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V 000	INITIAL COMMENTS An annual, follow up and complaint survey was completed on 9/2/21. The complaint was substantiated Intake #NC00178752. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. The Director of Operations/Qualified Professional (QP) referenced in this report is the Owner's wife. The Director of Operations/Qualified Professional & the Quality Improvement Director filled in as QP from January 2021 until August 9, 2021	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid	V 108		

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V 108	Continued From page 1 including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 3 of 5 audited staff (staff #1, #7 & Qualified Professional (QP#2)) were trained in goals and strategies as identified in the treatment plans. The findings are: A. Review on 8/25/21 of staff #1's personnel record revealed: - date of hire: 4/17/19 - annual supervision plan dated 4-10-20: "...elements of person centered plan, individualized treatment plans, documentation and accuracy..." signed by Director of Operations/QP & Quality Improvement Director B. Review on 8/25/21 of staff #7's personnel record revealed: - date of hire: 8/16/21 - inservice training form dated 8/11/21: understanding documentation, review of client #1, #2 & #3's treatment plan & review of client #1 & #2's behavior support plan	V 108		

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V 108	Continued From page 2 C. Review on 8/25/21 of QP#2's personnel record revealed: - date of hire: 8/9/21 - no documentation of training on the clients' treatment plans/behavioral plans The following are examples of how the facility failed to ensure staff received training to meet the needs for client #1 & #2: Review on 8/25/21 of client #1's record revealed: - admitted 7/16/20 - diagnoses of Autism, Intellectual Developmental Disorder (IDD), Bipolar, hearing loss, & nonverbal - refer to V112 for specific details regarding client #1's treatment/behavior support plan - a behavior support plan dated 9/2/20: "...prevention: a structured environment...will be given a key to the area where the knives are kept...all episodes of challenging behavior will be documented on the behavior tracking form..." Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) - refer to V112 for specific details regarding client #2's treatment/behavior support plan: "...staff should be trained to consistently follow behavioral intervention plan..." Review on 8/27/21 of the facility's behavior tracking forms from April 2021 - August 2021 for client #1 & #2 revealed: - 1 documented entry by staff #1	V 108		

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V 108	Continued From page 3 - 2 documented entries by staff #5 & #7 - 5/4/21 - physical altercation between client #1 & #2 - July 2021 - 17 documented behaviors - August 2021 - 8 documented behaviors Review on 9/1/21 of an incident reported dated 8/26/21 "...client (#1) went into manic episode. Started by walking towards me with a knife...agitated and throw dishes...broke 3 windows..." signed by staff #5 Observation between 2:02pm - 3:00pm at the facility revealed: - an unlocked floor level cabinet that had 2 kitchen knives with sharp points - a combination lock was attached to a metal piece on the cabinet, however, it was unlocked Observation & record review on 9/1/21 between 11:11am - 11:30am the Quality Improvement Director gave tour of the facility which revealed the following: - the cabinet remained unlocked with the same 2 kitchen knives - same treatment plans & behavior support plans in client #1 & #2's records During interview on 8/24/21, 8/27/21 & 9/1/21 staff #1 reported: - worked second shift from 3pm to 11pm - worked 2 years at the facility - worked at the facility the longest besides another staff - client #1 & #2 lived at the facility a year together - both had a lot of issues between the two since client #1 was admitted - a lot of days they physically fought each other - within last 2 weeks: a crockpot was thrown,	V 108		

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chairs thrown at each other, client #1 threw a box of chalk at client #2
- sharps were not locked & was not told they had to be
- staff does not have the combination to the lock where the knives were stored
- never known any of the clients to take the lock off
- client #1 might know how to remove the lock from the cabinet
- she always completed behavior tracking logs
- staff were not trained on how to complete the behavior tracking logs, but were given examples on how to complete them

During interview on 8/24/21 & 9/1/21 staff #5 reported:
- worked at the facility for 2 weeks
- the first day on the job client #1 threw a crockpot at client #2
- the crockpot did not hit client #2
- client #1 & #2 fought on the first day she worked
- both have "extreme" behaviors
- client #1 "needed to be institutionalized"
- last week client #1 had a behavior. She (staff) wiped down the kitchen table. Client #1 washed the dishes. Client #2 yelled client #1 had a knife. Staff #8 was outside. It was long kitchen knife with a sharp blade. She could not tell if client #1 came toward her to give her the knife or to hurt her (staff #5) with the knife. Client #1 had a look on her face that made it look like "she was coming for me." She told client #1 to run outside and she (staff #5) ran outside. She contacted the Director of Operations/QP. She instructed her to go back inside and offer coffee. She told her client #1 had broke the coffee jar, was throwing pots and pans & had a knife.
- there was nothing in the clients' behavior

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support plans about knives being locked
- there was a combination lock on the cabinet with the knives
- staff #1 informed her to leave the cabinet unlocked because staff didn't know the combination to the lock
- the clients' behavior support plans/treatment plans during orientation
- staff were to read the plans and ask the Director of Operations/QP any questions
- she would not call this training

During interview on 8/24/21 staff #7 reported:
- had worked at the facility for a month
- client #1 & #2 were aggressive towards one another & argued a lot
- there was one physical altercation between the two since she worked there
- does not feel comfortable working alone due to client #1 & #2's agitation & physical aggression towards each other
- both clients have behavior support plans
- during orientation, the Director of Operations/QP gave staff a list of each clients' behaviors
- she was not provided training on the behavior/treatment plans
- no one sat down with her and individually went through the clients' treatment plans or behavior support plans

During interview on 9/1/21 staff #8 reported:
- started work in August 2021 on second shift from 4:30pm - 10pm
- verified the 8/26/21 incident. Client #1 "went crazy"
- she does not complete behavior tracking logs
- worked with staff #5 & thought she completed the behavior tracking logs
- during orientation, the Director of

