and stealing -- 10/27/20 - Gave staff the middle finger. (the Police were called - fought with Client #2, Client #1 fell either on the porch, or off of the porch). -- 10/26/20 - Lying and yelling. -- 10/20/20 - Yelling. -- 10/19/20 - Yelling and "nagging another resident (Client #2)."	V 112		

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V 112	Continued From page 9 -- 10/14/20 - Stealing and yelling. -- 10/8/20 - "Three behaviors" Lying, swearing and stole food. -- 10/7/20 - Cursing and stole food. -- 10/5/20 - "Two behaviors" Swearing and stealing. 4. Review on 2/9/21 of internal Level 1 incident reports revealed the following information regarding Client #1; -- 12/11/20 - Staff called 911, the client is in his bedroom, has a gash on right side of head. EMS was dispatched to the facility to and transported Client #1 to the ER for evaluation and treatment. -- 10/19/20 - "Staff was assisting another resident (Client #2) with cooking dinner, and that resident (Client #2) was on the phone with his girlfriend ... Staff redirection of both residents. [Client #1] to his room and the other resident (Client #2) outside ... [I (the HM) have reviewed this report] After talking to [Client #1] "he stated that he did tell the other resident (Client #2) that he was going to call the Police on him for fussing and cussing at his girlfriend. He also admitted that when he reached for the other resident's phone that the other resident pushed him so he could get to his phone ... Staff will monitor both residents and keep them separated ..." 5. Review on 2/19/21 of daily progress notes submitted by the PD for the period of 1/31/21-2/18/21 revealed the following information regarding Client #1; -- 2/1/21 3p-11p: "[Client #1] was prompted not to get food out of the refrigerator because dinner was being prepared. [Client #1] than proceeds to go in the refrigerator after being prompted that dinner was being cooked. Staff redirects [Client #1] to the community room and set limits for him to follow. [Client #1] received an	V 112		

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non-compliance behavior for not complying with what he was prompted to do."
-- 2/2/21 3p-11p: "[Client #1] was prompt to leave another resident alone. Staff separate [Client #1] and resident on shift. [Client #1] was separated from another resident through shift (Client #2)."
-- 2/4/21 11p-7a: "[Client #1] was caught stealing food around 4am. Staff document behavior in book."
-- 2/10/21 11p-7a: "[Client #1] has been up through night. [Client #1] has been walking through house without his chair. Staff prompt him to get back in his chair. [Client #1] wants to argue. Staff check on resident through night."
-- 2/11/21 11p-7a: "[Client #1] was caught stealing food. [Client #1] woke up another resident. [Client #1] constantly begging staff to take him to the store saying morning staff took and hid his food."
-- 2/12/21 7a-3p: "Morning meds were administered to [Client #1] by staff and breakfast served. Staff later saw [Client #1] going into the kitchen and asked what he needed? [Client #1] told staff he needed to use the bathroom but when staff noticed he was taking too long to get there staff went to check on him and found him sitting by the trash can pulling stolen half eating food out of his pants pocket and trying to dispose of them before staff could see, staff documented the behavior and redirected [Client #1]. Staff later administered [Client #1] his afternoon meds and served lunch. Even with several prompts given by staff, [Client #1] continues to steal food and eat in his room."
-- 2/14/21 3p-11p: "[Client #1] returned to home by 8pm (from a home visit). [Client #1] had his meds and during snack time [Client #1] decides to go through cabinet looking for his snacks. Staff redirected [Client #1] to his chair and that she will get his snack. [Client #1] became irate.

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V 112	Continued From page 11 Staff calls House Manager. [Client #1] and House Manager talk and resolve issues." -- 2/15/21 3p-7a: "[Client #1] had a okay day with 2 behaviors for non compliance. He was given 3 verbal warnings before he received his behaviors... [Client #1] was prompted three time to complete (cleaning) his area that he choose." -- 2/16/21 3p-11p: "[Client #1] tried to bribe staff with money for a snack. Staff reminds [Client #1] of rules and why this is not appropriate. [Client #1] was directed to his room [Client #1] does not make healthy eating choices when begging for food on shift. Staff prompt [Client #1] on his interacting with others (Client #2). Residents asked him to leave them alone and [Client #1] constantly bothers residents. Directed to his room by staff [Client #1] tried to bribe staff with money for a snack. Staff directed him to his room and plan. Staff wrote incident in behavior log." -- 2/18/21 3p-11p: "Staff prompt [Client #1] on house rules. [Client #1] contantly asking for food. Staff prompt [Client #1] to leave other residents alone. [Client #1] was bothering other residnets. [Client #1] goes in kitchen looking for food. [Client #1] CONSTANTLY ASKING FOR FOOD." These notes (1/31/21-2/18/21) reflect a 19 day period. During this time period, Client #1 was away from the facility on home visits for 6 days. 6. Review on 2/17/21 of Client #1's "Behavior Log" and Police call logs revealed the following examples of inapropriate sexual behaviors displayed by Client #1; "Behavior Log:" -- 12/3/20 - Inappropriate sexual behaviors ("sexual comments to staff, touching staff hair, rubbing staff neck"). -- 12/2/20 - "Stuck tongue out (at staff) in a sexual way."	V 112		

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V 112	Continued From page 12 -- 10/27/20 - "Inappropriate sexual talk." -- 10/8/20 - "Came out of the bathroom with his male parts hanging out." -- 8/20/20 - "Hold staff hand and wouldn't let go, grabbed staff breast." -- 8/13/20 - "Touched [Client #4] on private area, made a sexual gesture to [Client #3]." Police call logs: -- 8/24/20 - A former staff called reporting "harassment/stalking/threat." "[Client #1] is ons (onsight) harassing caller- sexual harassment" Interview on 2/16/21 with the HM revealed the following information about Client #1; -- He frequently displays inapropriate sexual behavior. -- He makes inapropriate sexual remarks to staff about the size of his penis. -- Several staff have quit their jobs at the group home due to Client #1's sexual behavior/harassment towards them. -- He has also made inapropriate sexual remarks and behaviors to his peers. 7. Interview on 2/15/21 with Client #1's Mother revealed the following information; -- Client #1's first assault by a peer (Client #2) happened (date unknown) when he got hit in the van, and Client #2 was kicking him. -- The next day while on the van, Client #1 sat behind Client #2 and he reached around the seat and began choking Client #2. Interview on 2/16/21 with the HM revealed in the facility van there is only the passenger seat that would place a client not behind any one else. She stated all the clients took turns riding in the front passenger seat, thus it would not be possible for Client #1 to never have someone sitting in front of him while riding in the van.	V 112		

