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March 18, 2021

Lesa Williams, MSW
Facility Compliance Consultant II
Mental Health Licensure & Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Survey, completed 03-02-2021
Highway 117 Group Home
3801 Hwy 117 North
Goldsboro, NC 27530
Provider Number 34G175
MHL# 096-020

Dear Ms. Williams,

Attached you will find the plan of correction associated with your correspondence dated March 9, 2021, along with the statement of deficiencies from the survey completed March 02, 2021.

If additional information is needed, please do not hesitate to contact me.

Sincerely,

Jacqueline Johnson,
Program Director
NOVA-IC, Inc.

Attachments: Signed and dated pages of the state form
Plan of Correction: Hwy 117 Group Home

P.O. Box 11077 • Goldsboro, North Carolina 27532 • Phone (919) 734-8803 • Fax: (919) 735-7207

PRINTED: 03/08/2021
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICAID & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENIFICATION NUMBER: 34G175	(X2) MULTIPLE CONSTRUCTION A BUILDING ______ B WING ______	(X3) DATE SURVEY COMPLETED C 03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHWAY 117 GROUP HOME	**3801 US 117 NORTH GOLDSBORO, NC 27530**

(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 CROSSED-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 3/2/2021 for intakes NC00172219 and NC00174940. The intake NC00172219 was unsubstantiated however intake NC00174940 was substantiated. An immediate jeopardy was cited during the survey.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to ensure that clients were not subjected to physical abuse (W127); failed to prohibit mistreatment, neglect and abuse of the client and client safety (W149); and failed to thoroughly investigate allegations of abuse, neglect and mistreatment to clients (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.	W 122	DHSR - Mental Health MAR 22 2021 Lic. & Cert. Section	
W127	PROTECTION OF CLIENT RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that all clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.	W 127	The Consumer Affairs Coordinator will conduct a refresher training for all Group Homes regarding NOVA's policies pertinent to Consumer Rights, Abuse, Neglect and/or Exploitation, and Consumer Protection from Abuse, Neglect and	04/15/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jacqueline Johnson
TITLE: Program Director
(X6) DATE: 3-19-21

W 127	Continued From Page 1 This STANDARD is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure clients residing in the home were not subject to physical abuse. This affected 1 of 5 clients (#2). THE finding is: Review on 3/2/21 of the facility's incident report revealed, "Consumer assaulted another consumer with the intent to cause bodily harm using a deadly weapon." During an interview on 3/2/21, client #2 revealed discharged client (DC) #6 was sitting at the table eating when Staff B asked him to do something. DC #6 cursed at Staff B and client #2 told him not be disrespectful. Further interview revealed DC #6 then threw his plate after Staff B told him she would have to "write him up". DC #6 then broke into the medication room, got a knife and stabbed client #2 several times, until the knife broke into two pieces. DC #6 then got the mop and started to hit client #2 in the back of the head until the mop broke. Once the mop broke, DC #6 began to stab him with the sharp part of the broken mop. DC #6 later went outside poured gasoline on himself and around the outside of the house. He assumed DC #6 was going to try to burn down the house. The police arrived and he (client #2) was transported to the hospital due to his wounds. During an interview on 3/2/21, client #4 stated "[Client #2] got stabbed." Further interview revealed that while they were eating dinner on 2/28/21, DC #6 told Staff B to shut up and the began to curse at her. Client #4 then stated DC #6 went to the medication room and used his identification card, slid it in between the door jam and the door and was able to open the medication door, DC #6 took out a knife and fork from the unlocked lock box. Additional interview revealed DC #6 went after client #2 with both the knife and fork, while he was sitting at the table. Client #4 then proceeded to reveal how client #2 told him to call 911; which he did,	W 127	Exploitation. This training will be documented on the Inservice Training Form. In addition, NOVA's CEO will modify its Admissions Policy and Philosophy to screen out any applicant that has a history of or DSM-V diagnosis suggesting the potential for aggressive behavior. Lastly, one or more PhD-Level Clinical Psychologists, independent of NOVA-IC, employment will conduct a Diagnostic Assessment of each Group Home Consumer that will update the diagnosis, identify the risk of aggressive / assaultive behavior based on the diagnosis, and make staffing recommendations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