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V 108	Continued From page 6 Operations/QP requested she read the clients' behavior plans and ask questions During interview on 8/24/21 client #2's guardian reported: - client #2 had disruptive behaviors, however, staff were supposed to be trained to address the behaviors During interview on 8/25/21 QP#2 reported: - started work 8/9/21 - he did not receive any training on the clients' behavior support plans & treatment plans - he read the clients' behavior support plans & treatment plans on his own at the facility - was not sure what ETO (Exclusionary Time Out) in client #2's behavior support plan - he read something about knives in one of the client's behavior support plans - it was important to be trained on the clients' treatment plans and behavior support plans - it could help decrease clients' behaviors & be aware of their triggers - had not reviewed any of the clients' behavior tracking logs During interview on 8/27/21 & 9/1/21 the Director of Operations/QP reported: - she went over "key elements" in the clients' behavior support plans with staff during orientation - reviewed the clients' likes and dislikes, what triggered the clients - it was staffs' responsibility to review the behavior support plans and ask questions for discussion - she would have QP#2 to review the clients' treatment plan goals & behavior support plans with staff again - the Quality Improvement Director was	V 108		

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V 108	Continued From page 7 responsible for the behavior tracking logs - the Quality Improvement Director informed staff on how to complete the behavior tracking logs - sharps are locked in a cabinet - staff knew the combination to the lock, it was the same as the combination to the medications - client #1 had something in her behavior support plan about knives - client #1 had a history of cooking and staff needed to assist her with knives - there was nothing about knives in client #2's behavior support plan - during further interview, she was not aware knives being secured was in client #2's behavior support plan - each time a treatment plan or behavior support plan was updated, a copy should be placed in the clients' record at the facility During interview on 9/1/21 the Quality Improvement Director reported: - the knives at the facility were not locked - there was no history that clients grabbed knives or scissors to hurt themselves or others - staff recognized signs of behaviors and redirected the clients' behaviors - during further interview, he was not aware knives being secured was in client #2's behavior support plan - the Director of Operations/QP provided training on the clients' treatment plans and behavior support plans - he provided the annual training on the clients' plans - the behavior support plans were also reviewed during monthly meetings - the Director of Operations/QP provided training on the completion of the behavior tracking logs	V 108		

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V 108	Continued From page 8 This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.	V 109		

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V 109	Continued From page 9 (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on observation, record review and interview, 2 of 3 audited Qualified Professionals (QP) (Director of Operations/ (QP) & Quality Improvement Director) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: A. Cross-reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108). Based on observation, record review and interview the facility failed to ensure 3 of 5 audited staff (staff #1, #7 & Qualified Professional (QP#2)) were trained in goals and strategies as identified in the treatment plans. B. Cross-reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112). Based on observation, record review and interview the facility failed to develop & implement goals and strategies to meet the needs for 2 of 3 audited clients (#1 & #2) & failed to implement goals & strategies for 1 of 3 audited clients (#3). C. Cross-reference: 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (V114). Based on record review and interview the facility	V 109		

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failed to ensure fire and disaster drills were completed quarterly & on each shift.

D. Cross-reference: 10A NCAC 27G 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118). Based on observation, record review and interview the facility failed to ensure medications were administered on the written order of a physician and MARs were kept current for 2 of 3 audited clients (#2 & #3).

E. Cross-reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V121). Based on record review and interview the facility failed to ensure 1 of 1 audited client (#2) who was taking psychotropic medications for more than 6 months had a drug regimen review every 6 months.

F. Cross-reference: G.S.§131E-256 HEALTH CARE PERSONNEL REGISTRY (V132). Based on record review and interview the facility failed to have evidence an alleged abuse was investigated and failed to report within five working days to Health Care Personnel Registry (HCPR).

G. Cross-reference: 10A NCAC 27G .5603 OPERATIONS (V291). Based on observation, record review and interview the facility failed to coordinate with other qualified professionals who are responsible for 2 of 3 audited clients' (#1 & #2) treatment/habilitation.

H. Cross-reference: 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V366). Based on record review and interview the facility failed to implement their own incident reporting policy.

I. Cross-reference: 10A NCAC 27G .0604

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V 109	Continued From page 11 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V367). Based on record review and interview the facility failed to ensure a level II incident report was submitted to the LME/MCO (Local Management Entity and the Managed Care Organization) within 72 hours. J. Cross-reference: 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (V500). Based on record review and interview the facility failed to report allegations of abuse for 1 of 3 audited clients (#2) to the County Department of Social Services (DSS). K. Cross-reference: 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (V736). Based on observation & interview the governing body failed to maintain the facility in a safe, clean, attractive and orderly manner and kept free from offensive odor. L. Cross-reference: 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (V752). Based on observation, record review and interview the facility failed to ensure water temperatures were maintained between 100-116. Review on 9/1/21 of the Director of Operations/ (QP) record revealed: - hire date 6/1/05 - job description: "...arrange, coordinate and monitor services, provide face-to-face therapeutic interventions to recipient and their family, facilitate initial development and ongoing revision of person centered plan, implementation of the consumer's individualized person centered plan, assist staff with training monthly, orientate and supervise employees that provide active	V 109		

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treatment, participate and/or coordinate in treatment plan meeting, keep in close contact with families and people involved in the consumer's care to encourage and promote family involvement..."

During interview on 8/27/21 the Director of Operations/QP reported:
- she did not work any shifts at the facility
- she filled in when there was an absent QP
- a QP was terminated January 2021
- another QP was hired either March 2021 or April 2021 and worked a month
- this QP quit without notice & moved to another State
- filled in as QP until August 9, 2021 when QP#2 was hired
- assisted with completion of treatment plans, accuracy of medication administration records (MAR), monthly meetings & orientation of new staff

Review on 9/1/21 of the Quality Improvement Director's record revealed:
- hire date 11/1/11
- job description: "...oversight for quality improvement program areas such as incident management system, continuous quality improvement, regulatory compliance, policy reviews...work closely with Director of Operations, completion of audit process for all charts, assist with coordination and provide trainings as needed...overall operational direction of the organization..."