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V 112	Continued From page 13 B. Review on 2/10/21 of Client #2's record revealed the following information; -- 23 year old male. -- Date of admission 5/19/19. -- Diagnoses include Intermittent Explosive and Mood Disorders, Oppositional Defiant Disorder, Bipolar Disorder, ADHD (Attention Deficit Hyperactivity Disorder), Autism Spectrum Disorder, GERD (Gastroesophageal Reflux Disorder), Obesity and Diabetes Mellitus Type II. -- Has a court appointed Guardian (his Mother). -- FSIQ (full scale Intelligence Quotient) = 82, low average (dated 4/28/17). Review on 2/10/21 of an admission assessment titled "Initial Assessment of Services" completed by a QP and undated identified the following information regarding Client #2; -- He has had multiple placements (outside of his family's home). -- He has a history of multiple behavior problems including aggressive behaviors, fighting, assault, disorderly conduct and destruction of property. Review on 2/10/21 of Client #2's treatment plan completed by the QP dated 3/13/20 revealed the following information; -- "He has lived in Peach Farm Road House for over a year now. He acts as the leader of the group home which at times can be problematic." -- A "Safety Plan/Risk Identification Results" assessment completed on 7/13/20 by the PD with the following "Risk Categories" identified: verbal aggression ("towards anyone around him, especially towards the person he's targeting") and physical aggression. -- No documentation of any goals, strategies or interventions related to the above identified areas.	V 112		

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V 112	Continued From page 14	V 112		

1. Review on 2/6/21 of the North Carolina Incident Response Improvement System (IRIS) revealed the PD submitted a report of an incident occurring on 8/19/20 involving Client #2 and Client #3 physically assaulting each other and displaying destructive behavior.

2. Review on 2/8/21 of Police call logs from 1/17/20 through 1/25/21 revealed the following information regarding Client #2;
-- 11/7/20 - Staff called reporting Client #2 is causing a disturbance and has been making threats since 7:00 am. EMS responded and transported the client to the ER for evaluation/treatment.
-- 10/27/20 - Staff called reporting Client #1 and Client #2 creating a disturbance "two resd (residents) got into it."
-- 9/16/20 - A former staff called reporting Client #2 is "acting out. Subject (Client #2) violent active disturbance. The subject is reportedly violent."
-- 8/19/20 - HM called reporting a physical disturbance, "two residents fighting in the group home (Client #2 and Client #3)".
-- 5/10/20 - Former staff called reporting a physical disturbance, resident at group home aggressive, Client #2 is "throwing stuff around the house."

3. Review on 2/12/20 of the "Behavior Log" from August 2020 through date of review revealed the following information regarding Client #2;
NOVEMBER 2020:
-- 11/22/20 - Got loud, slamming door and yelling.
-- 11/17/20 - lying and stealing food.
-- 11/9/20 - "Two behaviors" Yelling.
-- 11/6/20 - "Two behaviors" Yelling and stealing.
OCTOBER 2020:
-- 10/27/20 - Yelling. (the Police were called -

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V 112	Continued From page 15 Client #3 was fighting with Client #1). -- 10/19/20 - Yelling, swearing, false accusations and pushing others (Client #1). SEPTEMBER 2020: -- 9/25/20 - Stole food. -- 9/16/20 - Attacked staff (the Police were called). -- 9/15/20 - Cursing and yelling at staff. -- 9/8/20 - Stole milk from kitchen. 4. Review on 2/19/21 of daily progress notes submitted by the PD for the period of 1/31/21-2/18/21 revealed the following information regarding Client #2; -- 2/2/21 3p-11p: "Staff prompt [Client #2] on his interactions with others. [Client #2] was separated from other resident (Client #1)." -- 2/11/21 11p-7a: "Resident was awaken by the loudness of anther resident (Client #1). Staff directed [Client #2] to stay in his room to separate the two no issues." -- 2/16/21 3p-11p: "[Client #2] does not know how to stay out of others business (Client #1) and would not comply when staff constantly asked him to leave the area. Staff wrote incidnet in behavior log. Staff had to threaten to call House Manager herself for [Client #2] to do as asked [Client #2] does not know how to mind his business. Staff gave a direction for him to stay out of a conversation with other resident. [Client #2] did not comply until staff threatened to call House Manager." -- 2/18/21 3p-11p: "[Client #2] asks another residents for his snack at snack time. Staff caught [Client #2] trying to hide the snack. When asked, [Client #2] states he did not know that he couldn't receive anything from others [Client #2] was caught trying to hide snack that he asked for from another resident. Staff wrote in behavior log."	V 112		

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V 112	Continued From page 16 5. Additional review on 2/12/21 of Client #2's record revealed the following documentation pertaining to property damage; -- A receipt dated 5/4/20 to "repair hole in wall and put up blind." -- A document dated 3/13/20 "[Client #2's initials] Repayment Plan [Client #2] agrees to make full and complete reimbursement for the damage to the windshield of the vehicle belonging to PAMCO Care (the Licensee). The total replacement cost is $297.00. [Name of company] was secured by PAMCO to replace the windshield." Interview on 2/12/21 with the HM revealed that Client #2's Care Coordinator "was supposed to give us some extra interventions." She confirmed that no additional support was given. C. Review on 2/11/21 of Client #3's record revealed the following information; -- 20 year old male. -- Date of admission 10/28/19. -- Diagnoses include Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder (Childhood Onset), ADHD - Combined Type and Autism. -- Has a court appointed Guardian through the county Department of Social Services. Additional review on 2/11/21 of Client #3's treatment plan dated 2/27/20 revealed the following information; -- A "Safety Plan/Risk Identification Results" assessment completed on 7/13/20 by the PD with the following "Risk Categories" identified: self harm/suicidal ideation, physical aggression, property destruction and AWOL behavior. -- No goals, strategies or interventions addressing any of these behaviors.	V 112		