W 127	Continued From page 2 giving the 911 operator information about the situation. Client #4 also stated DC #6 went to the house next door and got a container of gas out of a dumpster and poured the gasoline on himself. The police arrived and tackled DC #6. During an interview on 3/2/21, staff B revealed she was working alone in the home on 2/28/21. DC #6 started repeatedly changing his clothes right before dinner and when asked why he was changing his clothes, he began to curse at her and threw his plate. DC #6 then left the dining room table and went into his bedroom. Further interview revealed DC #6 then came back into the dining room and began to clean up where he threw his plate. Staff B stated she went into the living room and then she realized client #2 was being stabbed in the face with a knife and fork. Staff B stated she does not know where DC #6 got the knife. DC #6 then went outside and was standing in the middle of the street. Cars were stopped in the street because DC #6 would not move. She was trying to get DC #6 out of the street while still running back and forth inside to check on client #2 who was laying on the floor bleeding. Staff B stated she also called the administrator on call (AOC) and the administrator during this time. Continued interview with staff B revealed DC #6 then went to the house next door and got a container of gasoline and poured it on himself. DC #6 picked up a shovel and started walking back to the house. Staff B shut the door and then	W 127		
W 127	the police arrived. She stated DC #6 did not have a lighter on him at the time. Staff B was able to show the surveyors the lighter (she had it in her pocket) which the clients who smoke use under the supervision of staff at all times. Staff B stated she had never had any problems with working alone before however she's only been working in the home for 2 weeks.			

W 127	Continued From page 3 Interview on 3/2/21 with the Sheriff's Department Lead Investigator revealed he responded to the group home due to the stabbing incident on 2/28/21. When they arrived, DC #6 poured gasoline on himself and 2 officers tackled him. It was unknown if DC #6 had a lighter, but the officers did not wait around to find out. The scene was very bloody. Inside the home, there was a bloody fork that was bent completely back. "You could tell the impact that was made based on how the fork was bent." There was also a bloody broken mop handle on the floor. When he interviewed DC #6 at the hospital, he admitted to stabbing client #2 with a knife and fork. He also admitted to beating him with the mop handle. DC #6 stated that he obtained the knife from on top of the TV. DC #6 and client #2 knew the knife was there. Further interview revealed DC #6 will be charged with 2 counts of assault with a deadly weapon with the intent to kill and inflict bodily harm. Review on 3/2/21 of a nursing note written on 3/1/21 stated, "Consumer returned from Wayne UNC to group home S/P observation. Consumer alert and verbally communicating, VS WNL, RESP even et unlabored. Abdomen soft/nondistended, consumer has 3 stitches to left upper rib area, (L) hand swollen x2 edema with 2 puncture marks. Consumer had bruising over entire back, center of forehead, swollen with abrasions over each eye, (R) eyelid swollen and red, no drainage noted. Consumer denies pain @ this time NAD noted." Review on 3/2/21 of DC #6's record revealed he was admitted to the facility on 11/17/20. An Initial Psychiatric Assessment dated 2/5/20 documented DC #6 was IVC (involuntarily committed) at a local state hospital due to hallucinations and suicidal ideations. He was recently discharged from local psychiatric hospital to a group home where he immediately threatened the provider and destroyed property. He became aggressive with staff 15 minutes after his arrival to the group home. According the DC #6's Biopsychosocial History Assessment dated 9/23/20 the group home pressed charges and he was sent to the county jail.	W 127		

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W 127	Continued From page 4 Continued review of DC #6's record revealed an Admission Application dated 11/4/20. "[DC #6] has made threats to kill others when angry." A Comprehensive Functional Assessment (CFA) dated 12/14/20 revealed a diagnoses of Intellectual Developmental Disability Disorder (Mild), Schizophrenia, Multiple Episodes, Acute Severe. He was admitted to a local inpatient psychiatric hospital for worsening of psychosis and aggressive behaviors due to noncompliance with medications. He has a history of aggressive behaviors, delusions, auditory hallucinations and threats to harm himself and others. Further review of DC #6's record revealed a Mental Health Plan dated 12/15/20 that reflected DC #6 currently needs "eyes on supervision." 1:1 monitoring may be needed due to his history of elopement at other placements. He should be supervised closely by staff; especially during periods of instability and when engaged in outdoor tasks. Other special precautions..."when [DC #6] displays aggression of any kind, staff should try one or more of the following: Change the topic to a positive topic of conversation or interject reality-based questions; Give him space but ensure you have a line of sight; avoid talking about anything related to situation that may have triggered his aggression." Review on 3/2/21 of a clinical note signed by the Program Director dated 2/28/21 revealed "[DC #6] assaulted another consumer at NOVA Highway 117 Group Home. The event necessitated the involvement of Law Enforcement who ordered [DC #6] to be taken to [local hospital]. There he was IVC however placement is not known to NOVA. Given this, [DC #6] has become a threat to himself and others and requires another level of care therefore he has been discharged from NOVA-IC effective February 28, 2021. During an interview on 3/2/21, the Program Director revealed DC #6 was IVC on Sunday night because he attacked another consumer. The doctor determined he needed to be IVC, not the facility. DC #6 stabbed client #2 several times with a steak knife. He then went to the vacant home next door and got a gas can and	W 127		