During interview on 9/1/21 the Quality Improvement Director reported:
- does not provide direct care services like ADL's (activities of daily living)
- does not participate in treatment team

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V 109	Continued From page 13 meetings - does not work on goals with the clients - does not take clients to appointments (last 2 physician appointments for client #2 he attended due to her behaviors) - he currently filled in as QP because the facility was absent a QP - as the Quality Improvement Director, he monitored the condition of the facility, periodically reviewed MARs & annual or as needed, abuse/neglect training - the oversight of the facility would be the QP's job - the QP monitored the entire facility like: the physical environment, bedrooms and bathrooms - he did not supervise any staff Review on 9/2/21 of the facility's Plan of Protection dated 9/2/21 written by the Quality Improvement Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? [client #1] will be assigned 1:1 staffing effective immediately during waking hours. This will prevent client behaviors between the 2 peers. The [QP#2] will in-service staff on [client #2] and [client #1] behavior support plans effective today, and separation strategies to prevent future confrontations. [QP#2] will in-service all assigned staff effective immediately on incident reporting and documentation of behavior data on log sheets. The Director of Operations/QP has requested and emergency team meeting to address the behavior concerns with [client #1] and [client #2]. The Care Coordinators and guardian were notified. The ISP (individualized support plan) will be updated. [Client #1 will move on 8/13/21 or before Describe your plans to make sure the above happens. Quality Management Director will monitor to ensure the actions are in place and	V 109		

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V 109	Continued From page 14 documented accordingly." This facility served clients with Autism, Intellectual Developmental Disorder, Bipolar, Mood Disorder, Psychotic Disorder; Schizoaffective Disorder, Intermittent Explosive Disorder & Type II Diabetes. Client #1 was admitted to the facility a year ago. She and client #2 were verbally & physically aggressive towards one another. The altercations between the two have resulted in client #2 with a black eye and sutures. Client #1 & #2's treatment plans didn't have goals or strategies to address the aggression between the two clients. Both had behavior support plans, however, staff reported they were not trained to deal with the aggression between client #1 & #2. Behavior tracking logs were not completed consistently as recommended in the behavior support plans, therefore, the Director of Operations/QP & the Quality Improvement Director reported the treatment plans were not updated. Client #2 was allegedly hit in the face with a frying pan by a former staff & the Quality Improvement Director was made aware of the incident. He did not complete an incident report, investigate the allegations or report the incident to the LME/MCO and DSS. Clients did not receive their medications as ordered by their physician & MARs were not accurate. Staff did not initial if client #2 received medications for an entire day on 8/24/21. There were no blood sugars documented the entire month of August 2021 for client #2. Readings in client #2's glucometer were missing days. The water temperatures were not maintained between 100-116. Upon entry to the facility, it had an offensive odor & a surplus of gnats throughout the facility. The clients' bedrooms had clothes on their beds, the floor and dressers. Client #2's bed frame was broken which caused the mattress to hang off the bed, several	V 109		

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V 109	Continued From page 15 depends with feces were on her bathroom floor, feces were in her toilet and around the toilet. There was a missing vent in client #1 & #3's bathroom which left a hole in the floor. The Director of Operations/QP & the Quality Improvement Director were responsible for the oversight of the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facilty is out of compliance beyond the 23rd day.	V 109		
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	V 112		

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V 112	Continued From page 16 provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to develop & implement goals and strategies to meet the needs for 2 of 3 audited clients (#1 & #2) & failed to implement goals & strategies for 1 of 3 audited clients (#3). The findings are: Review on 8/25/21 of client #1's record revealed: - admitted 7/16/20 - diagnoses of Autism, Intellectual Developmental Disorder (IDD), Bipolar, hearing loss, & nonverbal - treatment plan dated 4/13/21: goals: personal hygiene goals, independent living skills & communication goals: "...when [client #1] becomes upset or something does not go her way she exhibits a multitude of behaviors...important to follow behavior support plan...picking up and throwing furniture and televisions...threatened harm to herself and staff and other consumers..." - a behavior support plan dated 9/2/20: "...prevention: respond best to firm limits, a structured environment, minimize changes to [client #1's] schedule...assist her in a cup of coffee...will be given a key to the area where the knives are kept...staff will always be available to assist [client #1] in obtaining access to a knife	V 112		

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V 112	Continued From page 17 during appropriate times...all episodes of challenging behavior will be documented on the behavior tracking form" signed by Director of Operations/Qualified Professional (QP) & Quality Improvement Director - no goals or strategies to address verbal & physical aggression between client #1 & #2 Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) - a treatment plan dated 8/1/21: goals: socialization skills, independent living skills, budgeting & physical aggression: "...because she does not get her way...exhibits extreme verbal and physical aggression...remove her from the environment, encouraged to discuss what is bothering her...has a behavior support plan in place and according to her treatment team and according to the residential staff should make use of [client #2's] behavioral plan which addresses verbal aggression, physical aggression... - a behavior support plan with no date but goals are to be met by 8/15/21: "historically, [client #2] has threatened to harm others with a knife. That being the case, knives at the group home will be kept in a secured area and will be used under staff supervision ...if [client #2] exhibits aggressive behavior staff will initially ask her to leave for - exclusionary time out (ETO)...all episodes of challenging behavior will be documented on the behavior tracking form..." - no goals or strategies to address verbal & physical aggression between client #1 & #2 Review on 8/27/21 of a medical consultation	V 112		

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dated 4/15/21 for client #2 revealed:
- "...patient presents with staff. The combative behavior continues. She has a black-eye due to an altercation with a peer (client #1)..."