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V 112	Continued From page 17 1. Review on 2/6/21 of the North Carolina IRIS system revealed the PD submitted a report of an incident occurring on 8/19/20 involving Client #2 and Client #3 physically assaulting each other and displaying destructive behavior. 2. Review on 2/8/21 of Police call logs from 1/17/20 through 1/25/21 revealed Client #3 made 1 call, and 5 calls were made about him as follows; -- 8/19/20 - HM called reporting a physical disturbance, "two residents fighting in the group home (Client #2 and Client #3)." -- 7/5/20 - Staff called requesting assistance for a disturbance because Client #3 is "acting out." No further information documented. -- 6/24/20 - Client #3 called 911 reporting he "punched window." Client #3 stated "someone was calling him names and he got mad." EMS responded and transported the client to the ER for treatment to the injury. Police call log indicates trauma, bleeding and laceration (cut) to hand. -- 6/1/20 - (An unidentified person) called reporting Client #3 has a penetrating wound, "stepped on a nail and it's stuck." EMS responded to the facility and transported the client to the ER for evaluation and treatment. -- 3/15/20 - Client #3's Ex Girlfriend called and reported Client #3 was "violent... threatening to cut his wrist, shoot himself or OD (overdose) on pills." The police narrative indicates "weapons were involved or mentioned. A knife is involved: Exacto knife. The weapon is in the subjects (Client #3's) possession. Male (Client #3) threatening to harm himself and also impersonating a Sheriff... Male is threatening to shoot himself. Caller (Ex Girlfriend) advised that he is threatening to shoot himself. Caller also	V 112		

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V 112	Continued From page 18 advised that he is also impersonating the Sheriff right now. Male has been calling friend for a while pretending to be Deputy. Caller advises that male has guns in his dresser drawer at this location (the facility)." -- 3/14/20 - Anonymous caller (from the same phone number as the above phone call) reports "the subject (Client #3) has pills that are red and believes they are Coke or something you use for coke." Possible suicide attempt, possibly took pills. Threatening suicide, subject (Client #3) has been collecting pills to OD. EMS was dispatched to the facility and the client was transported to the ER for evaluation and treatment. 3. Review on 2/12/20 of the "Behavior Log" from August 2020 through date of review revealed the following information regarding Client #3; -- 12/15/20 - Slammed door. -- 12/14/20 - Yelling and slamming door. -- 10/17/20 - Yelling and cursing at staff. -- 10/2/20 - Cursing at staff. -- 9/7/20 - Cursed at staff and refused to eat. 4. Review on 2/6/21 of the facilities internal Level 1 incident reports revealed the following information regarding Client #3; -- 10/12/20 - Caused property damage (no additional information documented). -- 9/12/20 - Displayed threatening behavior (no additional information documented). D. Review on 2/11/21 of Client #4's record revealed the following information; -- 49 year old male. -- Date of admission 8/12/19 -- Diagnoses include Unspecified Schizophrenia Spectrum and Unspecified IDD (Intellectual and Developmental Disability).	V 112		

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V 112	Continued From page 19 Review on 2/12/21 of documentation in a binder titled "Body Checks" revealed the following information regarding Client #1; -- 12/10/20 - Got hit in the nose by another resident (Client #4). Had a bloody nose. Revealed information that Client #4 punched Client #1 in the nose. Behavior Log" Client #1 -- 8/13/20 - "Touched [Client #4] on private area, made a sexual gesture to [Client #3]." Interview on 2/16/21 with the HM revealed the following information; -- She had only been in the HM position for about the past 6 months (since the last HM left). -- The PD and/or the QP were responsible for the treatment plans. -- She did not know how often the treatment plans were updated. -- All of the current clients have had the same behaviors since she began as the HM. Interview on 2/17/21 with the PD revealed the following information regarding client treatment plans; -- They are updated at least annually. -- None of the 4 client's treatment plans had been reviewed or updated any sooner than annually. -- No further information regarding client behaviors documented above. [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (Tag V-289) for a Type A1 rule violation and must be corrected within 23 days]	V 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 118		

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V 118	Continued From page 20 REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility management failed to assure that 1) medications were administered to clients	V 118		

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on the written order of a Physician, 2) failed to assure that all MARs were kept current and 3) failed to assure that medications administered were recorded immediately after administration affecting 2 of 2 clients audited for medication compliance (#1 #2).
The facility management also failed to assure that medications that were self-administered by clients were authorized to do so by a Physician affecting 1 of 1 client self administering medications (#2).
The findings are:

** Note: This facility uses a Pharmacy based in Virginia who employ FedEx for delivery of medication. The facility also uses electronic MARs available on a laptop computer.

A. Review on 2/6/21 of Client #1's record revealed the following information;
-- 42 year old male.
-- Date of admission 6/15/20.
-- Diagnoses include Open TBI (Traumatic Brain Injury) with Depressed Skull Fracture with loss of consciousness, Past Surgery - Craniotomy, Unspecified Mood Disorder, Depressed Mood, Impulse Control Disorder, Adjustment Disorder with Mixed Anxiety Disorder, Right Eye Blindness, Generalized Anxiety Disorder, Insomnia, Hypersexual Behavior, Right Side Weakness, Repeated Falls, Hyperlipidemia and Obesity.
-- Has a court appointed Guardian (his Mother).

Observation of Client #1 on 2/6/21 from 10:30 am through 1:30 pm revealed he had very short patchy areas of hair on his head with multiple scars on many portions caused by severe trauma and/or injury.