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W 127	Continued From page 5 poured gas all over himself. Law enforcement intervened. Continued interview with the Program Director revealed, prior to admission, they were informed that DC #6 had physically aggressive behaviors but not to this extent. They were aware that he had charges pending for the incident at the previous group home however they told the local psychiatric hospital they could not accept him until the charges were dropped. The local psychiatric hospital had all previous charges dropped for DC #6. Since admission, DC #6 had done well. He had a few elopements but had not been physically aggressive in the home. The program director stated that since the incident, all of the knives were removed from the home and are currently in her office; but the scissors are kept locked in the medication room. DC #6 was discharged from the facility due to the need for a higher level of care. No other interventions have been implemented. During an interview on 3/2/21, the Chief Executive Officer (CEO) stated for whatever reason DC #6 threw a plate of food on 2/28/21. DC #6 started to clean up what he threw, but then he picked up a knife and attacked another consumer. DC #6 then got a mop and began hitting the other consumer in the face and neck area. Additional interview revealed the police were called. The CEO stated DC #6 was admitted on 11/17/20 and previously had been discharged from other places for behaviors. While here, his behaviors just "came out of the blue." The CEO reported that he felt they were not provided full disclosure of DC #6's behaviors prior to admission and they would be making changes on how they screen potential clients in the future. Surveyors requested to review behavior data for DC #6 since his admission. The PD and CEO refused to allow the survey team access to this data. The facility's neglect to provide sufficient staffing to meet the needs of the clients and ensure client safety resulted in client-to-client physical abuse between DC #6 and client #2 and resulted in an immediate jeopardy being identified during the survey.	W 127		

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W 127	Continued From page 6 The facility's plan of protection completed on 3/2/21 by the CEO to remove the Immediate Jeopardy revealed 1) the consumer initiating the aggressive episode has been discharged and involuntarily committed. This consumer was discharged from NOVA on 3/1/21. 2) In the future, NOVA will improve the review of applicants for admission and screen out hyper-aggressive consumers for admission. 3) effective 3/3/21, NOVA will ensure that sufficient staffing at a minimum of 2 staff at all times unless future clarification is obtained and available to manage all potential events identified in consumers' Individual Program Plans. 4) Effective 3/3/21, Facility Support Coordinator will conduct a daily health and safety inspection of the home and immediately correct any potential issue.	W 127		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure written policies and procedures were implemented that prohibit neglect by maintaining appropriate staffing to meet clients needs and maintaining client safety in the home. This affected 5 of 5 clients (#1, #2, #3, #4 and #5) and 1 of 1 discharged client (#6). The findings are: A. The facility failed to prohibit neglect by maintaining appropriate staffing to meet client needs for all clients (#1, #2, #3, #4, #5 and #6). For example: Review on 3/2/21 of the facility's incident report revealed, "Consumer assaulted another consumer with the intent to cause bodily harm using a deadly weapon."	W 149	The RSDS will conduct refresher training in NCI+ for all Group Home Staff and document training on the In-Service Training Form. NCI+ as the validated curriculum for de-escalating potentially aggressive behavior and intervening when such behavior occurs. The FSC will conduct routine monitoring of the Group Home to identify and immediately correct any health and safety issues.	04/15/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