Review on 8/20/21 of client #3's record revealed:
- admitted 6/25/18
- diagnoses of: Autistic Spectrum Disorder, Profound Intellectual Developmental Disorder, Cerebral Palsy, Mood Disorder, history of Dyslipidemia, Hypertension, Chronic Constipation and Seizure Disorder
- a treatment plan dated 10/1/20: encouraged to greet others daily, socialization, exercise daily & independent living skills (wipe mouth, wash hands)

Review on 8/27/21 of the facility's behavior tracking forms from April 2021 - August 2021 for client #1 & #2 revealed:
- May 2021 - 1 physical altercation
- July 2021 - 1 physical altercation
- August 2021 - 2 physical altercation s

Review on 8/27/21 of the facility's incident report log regarding an incident which occurred at the day program revealed:
- "8/9/21...to whom it may concern [client #1] hit [client #2] with time clock. [Client #2] went to hit [client #1] back but staff intervened..." signed by the day program Qualified Professional (QP)

Observation & interview with client #2 on 8/13/21 between 1:42pm - 1:49 pm of client #2 at the day program revealed:
- right side of client #2's forehead covered with a white bandage
- spoke in broken sentences
- "get me out ...[client #2] dangerous" then pointed at her forehead, "a clock"

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V 112	Continued From page 19 - a time clock was on a shelf outside the front office window at the entrance of the day program During interview on 8/13/21 the day program QP reported: - was not sure if client #1 and #2 had a conflict the morning of 8/9/21 prior to the arrival at the day program - as soon as they arrived to the day program, client #1 grabbed the time clock, threw it and hit client #2 in the head - it happened so fast, however, staff were able to separate the two - they were kept separate at the day program by their 1:1 - no physical aggression between the two at the day program Review on 9/1/21 of the facility's incident report log revealed: - 8/26/21 - "Client (#1) went into manic episode. Started by walking towards me with a knife, proceeded to get agitated and throw dishes. Broke 3 window and coffee table. Threw fire extinguisher, threw dish water, threw coffee container (glass) on the ground..." signed by staff #5 Observation & interview on 8/27/21 with an office staff between 2:00pm - 3:00pm at the facility revealed: - an unlocked floor level cabinet that had 2 kitchen knives with sharp points - a combination lock was attached to a metal piece on the cabinet, however, it was unlocked - 3 kitchen windows broken out covered up with tall kitchen drawstring bags - office staff reported maintenance was in route to board up windows until new windows could be ordered	V 112		

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V 112	Continued From page 20 Observation on 9/1/21 between 11:11am - 11:30am the Quality Improvement Director gave tour of the facility which revealed the following: - the cabinet remained unlocked with the same 2 kitchen knives During interview on 8/24/21 staff #1 reported: - worked for 2 years at the facility on second shift from 3pm - 11pm - client #1 & #2 lived at the facility about a year together - they had a lot of behavioral issues - a lot of days client #1 & #2 fought - both have thrown kitchen chairs at each other - client #2 was the aggressor - client #2 talked a lot - client #1 was nonverbal & hearing impaired but "felt a person's mood" - within the last 2 weeks: a crockpot was thrown, chairs were thrown at each other and client #1 threw a box of chalk at client #2 - no injuries witnessed - it could be hard to get client #1 to calm down - she used a firm voice & redirected client #1 & #2's behaviors - the behavior plans did not explain how to handle client #1 & #2's aggressive behaviors between each other - staff had to "figure it out for themselves" - sharps were not locked & she was not told they had to be locked - staff does not have the combination to the lock where the knives were stored During interview on 8/24/21 staff #5 reported: - worked at the facility for 2 weeks on second shift from 3pm - 11pm - the first day she worked client #1 threw a crockpot at client #2. The crockpot did not hit	V 112		

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client #2. Both fought that day.
- both have aggressive behaviors
- last week client #1 had a behavior. She (staff) wiped down the kitchen table. Client #1 washed the dishes. Client #2 yelled client #1 had a knife. Staff #8 was outside. It was long kitchen knife with a sharp blade. She could not tell if client #1 came toward her to give her the knife or to hurt her (staff #5) with the knife. Client #1 had a look on her face that made it look like "she was coming for me." She told client #1 to run outside and she (staff #5) ran outside. She contacted the Director of Operations/QP. She instructed her to go back inside and offer coffee. She told her client #1 had broke the coffee jar, was throwing pots and pans & had a knife.
- there was nothing in the clients' behavior support plans about knives being locked
- there was a combination lock on the cabinet with the knives
- staff #1 informed her to leave the cabinet unlocked because staff didn't know the combination to the lock
- client #2 liked certain staff
- she was new & client #2 did not listen to her
- she sent client #2 to her bedroom when she was upset
- it was difficult to redirect client #1 because she was nonverbal
- the behavior plans did not explain how to handle client #1 & #2's aggressive behaviors between each other

During interview 9/1/21 on staff #8 reported:
- started work in August 2021 on second shift from 4:30pm - 10pm
- verified the 8/26/21 incident. Client #1 "went crazy"
- she does not complete behavior tracking logs
- worked with staff #5 & thought she completed

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V 112	Continued From page 22 the behavior tracking logs During interview on 8/24/21 staff #7 reported: - had worked at the facility a month from 11pm - 7am - client #1 & #2 were aggressive towards one another - one of them was supposed to move out of the facility but she was unsure which one - client #1 & #2 argued a lot - client #1 & 2 had one physical altercation since she had been at the facility. She was getting off shift and client #2 pointed at client #1. Then client #1 threw a pillow at client #2. Client #1 was deaf and nonverbal. It was hard to redirect her during this incident. Client #1 was "a big girl" and moved her out of the way. - could usually redirect client #1 & send client #2 to her room to calm down - didn't feel comfortable being alone with client #1 & #2 due to the agitation & physical aggression toward each other - does not work on any goals with the clients - the day program worked with the clients on their goals During interview on 8/24/21 client #1's guardian reported: - guardian for 6 years - another client at the facility attacked client #1 - she didn't blame client #1 for protecting herself - the other female (client #2) taunted and pointed at client #1 - client #1 was nonverbal and hearing impaired, however could read lips - client #1 picked up a clock and hit the other client (#2) and she required stitches - client #1's behaviors were not getting better - she had not been in the facility long	V 112		

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V 112	Continued From page 23 - Quality Improvement Director called August 12, 2021 to discuss moving client #1 - client #1 & #2 were not getting along - she had not heard back from him - a treatment team meeting had not been discussed to address the behaviors between the two clients - a team meeting could be beneficial to address the clients' behaviors - would like to know why client #1 had to be moved if she was not the aggressor - client #1 needed the same staff - the reasons for her behaviors could be the high turnover of staff During interview on 8/30/21 client #2's Care Coordinator reported: - care coordinator since March 2021 - there had been no issues with client #2 getting along with her housemates - if she was not getting along with housemates, he would like to know - a team meeting could have happened to put strategies in place - strategies could be to increase monitoring with additional staff - he spoke with the Director of Operations/QP on 8/17/21 to see how client #2 was doing - she informed him of a medication being increased due to client #2's behaviors - he was concerned and asked if funds for additional staff were needed - the Director of Operations/QP said additional funds were not needed as they hired a new QP that filled in at the facility During interview on 8/25/21 QP#2 reported: - started 8/9/21 at the facility - he did not work full shifts at the facility - he had a sister facility he also provided	V 112		