Interview on 2/15/21 with Client #1's Mother revealed the following information;

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V 118	Continued From page 22 -- On 12/11/20 the client fell in his room and hit his head against a brick fireplace hearth that is in his room. The bricks on this hearth are raised above the floor about 2 or 3 inches. -- EMS (Emergency Medical Services) was dispatched to the facility and the client was transported to the ER(emergency room). -- He had 13 staples placed in his head to close and treat a large gash on his head. -- His Mother was not made aware of when the staples needed to be removed. -- She took him to his primary care Physician on 1/4/21 who removed the staples and told her the staples had been in for so long that they had caused an infection to the site on his head and he prescribed a course of antibiotics. -- A Physicians order dated 1/4/21 for Keflex (an antibiotic prescribed for an infection the client had been diagnosed with) 500 mg. (milligrams) twice a day for 7 days starting on 1/4/21 and discontinue (complete) on 1/11/21. -- Review on 2/16/21 of Client #1's January 2021 MAR revealed the following information; -- A transcription for Keflex 500 mg. twice a day beginning on 1/4/21 in the morning and ending on 1/11/21 at bedtime. -- Documentation on this MAR revealed that the client was administered this antibiotic from 1/8/21 at bedtime through 1/11/21 at bedtime (for a total of 7 doses out of the 14 doses ordered by the Physician). -- This documentation reflects that there was a 4 day delay in administering a Physician ordered antibiotic for an infection to Client #1's head. Interview by phone on 2/16/21 with a Pharmacist at the facilities pharmacy revealed the following information;	V 118		

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V 118	Continued From page 23 -- The Pharmacy received the prescription from the Physician on 1/4/21. -- "It was a routine medication and should have gone out (into the mail) on 1/5/21 (the following day of the prescription). They (the facility) should have gotten it (the medication) on 1/5/21 (the same day it was shipped)." Interview on 2/16/21 with the House Manager (HM) revealed the following information; -- The facility frequently does not get medications for clients delivered to the facility by the pharmacy in a timely manner. -- The facility did not receive the antibiotic from FedEx until 1/7/21 (three days after the medication was ordered). -- The computer would not allow the staff to document on the MAR after the 1/11/21 discontinue date. -- Client #1 did receive the whole course of the antibiotic starting on 1/8/21 through the 7 days it was ordered for, however there was no way to override the computerized MAR to reflect administration after the discontinue date (1/11/21). Review on 2/16/21 of the packing slip that accompanied the delivered antibiotic revealed the HM signed the invoice for the antibiotic on 1/7/21. B. Review on 2/10/21 of Client #2's record revealed the following information; -- 23 year old male. -- Date of admission 5/19/19. -- Diagnoses include Intermittent Explosive and Mood Disorders, Oppositional Defiant Disorder, Bipolar Disorder, ADHD (Attention Deficit Hyperactivity Disorder), Autism Spectrum Disorder, GERD (Gastroesophageal Reflux Disorder), Obesity and Diabetes Mellitus Type II.	V 118		

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V 118	Continued From page 24 -- Has a court appointed Guardian (his Mother). -- FSIQ (full scale Intelligence Quotient) = 82, low average (dated 4/28/17). 1. Review on 2/10/21 of Client #2's record revealed a Physicians order dated 4/2/20 for Lantus Insulin 100u/ml. (units per milliliter) inject 10 units subcutaneously (just under the skin) at bedtime (used to help controll and regulate blood sugar levels in Diabetics). Increase by 2 units per day until morning blood sugar is less that 130. Maximum dose of 125 units per day. Interview on 2/16/21 with the HM revealed the extra units of Insulin added to the ordered base dose of 10 units is based on what the client's blood sugar reading was that morning. Review on 2/16/21 of Client #2's MARs revealed the following blood sugar readings ranges as follows; -- February 2021 (2/1/21 through 2/16/21): 172 - 311 -- January 2021: 158 - 366 -- December 2020: 163 - 429 -- November 2020 (11/18/20 through 11/30/20): 167 - 350 ** In the Month of November 2020, of the 12 days of blood sugar readings recorded, this client had two readings of 350, and 4 readings of over 300 (but less than 350). Additional review on 2/16/21 of the above MARs revealed no documentation of any additional units of Insulin administered to the client (in addition to the ordered base dose of 10 units at bedtime). Review on 2/12/21 of the staff communication book revealed that staff working on 12/30/20 recorded (to be passed along to other staff) that	V 118		

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V 118	Continued From page 25 Client #2 had a blood sugar reading of 429. Review on 2/12/21 of police call logs revealed that on 4/2/20 the staff called EMS (emergency medical services) because Client #2's blood sugar was "over 500" and he was transported to the hospital for treatment. Interview on 2/16/21 with the HM revealed the following information; -- She confirmed that additional units of Insulin administered were not documented on the MAR or anywhere else in the Client's record. -- Client #2 checks his own blood sugar and administers his Insulin to himself. 2. Review on 2/16/21 of Client #2's record revealed no Physician's order allowing the client to perform his own blood sugar checks, or administer his own Insulin injections. Interview on 2/16/21 with the HM revealed she was not aware that when a client self-administers their own medications, there has to be a Physician's order for the client to be allowed to do this. Interview on 2/17/21 with the Program Director revealed that he was also unaware of the required Physician's order for clients to be able to self-administer medications. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (Tag V-289) for a Type A1 rule violation and must be corrected within 23	V 118		

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V 118	Continued From page 26 days]	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on interview and record review, the facility management failed to assure that clients being administered psychotropic medications obtained a review of each client's medication regimen at least every 6-months performed by a pharmacist or Physician, with the results of the review recorded in each client's record, and each client's Physician informed of the results of the review when medical intervention is required affecting 2 of 2 clients audited for medication compliance (#1 #2). The findings are: Review on 2/6/21 of Client #1's record revealed the following information; -- 42 year old male.	V 121		