W 149	Continued From page 7 During an interview on 3/2/21, client #2 revealed discharged client (DC) #6 was sitting at the table eating when Staff B asked him to do something. DC #6 cursed at Staff B and client #2 told him not be disrespectful. Further interview revealed DC #6 then threw his plate after Staff B told him she would have to "write him up." DC #6 then broke into the medication room, got a knife and then stabbed client #2 several times, until the knife broke into two pieces. DC #6 then got the mop and started to hit him in the back of his head until the mop broke. Once the mop broke, DC #6 began to stab him with the sharp part of the broken mop. DC #6 later went outside poured gasoline on himself and also around the outside of the house. He assumed DC #6 was going to try to burn down the house. The police arrived and he (client #2) was transported to the hospital. He's been telling management they need more than one staff in the home. He personally thinks they need a male staff and a female staff. During an interview on 3/2/21, staff B revealed she was working alone in the home on 2/28/21. DC #6 started repeatedly changing his clothes right before dinner and when asked why he was changing his clothes, he began to curse at her and threw his plate. DC #6 then left the dining room table and went into his bedroom. Further interview revealed DC #6 then came back into the dining room and began to clean up where he threw his plate. Staff B stated she went into the living room and then she realized client #2 was being stabbed in the face with a knife and fork. Staff B stated she does not know where DC #6 got the knife. DC #6 then went outside and was standing in the middle of the street. Cars were stopped in the street because DC #6 would not move. She was trying to get DC #6 out of the street while still running back and forth inside to check on client #2 who was laying on the floor bleeding. Staff B stated she also called the administrator on call (AOC) and the administrator during this time. Continued interview with staff B revealed DC #6 then went to the house next door and got a container of gasoline and poured it on himself. DC #6 picked up a shovel and started walking back to the house. Staff B shut the door and	W 149		

W 149	Continued From page 8 then the police arrived. She stated DC #6 did not have a lighter on him at the time. Staff B was able to show the surveyors the lighter (she had it in her pocket) which the clients who smoke use under the supervision of staff at all times. Further interview with Staff B revealed she had never had any problems with working alone before however she's only been working in the home for 2 weeks. Staff B also revealed how this past Friday and Saturday she was working alone, but a "floater" came by to check on her to see if everything was going fine. Staff B stated she thought the "floater" would stop by on 2/28/21 to check on her however no one ever did. When asked if she's worked alone in the home since the incident, she stated she worked alone "this morning." She was responsible for getting all of the clients dressed, cooking breakfast and administering medications this morning. During an interview on 3/2/21, Staff C revealed there have been times when only one staff has been on duty in the home; but there should be two. Further interview revealed if there is a call out, then calls would be made to see if anyone else would like to work. Review on 3/2/21 of client #1's record revealed a Mental Health Plan dated 10/13/20 that indicated requires "awake supervision with periodic eyes on when stable and within arm's reach during episode of instability to avoid elopement and assaultive/destructive symptoms relative to his Schizoaffective Disorder, Bipolar." Review on 3/2/21 of client #2's record revealed a Mental Health Plan dated 10/28/20 that indicated requires, "24-hour supervision, close monitoring when stable. During times of instability, he requires increased monitoring. With incidence of stealing, lying, impulsivity and physical and verbal aggression staff should use a therapeutic bridge and talk to him about the incident." Review on 3/2/21 of client #3's record revealed a Mental Health Plan dated 12/22/20 that indicated needs "24 hour, awake, supervision. Staff should monitor closely at night due to night	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

W 149	Continued From page 9 terrors that staff may witness him yelling and engaging in self-injurious behaviors. Staff should intervene and remove [client #3] from the room to allow him to calm down if he is responsive. Staff should maintain a safe distance when intervening as he may be swinging in the air unknowingly. [Client#3] should also be removed from area during explosive outbursts involving peers." Review on 3/2/21 of client #4's record revealed a Mental Health Plan dated 6/24/20 documenting client #4 has a long history of behavioral problems. Since admission on 6/1/20 client #4 has engaged in acts of physical aggression, verbal aggression, property destruction and leaving assigned areas and threats. He requires awake supervision. Review on 3/2/21 of client #5's record revealed a Mental Health Plan dated 6/30/20 that indicated requires "periodic eyes-on when stable. Staff should be within arm-reach during periods of instability. Staff should approach [client #5] in a non-confrontational manner, using a neutral tone of voice. [Client #5] responds better to male staff and will target female staff at times." Review on 3/2/21 of DC #6's record revealed an admission application dated 11/4/20 that revealed "[DC #6] has made threats to kill others when angry." A Comprehensive Functional Assessment (CFA) dated 12/14/20 revealed a diagnoses of Intellectual Developmental Disability Disorder (Mild), Schizophrenia, Multiple Episodes, Acute Severe. He was admitted to a local inpatient psychiatric hospital for worsening of psychosis and aggressive behaviors due to noncompliance with medications. He has a history of aggressive behaviors, delusions, auditory hallucinations and threats to harm himself and others. Further review of DC #6's record revealed a Mental Health Plan dated 12/15/20 that revealed DC #6 currently needs eyes on supervision. 1:1 monitoring may be needed due to his history of elopement at other placements. He should be supervised closely by staff; especially during periods of instability and when engaged in	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