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monitoring to
- the first day he worked at the facility, client #1 hit client #2
- he was able to deescalate before it went any further
- client #1 seemed to be the aggressor
- he requested staff to monitor signs of agitation & engage client #1 in something

During interview on 8/27/21 the Director of Operations/QP reported:
- client #1 & #2 were not "compatible"
- verified the 4/15/21 medical consult
- spoke with client #1's guardian and she was in favor with her being relocated to a sister facility
- no treatment team meetings to address client #1 & #2's behaviors
- the Care Coordinator called monthly and was made aware of the clients' behaviors
- staff were to keep their eye sight on both clients at all times, keep them deescalated, give client #1 a cup of coffee & redirect client #2
- QP#2 will work from 3:30pm - 7:30pm on second shift
- during staff meetings, it was discussed staff needed to complete the behavior tracking logs
- it helped to update the behavior support plans/treatment plans if behavior tracking logs were completed consistently

During interview on 8/13/21 & 9/1/21 the Quality Improvement Director reported:
- client #1 & #2 do not get along
- waiting for the Local Management Entity/Managed Care Organization's approval to relocate client #1 to a sister facility
- Monday (8/9/21) client #1 hit client #2 with a time clock and client #2 required 4 - 5 sutures
- Wednesday (8/11/21) client #1 threw a pot to hit client #2 but it hit a staff in the face

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V 112	Continued From page 25 - client #2 used to be the aggressor but client #1 fought back now - client #1's behaviors have increased since admitted to the facility with client #2 - both have behavior plans to address their behaviors - client #2's Depakote had been adjusted due to the high frequency of behaviors between she and client #1 - hired QP#2 as additional staff to work 3pm - 11pm - staff were requested to keep them both separated, get in front of client #1 & redirect client #2 to her bedroom, ignore client #2's behaviors, direct positive attention to questions and follow the clients' behavior support plans - staff did not document all client #1 & #2's behaviors on the behavior tracking logs - the completion of the behavior tracking forms was an issue that QP#2 would correct - the behavior support plans & treatment plans could be updated to address client #1 & #2's aggression between each other This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff	V 114		

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V 114	Continued From page 26 and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were completed quarterly & on each shift. The findings are: Review on 9/1/21 of the facility's fire and disaster log revealed: - one documented fire & disaster drill conducted on 8/23/21 - no documentation of fire & disaster drills for the last year During interview on 9/1/21 staff #1 reported: - had worked at the facility since 2019 - there had been no QP (Qualified Professional) since early 2021 - the QP would send a schedule of when fire & disaster drills would be completed - she had not completed any drills since she had been at the facility - for a fire drill, she would have the clients to meet outside in the yard - tornado drill they would get in a closet During interview on 8/20/21 the Director of Operations/QP reported: - the QP was responsible for ensuring fire and	V 114		

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V 114	Continued From page 27 disaster drills were completed - the prior QP worked a month in March or April 2021 - staff have not been able to locate the facility's fire and disaster drill logs since she left - QP#2 started August 2021 & has resumed the fire and disaster drills During interview on 9/1/21 the Quality Improvement Director reported: - the QP was responsible for fire & disaster drills being done - QP#2 completed the 8/23/21 drill This deficiency constitutes a re-cited deficiency This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 days.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION 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.	V 118		

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V 118	Continued From page 28 (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, record review and interview the facility failed to ensure medications were administered on the written order of a physician and MARs were kept current for 2 of 3 audited clients (#2 & #3). The findings are: A. Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) - FL2 dated 3/3/21 check blood sugars daily Review on 8/20/21 of the following physician	V 118		

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V 118	Continued From page 29 orders for client #2 revealed: - 12/10/20 - Levothyroxine Sodium 50mcg (microgram) daily (hypothyroidism) 12/2/20 - Duloxetine 30 mg (milligram) daily (depression) 4/15/21 - Quetiapine Fumarate 200mg twice a day (Schizophrenia) 2/22/21 -Metformin 500mg three times a day (Diabetes) 8/3/21 - Divalproex 1000mg QHS (bedtime) (bipolar) Observation on 8/20/21 at 3:40pm of client #2's medications revealed: - Divalproex 2 500mg QHS - dispensed on 8/12/21 Observation on 9/1/21 between 11:21am - 11:22am of some of client #2's blood sugar readings in the glucometer revealed: - 8/24/21 - 143 - 8/25/21 - 137 - 8/26/21 - 148 - no reading for 8/27/21 - 8/28/21 - 168 - 8/29/21 - 159 - 8/30/21 - 147 - no reading for 8/31/21 Record review on 8/20/21 & 9/1/21 of client #2's August MAR 2021 revealed: - no documentation of blood sugar checks for the entire month - Divalproex 500mg at QHS - no staff initials documented on 8/24/21 for the following medications: Levothyroxine Sodium Duloxetine Quetiapine Fumarate Metformin	V 118		

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V 118	Continued From page 30 Divalproex During interview on 8/30/21 the pharmacy technician reported: - received physician order for Divalproex 1000mg QHS on 8/3/21 for client #2, however, it could not be filled until the previous Divalproex was discontinued - she contacted the physician's office on 8/3/21 and left a message - on 8/11/21 she left another message & requested the discontinue order - the discontinue order was received on 8/12/21 - the facility started with their pharmacy on 8/1/21 because the previous pharmacy closed During interview on 8/20/21 the Director of Operations/Qualified Professional (QP) reported: - switched pharmacy on 8/1/21 - was not sure if the previous pharmacy sent the 8/3/21 Divalproex prescription to the new pharmacy - the documentation error for Divalproex was missed During interview on 8/25/21 QP#2 reported: - started 8/9/21 at the facility - he observed missing staff initials on several days - he contacted staff and made them aware of the medication errors - medications were administered but staff forgot to initial During interview on 9/1/21 the Quality Improvement Director reported: - no documentation of the August 2021 blood sugar checks - the previous pharmacy developed a blood	V 118		