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V 121	Continued From page 27 -- Date of admission 6/15/20. -- Diagnoses include Open TBI (Traumatic Brain Injury) with Depressed Skull Fracture with loss of consciousness, Past Surgery - Craniotomy, Unspecified Mood Disorder, Depressed Mood, Impulse Control Disorder, Adjustment Disorder with Mixed Anxiety Disorder, Right Eye Blindness, Generalized Anxiety Disorder, Insomnia, Hypersexual Behavior, Right Side Weakness, Repeated Falls, Hyperlipidemia and Obesity. -- Currently taking the following psychotropic medications: Luvox (for anxiety), Depakote (for mood regulation), Nuedexta (for impulse control), Hydroxyzine (for anxiety/agitation), Belsomra (for sleep) and Banophen (for sleep). -- No documentation of any 6 month medication regimen reviews. Review on 2/10/21 of Client #2's record revealed the following information; -- 23 year old male. -- Date of admission 5/19/19. -- Diagnoses include Intermittent Explosive and Mood Disorders, Oppositional Defiant Disorder, Bipolar Disorder, ADHD (Attention Deficit Hyperactivity Disorder), Autism Spectrum Disorder, GERD (Gastroesophageal Reflux Disorder), Obesity and Diabetes Mellitus Type II. -- Currently taking the following psychotropic medications: Depakote (for mood regulation), Abilify (for depression) and Tenex (for ADHD). -- No documentation of any 6 month medication regimen reviews. Interview on 2/16/21 with the House Manager revealed that she was unaware that these medication reviews are required, or if they are performed where they would be kept. She stated that a nurse that works for the company comes every 3 months to do a medication review, but	V 121		

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V 121	Continued From page 28 she doesn't know the results of these reviews. Interview on 2/22/21 with the Program Director revealed that these required medication reviews are being performed according to the rule language, and he would reach out to the pharmacy to have them done. [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (Tag V-289) for a Type A1 rule violation and must be corrected within 23 days]	V 121		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other	V 289		

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V 289	Continued From page 29 diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by:	V 289		

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V 289	Continued From page 30 Based on observation, record review and interview the facility failed to provide residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation of individuals who have a mental illness, a developmental disability or substance abuse disorder, and who require supervision affecting 4 of 4 clients (#1 #2 #3 #4). The findings are: Cross-reference tag V-112. 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN. Based on observation, interview and record review, the facility management failed to develop and implement strategies to address client needs and behaviors affecting 4 of 4 clients (#1 #2 #3 #4). Cross-reference tag V-118. 10A NCAC 27G .0209 MEDICATION REQUIREMENTS. Based on observation, interview and record review, the facility management failed to assure that 1) medications were administered to clients on the written order of a Physician, 2) failed to assure that all MARs were kept current and 3) failed to assure that medications administered were recorded immediately after administration affecting 2 of 2 clients audited for medication compliance (#1 #2). The facility management also failed to assure that medications that were self-administered by clients were authorized to do so by a Physician affecting 1 of 1 client self administering medications (#2). Cross-reference tag V-121. 10A NCAC 27G .0209 MEDICATION REQUIREMENTS. Based on interview and record review, the facility management failed to assure that clients being	V 289		

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V 289	Continued From page 31 administered psychotropic medications obtained a review of each client's medication regimen at least every 6-months performed by a pharmacist or Physician, with the results of the review recorded in each client's record, and each client's Physician informed of the results of the review if medically needed affecting 2 of 2 clients audited for medication compliance (#1 #2). Cross-reference tag V-290. 10A NCAC 27G .5602 STAFF. Based on interview and record review, the facility management failed to assure a minimum of one staff member was present with the clients except when the client's treatment or habilitation plan documented the client was capable of remaining in the community without supervision affecting one of 1 of 4 clients (#3). Cross-reference tag V-291. 10A NCAC 27G .5603 OPERATIONS. Based on observation, interview and record review, the facility management failed to assure that coordination was maintained between the facilty operator and the Qualified Professionals (QPs) who are responsible for treatment/habilitation or case management affecting 2 of 4 clients (#1 #2). Cross-reference tag V-366. 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS. Based on interview and record review, the facility management failed to assure all Level 2 incidents were reported with responses documented to the LME (Local Management Entity). Cross-reference tag V-367. 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS.	V 289		

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V 289	Continued From page 32 Based on interview and record review, the facility management failed to assure all Level 2 incidents were reported and failed to notify the LME (Local Management Entity) within 72 hours of becoming aware of the incident. Review on 2/23/21 of the Plan Of Protection dated 2/23/21 written by the QP revealed the following information; "What immediate action will the facility take to ensure the safety of the consumers in your care? PAMCO Care (the Licensee) will provide enhanced oversight of the Peach Farm Road Supervised Living Program, Oversight measures will include medical services, daily operations report to the Program Director and Qualified Professional, review and updates to the individuals' PCP (Personal Care Plan/treatment plan), review and updates to the individuals' risk and safety assessments, written procedural guidelines for incident reporting, staff training, enhanced medication administration oversight, documentation revision, individual preferred community and leisure activities, weekly house meetings, and establishment of House Rules. Describe your plans to make sure the above happens: Objective: To provide enhanced oversight of the Peach Farm Road Supervised Living Program. Process: The Program Director and the Qualified Professional assigned to the program will increase oversight of the daily operations of the program to ensure the standards of operations meet the individualized needs of the residents. I. Medical Services: Appointment Calendar/Documentation a. All appointments will be uploaded on an Appointment Calendar on out database. b. The appointment calendar will be accessible to the house supervisor, Qualified Professional,	V 289		

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Program Director, and Director of Quality Assurance and Compliance.
c. All appointment documentation, including but not limited to intake forms, discharge forms, informed consent, prescriptions, etc. will be emailed to Qualified Professional, Program Director, and Director of Quality Assurance and Compliance and uploaded to an Appointment Documentation file on our database.
d. The Program Director or Qualified Professional will follow up with the house supervisor or staff within 24 hours if concerns are noted.
II. Operations Report
a. A daily report of a summary of all events, including but not limited to resident interactions, medical appointments, visits to the home, staffing issues, medication errors, etc., that occurred throughout the day to be sent no later than 9 am the following day to the Qualified Professional, Program Director, and Director of Quality Assurance and Compliance and uploaded to Operations Report file on our database.
b. Operations Report are to be reviewed by Qualified Professional, Program Director, and Director of Quality Assurance and Compliance daily.
III. Individual Service Plans
a. All PCPs will be reviewed within 15 business days of the initiation of this Plan of Protection and updated to reflect the participants' current level of support needs. The revised PCP will be forwarded to the individual and their support team for review and signatures.
b. PCPs will be reviewed by Qualified Professional, Program Director, and Director of Quality Assurance and Compliance quarterly.
IV. Risk Assessments and reviews
a. Updates Risk Assessments are to be completed on all participants within 30 days of the