W 149	Continued From page 10 outdoor tasks. Other special precautions..."when [DC #6] displays aggression of any kind, staff should try one or more of the following: Change the topic to a positive topic of conversation or interject reality-based questions; Give him space but ensure you have a line of sight; avoid talking about anything related to a situation that may have triggered his aggression." Surveyors inquired to review the behavior data for clients over the past 3 months however they were denied access to this information by the Chief Executive Officer (CEO) and the Program Director. Therefore, surveyors are unable to determine the frequency of behavioral episodes in the home. During an interview on 3/2/21, the Program Director confirmed they have one staff on a shift and she also mentioned how a "floater" goes between two homes to check with the staff to see if they are having any issues. It was their understanding that they could have one staff per shift according to federal regulations. She further stated DC #6 and 2 other clients who reside in the home have elopement behaviors. When asked if DC #6 had ever ran before, the Program Director reported at the day program last week he was discovered masturbating in the computer room and staff redirected him. Further interview revealed the Program Director believed that DC #6 became embarrassed and walked off. He was located in the field behind the day program; the staff drove the van and followed him there and brought him back. Subsequent interview with the Program Director on 3/2/21 revealed DC #6 eloped 3-4 times after he was first admitted. When asked what the expectation is of staff if a client eloped while working alone, she first stated she wasn't sure. They hadn't considered that. She later stated, staff would just have to call the administrator on call because they couldn't leave the other clients. The Program Director additionally confirmed that they had not implemented any changes to their staffing after the incident because they currently have a lot of vacant shifts at the home.	W 149		

W 149	Continued From page 11 B. The facility failed to maintain client safety in the home for all clients (#1, #2, #3, #4, #5 and #6). For example: Observation on 3/2/21 at 11:05am of the front door step revealed a red 2-3 gallon gas can located at the bottom of the steps and a snow shovel to the left of the steps. This Surveyor picked the gas can up and observed it to be 1/2 full of gas. Interview on 3/2/21 with the Program Director confirmed the gas can to be the same one that DC #6 used to pour gas on himself on 2/28/21. She stated this is a hazard to the health and safety of the consumers residing in the home and should have been immediately removed after the incident. She was not aware the gas can and shovel were still on the property. The facility's negligence to provide sufficient staffing to meet the needs of the clients and ensure client safety resulted in client-to-client physical abuse between DC #6 and client #2 causing serious injury. This also lead to a client having to call 911 for law enforcement assistance. The facility also neglected the remove the gas can from the facility which DC #6 used to pour gas on himself. The gas can still contained a large amount of gas inside. This was a hazard to the health and safety of the clients. The cumalative effect of these examples resulted in a Condition of Participation.	W 149		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure that an incident regarding client to client abuse was thoroughly investigated. This affected 1 of 5 current clients (#2) and 1 of 1 discharged client (#6). The finding is:	W 154	NOVA will develop and implement a new Investigation policy based on the existing Investigation protocol. All Leadership Council staff will be trained on the new policy, with training documented on the In-Service Training Form.	04/15/2021