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V 118	Continued From page 31	V 118		

sugar log sheet for staff to document blood sugars
- they started with a new pharmacy on 8/1/21
- he would inform staff to document blood sugar checks on the back of the MAR

B. Review on 8/20/21 of client #3's record revealed:
- admitted 6/25/18
- diagnoses of: Autistic Spectrum Disorder; Profound Intellectual Developmental Disorder, Cerebral Palsy, Mood Disorder, history of Dyslipidemia, Hypertension, Chronic Constipation and Seizure Disorder
- a physician's order dated 6/28/21 Divalproex sprinkles 125mg 6 twice a day on food

Review on 8/20/21 of client #3's July 2021 & August 2021 MAR revealed:
- Divalproex sprinkle three 125mg capsules twice a day on food

Observation on 8/20/21 at 2:32pm of client #3's medications revealed:
- Divalproex sprinkles three 125mg twice a day

During interview on 8/30/21 the pharmacy technician reported:
- a physician order dated 6/22/21 three 125mg sprinkles twice day was on file
- received a physician's order dated 8/24/21 for 6 capsules twice a day but it was discontinued on 8/26/21 & back to 3 twice a day

During interview on 8/27/21 the Director of Operations/QP:
- she & the Quality Improvement Director rotated who visited the facility once a week
- they checked MARs while at the facility
- she & the Quality Improvement Director

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V 118	Continued From page 32 ensured MARs & medications were accurate During interview on 8/20/21 the Quality Improvement Director reported: - MARs should be reviewed at least twice a week - QP#2 will have to "stay on top" of the MARs 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 constitutes a re-cited deficiency This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 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.	V 121		

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V 121	Continued From page 33 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 1 audited client (#2) who was taking psychotropic medications for more than 6 months had a drug regimen review every 6 months. The findings are: Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) - a physician's order dated 6/14/20: Depakote 500 milligrams at bedtime (treat bipolar) - no documentation of a drug regimen review During interview on 8/27/21 the Director of Operations/Qualified Professional (QP) reported: - they changed pharmacist the end of July 2021 - she was not able to locate the drug regimen reviews completed by the pharmacist During interview on 9/1/21 the Quality Improvement Director reported: - the pharmacist said he gave the Director of Operations/QP the last 3 completed drug regimens - the Director of Operations/QP said the pharmacist didn't give her any drug regimen reviews - there were no documented drug regimen reviews for the last year - the QP ensured drug regimen reviews were completed	V 121		

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V 121	Continued From page 34 This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 days.	V 121		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all	V 132		

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V 132	Continued From page 35 investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have evidence an alleged abuse was investigated and failed to report within five working days to Health Care Personnel Registry (HCPR). The findings are: Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) During interview on 8/23/21 a HCPR representative reported: - during a separate investigation at the facility, staff #1 alleged former staff (FS #6) hit client #2 in the face with a frying pan - she (HCPR) informed the Quality Improvement Director & requested he complete an internal investigation	V 132		

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V 132	Continued From page 36 - their agency still had not received the investigation During interview on 8/24/21 staff #1 reported: - a year ago, she (staff #1) witnessed client #2 spit in FS#6's face - it happened so fast with client #2 having a behavior - FS#6 prepared dinner - FS#6 reacted by "accidentally" hitting client #2 in the face with the frying pan - there were no bruises to client #2's face - FS#6 said she would write up an incident report - she did not report the incident to anybody because she thought FS#6 wrote an incident report - she informed a lady that worked for the State (HCPR) about the incident - did not recall the lady's name - management had not asked her about the incident During interview on 8/27/21 the Director of Operations/Qualified Professional (QP) reported: - she was not aware FS#6 allegedly hit client #2 in the face with a pan - all allegations of abuse should be reported During interview on 9/1/21 the Quality Improvement Director reported: - HCPR informed him 2 months ago during a separate investigation that FS#6 allegedly hit client #2 with a frying pan - the incident allegedly occurred in January 2021 - FS#6 was terminated in January 2021 due to another incident where she hit client #2 with a broom - he asked staff #1 about the frying pan	V 132		

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V 132	Continued From page 37 incident - staff #1 said FS#6 did not intentionally hit client #2 but accidentally hit her with a frying pan - there were no injuries - staff #1 thought FS#6 completed an incident report therefore she didn't tell anyone about the incident - client #2 would not recall what happened January 2021 - FS#6 was already terminated, therefore she could not be interviewed - HCPR representative said "I'm just throwing this out to you." - she did not give clear information the incident had to be reported to their agency This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 days.	V 132		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing	V 291		

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V 291	Continued From page 38 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, record review and interview the facility failed to coordinate with other qualified professionals who are responsible for 2 of 3 audited clients' (#1 & #2) treatment/habilitation. The findings are: A. Review on 8/25/21 of client #1's record revealed: - admitted 7/16/20 - diagnoses of Autism, Intellectual Developmental Disorder (IDD), Bipolar, hearing loss, & nonverbal Observation on 8/13/21 between 1:42pm - 1:49pm at the day program revealed: - client #1 in the classroom with a 1:1 - she smiled and waved - lower right eye was swollen, puffy, red and purple Review on 8/27/21 of an incident report dated	V 291		

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V 291	Continued From page 39 8/12/21 for client #1 revealed: - "...after being in her room all night, came out at 7am with a black eye as if she was hit in the eye. I did have a struggle with trying to get her in the room the night before but nothing transpired that could cause a black eye. She did fall when I was trying to get her towards her room but fell on her back..." written by staff #2 Attempted interview on 8/26/21 with staff #2: voicemail was not setup and message could not be left During interview on 8/25/21 the Director of Operations/Qualified Professional (QP) & the Quality Improvement Director reported: - they were unsure what caused client #1's eye to be swollen - no medical attention was sought for client #1's eye - the Quality Improvement Director said the injury was not in the eye cavity - he further stated it looked as if she rubbed her eye wrong & it did not affect her vision - even though client #1 was nonverbal, she would have pointed at the eye if it hurt - neither had medical background but stated they knew their clients B. Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) Observation & interview on 8/13/21 with client #2 between 1:35pm & 1:49 pm at the day program	V 291		