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initiation of this Plan of Protection.
b. Risk Assessments will be completed by the Program Director, and reviewed by Qualified Professional, Program Director, and Director of Quality Assurance and Compliance upon completion.
V. Incident Reporting Process Guidelines
a. All incidents will be completed in Therap as a GER (unknown abbreviations) and submitted within 24 hours to Qualified Professional, Program Director, and Director of Quality Assurance and Compliance.
b. Level II and III incidents are to be submitted over IRIS and to parents/guardians/Care Coordinator/LME within 48 hours and record uploaded to IRIS Reports file on our database.
c. Behavioral Data is to be reviewed by Qualified Professional, Program Director, and Director of Quality Assurance and Compliance quarterly.
d. An Incident Report Analysis with Root Cause Analysis is to be completed by the Program Director monthly. The Director of Quality Assurance and Compliance, Program Director, and Qualified Professional will conduct quarterly reviews of incident reports and root cause analysis.
VI. Staff training/acknowledgement form
a. All staff will be trained on Person-Centered Thinking.
b. All staff will be trained on Diabetes and Insulin Administration.
c. All staff will sign an Acknowledgment Form of completing trainings and in-services.
VII. Insulin administration log
a. A log of administration of Insulin for resident (Client #2's initials) will be put into place immediately. The log will be shared with the prescribing physician during appointments and reviewed by the House manager for compliance twice weekly. The Program Manager will monitor

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the completion of the form monthly.
VIII. Medication Administration Reviewed
a. Medication Administration Reviews will be completed by House Manager weekly and a nurse or pharmacist at least quarterly.
b. Medication Administration Records will be reviewed by the House Manager twice weekly..Qualified Professional and/or Program Director monthly. The Director of Quality Assurance and Compliance will conduct Medication Record Reviews quarterly.
c. All residents self-administering medications will receive written approval from their primary care physician.
IX. Staffing
a. Whenever possible there will be 2 staff scheduled on shift during times found to have the most frequent peer-to-peer altercations (typically evening shifts).
X. Unsupervised Time/Participants Activities
a. Unsupervised Safety Assessments are to be completed within 30 days for all residents to ensure unsupervised time is appropriate and to establish guidelines.
b. House Manager arrange for residents to be supported with accessing preferred personal places of interest in their community, including visits with friends and family, leisure activies, work, etc.
c. Staff will provide supports to residents as needed to find employment, volunteer projects, or other community activity.
d. Cable boxes will be requested to be placed in rooms to allow residents to engage in leisure activies in their personal space to decrease the probability of interpersonal conflicts.
e. The residents and their parents/guardians will be asked to provide televisions for the bedrooms.
f. Residents will be provided the opportunity to eat meals at their chosen times to decrease

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altercations during meals.
XI. House Rules
a. The participants and house supervisor will meet to develop House Rules. Each resident will be asked to sign an agreement to abide by the rules and given a copy. The House Rules will be posted in a common area.
b. The House Rules will be reviewed during weekly house meetings.
c. During the house meetings, residents will be given the opportunity to voice their concerns.
d. Whenever possible the Program Director or Qualified Professional will participate in the house meeting virtually."

The facility served four adult male clients with various diagnoses that included Autism, Traumatic Brain Injury (TBI), Anxiety Disorder, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Depression, Impulse Control Disorder, Oppositional Defiant Disorder, and Schizophrenia. Client #1 has a Traumatic Brain Injury, an unsteady gait and uses a wheelchair, had at least 22 falls from trying to get out of his wheelchair or walk. He has had falls that have required medical attention. Client #1 had falls that caused a scalp laceration requiring staples, a cut on his left eyebrow, and bruises and scrapes on multiple areas of his body. Client #1 has gotten into several altercations with the other residents of the facility, sometimes leading into physical attacks. He had at least two attacks made by Client #2 that had required medical attention because he was hit in the head. Client #1 has often verbally agitated and made inappropriate sexual comments towards the other clients in the facility. Sexually harassing comments and actions were also displayed to several staff. The facility did not develop goals or strategies to address Client #1's falls, safety and

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V 289	Continued From page 37 behaviors. The facility also failed to develop goals or strategies for Client #2's and Client #3's verbal and physical aggression. Client #1 after a fall causing a large gash in his head requiring 13 staples to treat it, was supposed to have these staples removed within 7 to 10 days. The removal of the staples did not occur until 19 days later than the Physician's order. At that time his Physician determined that the delay in removal of staples caused an infection in the client's head. An antibiotic was ordered to treat this infection, and due to preventable circumstances was delayed in administration for 4 days. The facility did not have a method of effectively of identifying, reporting, monitoring and evaluating incidents of behaviors by residents in IRIS. The facility had multiple visits to the facility by the police without an incident report being completed. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $5000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed each day the facility is out of compliance beyond the 23rd day.	V 289		
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) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.	V 290		

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V 290	Continued From page 38 (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 abuse counselor shall be available on an as-needed basis for each client.	V 290		

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V 290	Continued From page 39	V 290		

This Rule is not met as evidenced by:
Based on interview and record review, the facility management failed to assure a minimum of one staff member was present with the clients except when the client's treatment or habilitation plan documented the client was capable of remaining in the community without supervision affecting one of 1 of 4 clients (#3). The findings are:

Review on 2/11/21 of Client #3's record revealed the following information;
-- 20 year old male.
-- Date of admission 10/28/19.
-- Diagnoses include Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder (Childhood Onset), ADHD - Combined Type and Autism.
-- Has a court appointed Guardian through the county Department of Social Services.
-- He had previously been employed at a retail store in the community.
-- A treatment plan dated 2/27/20 had no assessment or documentation to indicate if Client #3 was capable of unsupervised time in the community.