W 154	Continued From page 12 Review on 3/2/21 of the facility's incident report revealed, "Consumer assaulted another consumer with the intent to cause bodily harm using a deadly weapon." Review on 3/2/21 of the facility's documents revealed no evidence of an investigation related to the incident. During an interview on 3/2/21, client #2 revealed discharged client (DC) #6 was sitting at the table eating when Staff B asked him to do something. DC #6 cursed at Staff B and client #2 told him not be disrespectful. Further interview revealed DC #6 then threw his plate after Staff B told him she would have to "write him up." DC #6 then broke into the medication room, got a knife and stabbed client #2 several times, until the knife broke into two pieces. DC #6 then got the mop and started to hit him in the back of his head until the mop broke. Once the mop broke, DC #6 began to stab him with the sharp part of the broken mop. DC #6 later went outside, poured gasoline on himself and also around the outside of the house. He assumed DC #6 was going to try to burn down the house. The police arrived and he (client #2) was transported to the hospital. During an interview on 3/2/21, client #4 stated "[Client #2] got stabbed." Further interview revealed that while they were eating dinner on 2/28/21, DC #6 told Staff B to shut up and then began to curse at her. Client #4 then stated DC #6 went to the medication room and used his identification card, slid it in between the door jam and the door and was able to open the medication door, DC #6 took out a knife and fork from the unlocked lock box. Additional interview revealed DC #6 went after client #2 with both the knife and fork, while he was sitting at the table. Client #4 then proceeded to reveal how client #2 told him to call 911; which he did, giving the 911 operator information about the situation. Client #4 also stated DC #6 went to the house next door and got a container of gas out of a dumpster and poured the gasoline on himself. The police arrived and tackled DC #6. During interview on 3/2/21 with the Program Director revealed the facility did not investigate the incident between client #2 and DC #6 because they saw everything on camera. She	W 154		

W 154	Continued From page 13 stated it was the facility's policy to investigate client to client abuse however they knew DC #6 was going to be involuntarily committed and felt the source of danger had been removed from the home. She further stated that she was not sure what lead up to the incident or where DC #6 obtained the knife from. She later confirmed the facility should have completed an investigation. Review on 3/2/21 of the facility's abuse policy revised on 1/01/14 revealed, "...The Program Director or designee, and the Qualified Professional shall compose the Formal Inquiry Team, and shall have the authority to interview, photograph, and obtain written statements from staff and consumers.	W 154		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide sufficient direct care staff to manage and supervise 1 of 1 discharged client (#6) based on the needs of the client. This finding is: During an interview on 3/2/21, client #4 stated "[Client #2] got stabbed." Further interview revealed that while they were eating dinner on 2/28/21, discharged client (DC) #6 told Staff B to shut up and then began to curse at her. Client #4 revealed DC #6 then threw his plate of lasagna on the floor and left the dining room. Client #4 then stated DC #6 went to the medication room and used his identification card, slid it in between the door jam and the door and was able to open	W 186	Based on the Diagnostic Assessment identified under W127, NOVA will identify and provide sufficient direct care staff in accordance with the individual program plan of Consumers.	04/15/2021

W 186	Continued From page 14	W 186		
	the medication door and took out a knife and fork from the unlocked lock box. Additional interview revealed how DC #6 went after client #2 with both the knife and fork, while he was sitting at the table. Client #4 then proceeded to reveal how client #2 told him to call 911; which he did, giving the 911 operator information about the situation. Client #4 also stated how DC #6 went to the house next door and got a container of gas out of a dumpster, but he did not see DC #6 with a lighter. Client #4 said he saw the police "tackled [DC #6]." Additional interview revealed Staff B was there by herself; but normally there are two staff working in the home. Client #4 stated nothing like this has ever happened before. Client #4 revealed he would rather live in the city of Kinston, but he does feel safe living at his current home. During an interview on 3/2/21, client #2 revealed there was another client sitting at the table eating when Staff B asked him to do something. DC #6 then cussed at Staff B and client #2 told DC #6 not be disrespectful to Staff B. Further interview revealed DC #6 then threw his plate after Staff B told DC #6 she will have to "write him up." Client #2 stated that he "takes" up for the female staff in the home. Further interview with client #2 revealed DC #6 broke into the medication room and got a knife, stabbed him and the knife broke into two pieces. DC #6 then got the mop and started to hit him in the back of his head. Further interview revealed how DC #6 then began to stab him with a sharp part of the broken mop. Client #2 stated he feels there needs to be a male staff working in the home, when there is only one female staff working. Further interview with client #2 revealed some of the other clients try and leave the home when there is only one staff working. Client #2 stated he does feel safe living in the home. Client #2 concluded in saying Staff B did everything she could do in the situation. During an interview on 3/2/21, Staff B revealed before dinner DC #6 kept changing his clothes and when she asked him why, he began to cuss at her and threw his plate. Staff B reported DC #6 then left the dining room table and went into his bedroom. Further interview revealed how DC #6 then came back into the dining room and began to clean up where he threw his plate.			