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V 291	Continued From page 40 revealed: - right side of client #2's forehead covered with a white bandage - spoke in broken sentences - "get me out...[client #2] dangerous" then pointed at her forehead, "a clock" - a time clock was on a shelf outside the front office window at the entrance of the day program Review on 8/27/21 of the facility's incident report log regarding an incident which occurred at the day program revealed: - "8/9/21...to whom it may concern [client #1] hit [client #2] with time clock. [client #2] went to hit [client #1] back but staff intervened..." signed by the day program QP During interview on 8/30/21 client #2's Care Coordinator reported: - care coordinator since March 2021 - there had been no issues with client #2 getting along with her housemates - if she was not getting along with housemates, he would like to know - a team meeting could have happened to put strategies in place - strategies could be to increase monitoring with additional staff - he spoke with the Director of Operations/QP on 8/17/21 to see how client #2 was doing - she informed him of a medication being increased due to her behaviors - he was concerned and asked if funds for additional staff were needed - the Director of Operations/QP said additional funds were not needed as they hired a new QP that filled in at the facility During interview on 9/1/21 the Director of Operations/QP reported:	V 291		

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V 291	Continued From page 41 - she spoke with client #2's care coordinator in August 2021 - he informed her he was looking into services to assist with client #2's behaviors - she explained they have 2 people on 2nd shift - additional staff was not discussed During interview on 9/1/21 the Quality Improvement Director reported: - client #2's care coordinator was new and did not understand her behaviors - they would take additional staff, however the medication increase was needed - the QP's kept the guardians and care coordinators informed about the care of the clients - it was the QP's responsibility to inform the guardians & care coordinators about the clients' care This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) 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;	V 366		

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V 366	Continued From page 42	V 366		

(3) developing and implementing corrective measures according to provider specified 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

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were not responsible for the client's direct care or with direct professional oversight of the client's 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

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V 366	Continued From page 44 provider; (D) the Department; (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 record review and interview the facility failed to implement their own incident reporting policy. The findings are: Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) Refer to V132 regarding details of the incident that occurred at the facility - Former staff #6 allegedly hit client #2 in the face with a frying pan During interview on 9/1/21 the Quality Improvement Director reported: - he did not complete an incident report This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 days.	V 366		

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V 367	Continued From page 45	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		

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V 367	Continued From page 46 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		

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V 367	Continued From page 47 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 record review and interview the facility failed to ensure a level II incident report was submitted to the LME/MCO (Local Management Entity and the Managed Care Organization) within 72 hours. The findings are: Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) Refer to V132 regarding details of the incident that occurred at the facility - Former staff #6 allegedly hit client #2 in the face with a frying pan During interview on 9/1/21 the Quality Improvement Director reported: - he did not complete an incident report This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 days.	V 367		

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V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of	V 500		

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V 500	Continued From page 49 restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interview the facility failed to report allegations of abuse for 1 of 3 audited clients (#2) to the County Department of Social Services (DSS). The findings are: Review on 8/20/21 of client #2's record revealed: - admitted 6/15/17 - diagnoses of Mild Intellectual Disorder, Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Hypertension & Methicillin-Resistant Staphylococcus Aureus (MRSA) Refer to V132 regarding details of the incident that occurred at the facility	V 500		

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V 500	Continued From page 50 - Former staff #6 allegedly hit client #2 in the face with a frying pan During interview on 9/1/21 the Quality Improvement Director reported: - he did not report to DSS This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 days.	V 500		
V 531	27E .0105(a) Client Rights - Protective Devices 10A NCAC 27E .0105 PROTECTIVE DEVICES (a) Whenever a protective device is utilized for a client, the governing body shall develop and implement policy to ensure that: (1) the necessity for the protective device has been assessed and the device is applied by a facility employee who has been trained and has demonstrated competence in the utilization of protective devices; (2) the use of positive and less restrictive alternatives have been reviewed and documented and the protective device selected is the appropriate measure; (3) the client is frequently observed and provided opportunities for toileting, exercise, etc. as needed. When a protective device limits the client's freedom of movement, the client shall be observed at least every hour. Whenever the client is restrained and subject to injury by another client, a facility employee shall remain present with the client continuously. Observations and interventions shall be documented in the client record;	V 531		

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V 531	Continued From page 51 (4) protective devices are cleaned at regular intervals; and (5) for facilities operated by or under contract with an area program, the utilization of protective devices in the treatment/habilitation plan shall be subject to review by the Client Rights Committee, as required in 10A NCAC 27G .0504. Copies of this Rule and other pertinent rules are published as Division publication RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES, APSM 30-1,and may be purchased at a cost of five dollars and seventy-five cents ($5.75) per copy. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a protective device was assessed and applied by a facility employee who was trained and demonstrated competence in the utilization of a protective device for 1 of 3 audited clients (#3). The findings are: Review on 8/20/21 of client #3's record revealed: - admitted 6/25/18 - - diagnoses of: Autistic Spectrum Disorder, Profound Intellectual Developmental Disorder, Cerebral Palsy, Mood Disorder, history of Dyslipidemia, Hypertension, Chronic Constipation and Seizure Disorder - a treatment plan dated 10/1/20: "she displays self-injurious behaviors...sit beside her and rub her arms..." - no documentation for the use of a helmet Observation on 9/1/21 at 11:10am revealed a blue helmet with holes similar to a bike helmet on	V 531		