Interview on 2/12/21 with the House Manager (HM) revealed that staff had taken Client #3 to fill out a job application at a fast food restaurant a few miles from the facility.

Interview on 2/16/21 with Client #3 revealed that he had a job interview that afternoon for the job.

Interview on 2/17/21 with Client #3 revealed that he had been offered the job, and had gone into the restaurant for orientation, and he would work

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V 290	Continued From page 40 his first shift tomorrow (2/18/21). Interview on 2/17/21 with the HM revealed the following information; -- While Client #3 was having his job interview on 2/16/21, the staff providing transportation left the client alone at the restaurant while she went to the grocery store, and then returned to pick him up. -- She was unsure if a safety assessment had been completed on Client #3 to assure his capability of being in the community without supervision. -- She was unaware that if unsupervised time was granted to a client it needed to be included in their treatment plan with a designated amount of time. -- She confirmed that there was no unsupervised time documented in Client #3's record or treatment plan. -- The client's treatment plans are completed by the Qualified Professional. -- She confirmed that there would be no staff with Client #3 while he was at his place of employment to provide supervision. -- Client #3 had had at least 3 other jobs in the community while staying at the facility and no supervision was provided during these times. Interview on 2/22/21 with the Program Director revealed he was unaware of the rule requirements of client unsupervised time. [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (Tag V-289) for a Type A1 rule violation and must be corrected within 23 days]	V 290		
V 291	27G .5603 Supervised Living - Operations	V 291		

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V 291	Continued From page 41 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 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 observation, interview and record review, the facility management failed to assure that coordination was maintained between the facilty operator and the Qualified Professionals (QPs) who are responsible for treatment/habilitation or case management	V 291		

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V 291	Continued From page 42 affecting 2 of 4 clients (#1 #2). The findings are: A. Review on 2/6/21 of Client #1's record revealed the following information; -- 42 year old male. -- Date of admission 6/15/20. -- Diagnoses include Open TBI (Traumatic Brain Injury) with Depressed Skull Fracture with loss of consciousness, Past Surgery - Craniotomy, Unspecified Mood Disorder, Depressed Mood, Impulse Control Disorder, Adjustment Disorder with Mixed Anxiety Disorder, Right Eye Blindness, Generalized Anxiety Disorder, Insomnia, Hypersexual Behavior, Right Side Weakness, Repeated Falls, Hyperlipidemia and Obesity. -- Uses a wheelchair/walker/cane for assistance with movement. -- Has a court appointed Guardian (his Mother). Observation of Client #1 on 2/6/21 from 10:30 am through 1:30 pm revealed the following information; -- He rolls himself throughout the facility in his wheelchair that he propels with his left hand/arm and his feet. The wheelchair does not have footrests or leg supports on it, so the client slightly drags his feet, or is able to barely lift his feet up enough to propel it. -- His movements are at a slowed pace. -- He had an unsteady shuffling gait and appears able to take a few steps by himself while holding on to a stationary object (couch, chair) to transfer himself from his wheelchair to a different area (such as sitting on the couch). -- His right arm/hand had severe contractures which makes it curl up and rest close to his body on the right side of his chest. This arm appears to be nonfunctional. -- His speech is severely affected by the TBI and is slurred/soft and slow, thereby making it very	V 291		

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difficult for others to understand what he is trying to communicate. His speech at that time was garbled and hard to understand. He generally communicated with 1 to 4 word phrases and had to be asked to repeat himself by staff, peers and Surveyor frequently.
-- He had very short patchy areas of hair on his head with multiple scars on many portions caused by severe trauma and/or injury.
-- He appeared quite frail.

1. Interview on 2/15/21 with Client #1's Mother revealed the following information;
-- On 12/11/20 the client fell in his room and hit his head against a brick fireplace hearth that is in his room. The bricks on this hearth are raised above the floor about 2 or 3 inches.
-- EMS (Emergency Medical Services) was dispatched to the facility and the client was transported to the ER(emergency room).
-- He had 13 staples placed in his head to close and treat a large gash on his head.
-- His Mother was not made aware of when the staples needed to be removed.
-- She took him to his primary care Physician on 1/4/21 who removed the staples and told her the staples had been in for so long that they had caused an infection to the site on his head and he prescribed a course of antibiotics.

Review on 2/6/21 of Client #1's record revealed documentation from the Physician at the ER on 12/11/20 with the following information;
-- "Seen for scalp laceration, nasal bone fracture."
-- Treatment: Staples. "Return to ER in 7 - 10 days for staple removal (12/18/20 - 12/21/20)."
-- These staples were removed from Client #1's head on 1/4/21, 17 to 19 days after the Physician ordered them to be removed.

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V 291	Continued From page 44 Interview on 2/10/21 with the House Manager (HM) revealed it would have been her that would have taken Client #1 to have the staples removed, however she was out of work sick for a good part of December 2020 apparently and no other staff took him for the staple removal. 2. A Physicians order dated 1/4/21 for Client #1 to be administered Keflex (an antibiotic prescribed for an infection the client had been diagnosed with-see above) 500 mg. (milligrams) twice a day for 7 days starting on 1/4/21 and discontinue (complete) on 1/11/21. -- Review on 2/16/21 of Client #1's January 2021 MAR revealed the following information; -- A transcription for Keflex 500 mg. twice a day beginning on 1/4/21 in the morning and ending on 1/11/21 at bedtime. -- Documentation on this MAR revealed that the client was administered this antibiotic from 1/8/21 at bedtime through 1/11/21 at bedtime (for a total of 7 doses out of the 14 doses ordered by the Physician). -- This documentation reflects that there was a 4 day delay in administering a Physician ordered antibiotic for an infection to Client #1's head. Interview by phone on 2/16/21 with a Pharmacist at the facilities pharmacy revealed the following information; -- The Pharmacy received the prescription from the Physician on 1/4/21. -- "It was a routine medication and should have gone out (into the mail) on 1/5/21 (the following day of the prescription). They (the facility) should have gotten it (the medication) on 1/5/21 (the same day it was shipped)." Interview on 2/16/21 with the HM revealed the	V 291		