W 186	Continued From page 15 Staff B then stated she went into the living room and realized client #2 was being stabbed in the face with a knife and fork. DC #6 then went outside and that is when Staff B began running back and forth checking on DC #6 and client #2 who was laying on the floor bleeding. Staff B stated while DC #6 was standing in the middle of the road she called the administrator on call (AOC) and the Program Director. Additional interview revealed how DC #6 then went to the house next door and got a container of gasoline and poured it on himself. While DC #6 was walking back to the house after doing this and carrying a shovel, Staff B shut the door and that is when the police arrived. Staff B was able to show the surveyors the lighter (she had it in her pocket) which the clients who smoke use under the supervision of staff at all times. Staff B stated she does not know where DC #6 got the knife, as she had the medication room keys on her and the box where the knives are kept is locked inside of the medication room. Continued interview with Staff B revealed how this past Friday and Saturday she was working alone, but a "floater" came by to check on her to see if everything was going fine. Staff B stated she was working alone on 2/28/21, but she thought the "floater" would stop by again to check on her. Further interview revealed she had been working at this facility for two weeks; she had previously worked at another one of the company's homes. Staff B stated she had never had any problems with working alone before; the clients do their "deep cleaning" on Saturday and then just "chill" in their rooms on Sunday. During an interview on 3/2/21, the AOC who was working on 2/28/21 revealed clients #2, #4 and DC #6 smoke, but their cigarettes are always locked in the medication room, along with their lighters. Further interview revealed only staff have keys to unlock the medication room door and the clients are never alone in the medication room. Further interview revealed he had heard how DC #6 was given instructions during dinner on 2/28/21 and he proceeded to throw his plate of food and then "charged" towards the staff who was working that day. He heard how DC #6 stabbed client #2 on his left	W 186		

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W 186	Continued From page 16 side 2 times and how they were fighting the week previous to this incident. Additional interview revealed he had thought DC #6 and client #2 were best friends. Further interview revealed how client #4 called him and told him, "[DC #6] stabbed [client #2]." It was then reported how client #4 called 911. Further interview revealed part of the clients' training is knowing their address, phone number and the city where they live. During an interview on 3/2/21, Staff C revealed there have been times when only one staff have been on duty in the home; but there should be two. Further interview revealed if there is a call out, then calls would be made to see if anyone else would like to work. Review of DC #6's record revealed an admission application dated 11/4/20: "[DC #6] has made threats to kill others when angry." A Comprehensive Functional Assessment (CFA) dated 12/14/20 revealed a diagnoses of Intellectual Developmental Disability Disorder (Mild), Schizophrenia, Multiple Episodes, Acute Severe. He was admitted to a local inpatient psychiatric hospital for worsening of psychosis and aggressive behaviors due to noncompliance with medications. He has a history of aggressive behaviors, delusions, auditory hallucinations and threats to harm himself and others. Further review of DC #6's record revealed a Mental Health Plan dated 12/15/20: DC #6 currently "needs eyes on supervision." 1:1 monitoring may be needed due to his history of elopement at other placements. He should be supervised closely by staff; especially during periods of instability and when engaged in outdoor tasks. Other special precautions..."when [DC #6] displays aggression of any kind, staff should try one or more of the following: Change the topic to a positive topic of conversation or interject reality-based questions; Give him space but ensure you have a line of sight; avoid talking about anything related to a situation that may have triggered his aggression."	W 186		

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W 186	Continued From page 17 During an interview on 3/2/21, the Program Director revealed after DC #6 stabbed client #2 with the knife and hit him with the mop, he went outside to the house next door and got a container of gasoline and a shovel. Additional interview revealed how DC #6 then poured the gasoline over himself. Further interview revealed DC #6 did not have a lighter. The Program Director also stated the gasoline container and the shovel were left outside of the home near the porch. When asked if DC #6 had ever ran before, the Program Director reported at the day program last week he was discovered masturbating in the computer room and staff redirected him. Further interview revealed the Program Director believes that DC #6 became embarrassed and walked off. He was located in the field behind the day program; the staff drove the van and followed him there and bought him back. The Program Director then added they have one staff on a shift and she also mentioned how a "floater" goes between two homes to check with the staff to see if they are having any issues. The facility's failure to provide adequate staffing to meet the needs of the clients and ensure client safety resulted in client to client physical abuse between DC #6 and client #2 causing serious injury and led to a client having to call 911 for law enforcement assistance.	W 186		

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