STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-375	A. BUILDING: _____ B. WING _____	09/15/2021

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V 000	INITIAL COMMENTS An Annual and Complaint Survey was completed on September 15, 2021. The complaint was substantiated (intake #NC00180963). Deficiencies were cited. This facility is licensed for the following service category: - 10A NCAC 27G .2300: Adult Developmental and Vocational Programs for Individuals with Developmental Disabilities	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105		

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V 105	Continued From page 1 can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on interview and record review, the facility staff failed to ensure applicable standards of practice were implemented, utilizing a prevailing level of knowledge, skill and care exercised by other practitioners in the field, including coordinating with other individuals and agencies in the client ' s care.
The findings are:

Review on 9-10-21 of client #1 ' s facility record revealed:
- admitted 8-19-19
- 24 years old
- diagnosed with:
  - Intellectual Disability, Mild
  - Unspecified Impulse Control Disorder
  - Intermittent Explosive Disorder
  - Major Depressive Disorder, Recurrent and Severe with Psychotic Symptoms
  - Morbid Obesity

Review on 9-10-21 of an internal incident report of an event that occurred on 8-19-21 revealed:
- client #1 was involved in an incident that occurred on the premises at approximately 1:00 pm
- client #1 was upset, believing there would be repercussions by her Alternative Family Living provider (AFL) because she had taken and had eaten a piece of cake from the facility refrigerator earlier in the day
- the client ' s agitation increased until her behavior became aggressive toward multiple staff
- intervention by staff to attempt to prevent

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injury to the client and staff, resulted in an altercation where the client fell
- "[client #1] was physically attacking staff [Qualified Professional] and lost her balance causing her to fall striking her head on a table that she was standing by"
- client #1 stated, " ...she ' was fine ' and refused first-aid"

Review on 9-14-21 of a video recording of the event, time/date-stamped 8-19-21 from 1:57 to 1:58 pm revealed:
- the event occurred in a space approximately 10 feet by 10 feet
- in that area was a sofa, two tables and 3 chairs
- there was an exit door with a floor mat/rug in front of the door
- Program Manager was standing with his back to the door
- PM was being struck by client #1
- PM was attempting to block client #1 ' s strikes towards his head
- Qualified Professional (QP) approached client #1 from her left, placing herself between client #1 and the sofa
- after approximately 10 seconds, client #1 directed her aggression toward the QP, and began striking towards her head
- the QP attempted to block client #1 ' s strikes towards her head
- approximately 4 seconds after client #1 began striking QP, client #1 appeared to grab the QP and pull her down
- as the two fell, client #1 struck the table with her head and landed next to a chair, while the QP went down to her knees beside client #1
- QP quickly got up and PM pushed the chair away from client #1

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V 105	Continued From page 4 Interview on 9-13-21 with the QP revealed: - she was in an altercation with client #1 - client #1 fell down - she realized client #1 ' s aggression was directed at her - when they fell, a table was struck and moved - after the fall, she tried to stay away from client #1 in the hope it would help her to become calm again - further interview failed to reveal whether or not the QP inquired if client #1 possibly sustained an injury when she fell; nor did she call client #1 ' s legal guardian immediately after the incident, or before she left work that afternoon, to inform him of the incident with client #1 Interview on 9-10-21 with client #1 regarding the event on 8-19-21 revealed: - the QP tried to restrain her - PM, QP and staff #1 all saw her fall - her face was injured in the fall - "you should ' ve seen my face, it was black and purple" Review on 9-13-21 of pictures texted to the Facility Licensee (FL) at 8:08 pm on 8-19-21 revealed: - two pictures of client #1 - the left side of her face around her cheek and eye was swollen - discoloration on her upper left cheek Interview on 9-14-21 with staff #1 revealed: - her supervisor is the FL	V 105		

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V 105	Continued From page 5 - until several months ago, she was the Program Manager - "anytime there ' s an incident, I was trained to complete an incident report and notify all members of the treatment team" - she did not see the altercation where client #1 fell and hit her head - during the incident, client #1 pulled the fire alarm, and all clients went outside to practice as a fire drill - "it was obvious [client #1] ' s face was hurt. We were outside because of the fire alarm. I could see that her face was bruised" - "it was red and started getting puffy" - client #1 refused first aid, ice, a wet towel or anything for her face - "she said she was fine and didn ' t want anything" - "I thought the fire department was on their way and would check her out, but [PM] was still inside (the facility) dealing with the alarm company and (I later found out he) called the fire department and told them not to come" - client #1 ' s legal guardian wasn ' t contacted about the incident or the injury until the next day - client #1 ' s AFL had contacted her legal guardian (LG) the same evening on the day it happened Interview on 9-14-21 with client #1 ' s LG revealed: - he was never contacted directly by the facility - he was included on email responses between client #1 ' s AFL and the facility - when there is an incident, his expectation is to be contacted as soon as possible - when there is an injury, his expectation is to	V 105		