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V 531	Continued From page 52 client #3's dresser During interview on 9/1/21 staff #1 reported: - client #3 had a helmet due to head banging - a staff at the day program informed her client #3 had a helmet at the facility - found the helmet last year in client #3's closet at the facility - if she showed signs of head banging she would put the helmet on - couldn't give time frame of how often she used the helmet - the straps on the helmet became loose a few days ago - she did not know how to tightened the straps - she tied the straps together to keep the helmet on her head - the helmet calmed the head banging - a month ago she had to get stitches due to head banging During interview on 9/1/21 staff #5 reported: - worked at the facility for 2 weeks - client #3 banged her head if she did not get her way - no injuries - she (staff #5) put the helmet on her head - no one in management requested she put the helmet on client #3 - client #3 does not like to wear the helmet - she stopped banging her head when the helmet was on her head During interview on 9/1/21 staff #8 reported: - started work in August 2021 - client #3 sometimes wore a helmet to prevent head banging During interview on 9/2/21 the Quality Improvement Director reported:	V 531		

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V 531	Continued From page 53 - client #3 should not be wearing a helmet - it was not part of her treatment plan - the helmet came with her from a previous provider - the helmet should not be used due to it being a restrictive intervention - a physician's order was needed to use the helmet - it was not approved in a behavior support plan - the facility's environment was modified, padding around chairs & recliner to make it less intrusive - majority of staff were new and only been at the facility a short period of time - there was not enough data to incorporate the helmet into a treatment plan or behavior support plan During interview on 8/25/21 the Director of Operations/Qualified Professional (QP) reported: - the helmet came with client #3 from a previous placement - if client #3 had a behavior of head banging, staff were to sit next to her & rub client #3's back and arm - she would ask client #3's primary physician about the use of a helmet	V 531		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 54 This Rule is not met as evidenced by: Based on observation & interview the governing body failed to maintain the facility in a safe, clean, attractive and orderly manner and kept free from offensive odor. The findings are: Observation on 8/13/21 between 12:45pm - 1:00pm revealed the following: - tour of the facility given by the Quality Improvement Director - entrance of the home had a strong unidentified offensive odor - facility filled with black gnats which covered the kitchen table & counter tops client #1's bedroom - clothes covered the floor and bed client #2's bedroom - gnats covered the entire bedroom - the mattress hung off the bed - clothes covered the bed, the floor and the dresser - bathroom had a strong offensive odor - several depends were filled with feces on the bathroom floor - the toilet was full of feces - feces covered the outside of the toilet client #3's bedroom - strong smell of urine - depends on the client's dresser - the mattress had brown stains throughout - there were clothes unfolded and folded spread out on the floor and dresser Bathroom used by client #1 and client #3	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-048	A. BUILDING: _____ B. WING _____	R 09/02/2021

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V 736	Continued From page 55 - missing vent in the floor which left an opened hole in the floor During interview on 8/27/21 staff #1 reported: - worked at the facility for 2 years - she worked second shift - it was third shift responsibility to clean the facility - clients slept during third shift - third shift staff could mop, sweep and not have to worry about behaviors - she had not seen the Director of Operations/Qualified Professional (QP) or the Quality Improvement Director at the facility During interview on 8/24/21 staff #5 reported: - worked at the facility for 2 weeks - QP#2 took client #2 on an outing one day so staff could clean her bedroom - it was her first day at the facility - she was "appalled" - gnats were all over client #2's bed - urine and feces stained client #2's mattress - 2 - 3 inches of feces stuck to the shower and toilet - it looked as if the bedroom had not been cleaned in years - client #2 liked certain staff and would listen when asked to clean her room - she was new & client #2 did not listen to her - had not seen the Quality Improvement Director at the facility During interview on 8/24/21 staff #7 reported: - worked at the facility a month from 11pm - 8am - the first day there were flies everywhere in the facility - client #2's bed was broken - second shift was responsible for the	V 736		

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V 736	Continued From page 56	V 736		

cleanliness of the facility
- the bathroom vent was missing but replaced a week ago
- since QP#2 started, the facility smelled better
- the gnats were no longer inside the facility

During interview on 8/25/21 QP#2 reported:
- started 8/9/21 at the facility
- gnats covered a banana on the floor
- client #2's bedroom was unacceptable
- feces was throughout her bathroom
- he helped clean the facility

During interview on 8/27/21 the Director of Operations/QP reported:
- she & the Quality Improvement Director rotated visits to the facility once a week
- they checked for cleanliness & if repairs were needed to the facility

During interview on 8/13/21 & 9/1/21 the Quality Improvement Director reported:
- the oversight of the facility was the responsibility of the QP
- the QP monitored the entire facility like the physical environment including the bedrooms & bathrooms
- client #2 had serious behaviors & the condition of her bedroom was behavioral
- staff were to redirect the behaviors
- he visited the facility last Friday (8/6/21) and it was not in that condition
- staff were to assist clients with chores
- if clients could not complete the chores, then staff were to ensure the cleanliness of the facility
- he found out about the gnats prior to coming to the facility on 8/13/21
- staff had contacted pest control and was told nothing could be done about gnats
- pest control requested staff put vinegar all

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V 736	Continued From page 57 over the counter - the vent would be replaced immediately During interview on 8/13/21 Pest Control reported: - nothing could be done about gnats - facility probably had a drainage issue - never heard to pour vinegar on the counters to prevent gnats This deficiency constitutes a re-cited deficiency This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 days.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure water temperatures were maintained between 100-116. The findings are: Observation on 8/13/21 between 12:45pm &	V 752		

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V 752	Continued From page 58 1:00pm revealed the following water temperatures: - the kitchen sink & clients' bathroom sink water temperatures were 128 degrees Review on 9/1/21 of the facility's water temperature log revealed: - 7/3/21 - 103 at 1pm - 8/27/21 - 110 at 7:30pm During interview on 9/1/21 staff #1 reported: - staff checked water temperatures - she could not find the thermometer to check water temperatures but was recently found - the Qualified Professional (QP) ensured the water temperatures were checked During interview on 9/1/21 the Quality Improvement Director reported: - 8/13/21 maintenance was contacted to turn down the water temperatures - the QP ensured the water temperatures were monitored - he recently located the water thermometer at the facility - would ensure staff checked water temperatures daily - he would check the water temperatures three times a week This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type A1 rule violation and must be corrected within 23 days.	V 752		