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V 291	Continued From page 45 following information; -- The facility frequently does not get medications for clients delivered to the facility by the pharmacy in a timely manner. -- The facility did not receive the antibiotic from FedEx until 4/7/21 (three days after the medication was ordered). -- The computer would not allow the staff to document on the MAR after the 1/11/21 discontinue date. -- Client #1 did receive the whole course of the antibiotic starting on 1/8/21 through the 7 days it was ordered for, however there was no way to override the computerized MAR to reflect administration after the discontinue date (1/11/21). -- It would have been a better idea for the facility to have used their emergency pharmacy (which is in town) instead of sending the prescription to the facility pharmacy in Virginia, however Client #1's Mother took him to this Physician's appointment, and the prescription was faxed to the pharmacy identified in the client's history from previous encounters. -- She agreed there was a lack of coordination for both of the above events. Review on 2/16/21 of the packing slip that accompanied the delivered antibiotic revealed the HM signed the invoice for the antibiotic on 1/7/21. 3. Review on 2/6/21 of Client #1's record revealed documentation from a Neurologist on 7/1/20 with the following information -- He was seen on 7/1/20 for Botox injections to aid with the spasticity (the ability to move and/or relax) of his contracted muscles. -- His previous appointment with this Neurologist was on 4/20/20 with Botox injections. -- "Next injection in 3 months."	V 291		

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V 291	Continued From page 46 Interview on 2/10/21 with the HM revealed the following information; -- Client #1 is administered his Botox injections every 3 months. -- His Mother takes him to these appointments in Chapel Hill. -- His Mother has never shared the documentation from these appointments except for the 7/1/20 note found in his chart. -- She confirmed that the staff at the facility wouldn't know if there were any Physician's orders or treatment changes or recommendations without this documentation. -- She had not looked into the process of signing up for electronic medical record access to obtain documentation on any of the clients. B. Review on 2/10/21 of Client #2's record revealed the following information; -- 23 year old male. -- Date of admission 5/19/19. -- Diagnoses include Intermittent Explosive and Mood Disorders, Oppositional Defiant Disorder, Bipolar Disorder, ADHD (Attention Deficit Hyperactivity Disorder), Autism Spectrum Disorder, GERD (Gastroesophageal Reflux Disorder), Obesity and Diabetes Mellitus Type II. -- Has a court appointed Guardian (his Mother). -- FSIQ (full scale Intelligence Quotient) = 82, low average (dated 4/28/17). Additional review on 2/10/21 of Client #2's record revealed the following information; -- 11/7/20 - The Police were called, and the client was evaluated at the ER. The ER Physician indicated the client was seen for "Mood Disorder and medication refill." The client was discharged with a prescription for a 10 day supply of Abilify (for Depression).	V 291		

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V 291	Continued From page 47 -- 10/23/20- The client was seen in the ER for Diabetes Mellitus and a medication refill." The client was discharged with a prescription for a 30 day supply of Metformin (for blood sugar controll). -- 9/14/20- The client was seen in the ER for Diabetes Mellitus and a medication refill." The client was discharged with a prescription for an 8 day supply of Metformin. Interview on 2/16/21 revealed the following information; -- She was unsure why Client #2 was seen so frequently in the ER for medication refills. -- Often there is no documentation provided by Physician's regarding any of the Client's treatment (including medications), recommendations and/or follow-up. -- There was no system in place to obtain this information concerning the Client's treatment. [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (Tag V-289) for a Type A1 rule violation and must be corrected within 23 days]	V 291		
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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V 366	Continued From page 48 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	V 366		

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V 366	Continued From page 49 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;	V 366		

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V 366	Continued From page 50 (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 interview and record review, the facility management failed to assure all Level 2 incidents were reported with responses documented to the LME (Local Management Entity). The findings are: Interview on 2/17/21 with the Program Director revealed the following information; -- It was his responsibility to complete Level 2 and 3 Incidents. -- He was unaware that only 1 incident was recorded in the IRIS system. -- He reported he had submitted many more than 1 incident report. Only one of the multiple incidents that occurred within the facility had an associated IRIS report, therefore the data for responses was not provided to the LME. ** See tag V-367 for specific incident information. [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (Tag V-289) for a Type A1 rule violation and must be corrected within 23 days]	V 366		

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V 367	Continued From page 51	V 367		
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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-103	A. BUILDING: _____ B. WING _____	02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACH FARM ROAD	1391 PEACH FARM ROAD LILLINGTON, NC 27546

(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 367	Continued From page 52 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 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	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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PEACH FARM ROAD	1391 PEACH FARM ROAD LILLINGTON, NC 27546

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V 367	Continued From page 53 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 management failed to assure all Level 2 incidents were reported and failed to notify the LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings are: Review on 2/6/21 of the North Carolina Incident Response Improvement System (IRIS) revealed only 1 report had been submitted by the facility Program Director (PD) (8/19/20 - Client #2 and Client #3 physically assaulting each other). Interview on 2/17/21 with the PD revealed the following information; -- It was his responsibility to complete Level 2 and 3 Incidents. -- He was unaware that only 1 incident was recorded in the IRIS system. -- He reported he had submitted many more than 1 incident report. -- He was not aware that anytime the police were involved it required a report in IRIS. -- He was not aware that any injury that required more medical intervention than 1st aid required a report in IRIS. Review on 2/8/21 of Police call logs from 1/17/20 through 1/25/21 (1 year and 8 days) revealed the	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-103	A. BUILDING: _____ B. WING _____	02/23/2021

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V 367	Continued From page 54 following information; -- 26 calls were made/received by the local county Sheriffs Department. -- 8 of these calls also required EMS (emergency medical services) response and intervention. Client #1: Made 10 calls and 3 calls were made about client #1. Client #2: 6 calls were made about him. Client #3: Made 1 call, 5 calls about him were made. Multiple incidents occurred within the facility requiring medical attention that were not documented in the IRIS system. ** See tag V-112 for specific details. [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (Tag V-289) for a Type A1 rule violation and must be corrected within 23 days]	V 367		