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V 105	Continued From page 6 be contacted within an hour - when there is a restraint, his expectation is to be contacted immediately - he would have wanted client #1 to be seen by a medical professional Interview on 9-14-21 with the PM regarding the events on 8-19-21 revealed: - client #1 was approximately 3 feet in front of him when she fell - he saw client #1 fall and hit the table - he couldn ' t tell what part of her body hit the table, "I just saw it move, along with a chair that was at the table" - "I thought maybe her head or face hit the floor" - "we asked her if she was okay and offered to administer first aid and she (client #1) refused" - her emergency contact, which was her AFL, had already been contacted and was supposed to be on her way - "we offered ice and she refused" - "I wanted Ms. [staff #1] to work with [client #1] to help keep her calm. I don ' t know if she was able to get her to apply some ice or not because I was dealing with the fire alarm that we couldn ' t get turned off until about 5:00 pm" - believes LG was called by facility staff the next day - further interview failed to reveal why client #1 was not seen by trained medical personnel, nor why her legal guardian was not contacted immediately following the incident.	V 105		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL	V 132		

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V 132	Continued From page 7 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 investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 8	V 132		

This Rule is not met as evidenced by:
Based on interview and record review, the facility staff failed to ensure the Health Care Personnel Registry Department was notified of all allegations against personnel, including injuries of unknown origin.
The findings are:

Review on 9-10-21 of client #1 ' s facility record revealed:
- admitted 8-19-19
- 24 years old
- diagnosed with:
  - Intellectual Disability, Mild
  - Unspecified Impulse Control Disorder
  - Intermittent Explosive Disorder
  - Major Depressive Disorder, Recurrent and Severe with Psychotic Symptoms
  - Morbid Obesity

Review on 9-13-21 of the Qualified Professional ' s personnel record revealed:
- hired; 10-2-18
- position; Qualified Professional (QP)
- credential; Bachelor ' s Degree in Health Care Management 3-25-17

Review on 9-10-21 of an internal incident report of an event that occurred on 8-19-21 revealed:
- client #1 was involved in an incident that occurred on the premises at approximately 1:00

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V 132	Continued From page 9	V 132		

pm
- client #1 was upset, believing there would be repercussions by her Alternative Family Living provider (AFL) because she had taken and had eaten a piece of cake from the facility refrigerator earlier in the day
- the client ' s agitation increased until her behavior became aggressive toward multiple staff
- intervention by staff to attempt to prevent injury to the client and staff, resulted in an altercation where the client fell
- "[client #1] was physically attacking staff [QP] and lost her balance causing her to fall striking her head on a table that she was standing by"

Review on 9-9-21 of the Complaint Intake Information revealed there was no Health Care Personnel Registry report received from the facility regarding the incident on 8-19-21

Interview on 9-10-21 with client #1 regarding the event on 8-19-21 revealed:
- the QP tried to restrain her
- Program Manager (PM), QP and staff #1 all saw her fall
- her face was injured in the fall
- "you should ' ve seen my face, it was black and purple"
- "Ms. [staff #1] saw [QP] push me down"
- "I felt one hand on my back, she pushed me hard"

Review on 9-14-21 of a video recording of the event, time/date-stamped 8-19-21 from 1:57 to 1:58 pm revealed:
- the event occurred in a space approximately

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V 132	Continued From page 10 10 feet by 10 feet - in that area was a sofa, two tables and 3 chairs - there was an exit door with a floor mat/rug in front of the door - QP approached client #1 from her left, placing herself between client #1 and the sofa - after approximately 10 seconds, client #1 directed her aggression toward the QP, and began striking towards her head - the QP attempted to block client #1 ' s strikes towards her head - approximately 4 seconds after client #1 began striking QP, client #1 appeared to grab QP and pull her down - as the two fell, client #1 struck the table with her head and landed next to a chair, while the QP went down to her knees beside client #1 Interview on 9-13-21 with the QP revealed: - she was in an altercation with client #1 - client #1 fell down - she realized client #1 ' s aggression was directed at her - when they fell, a table was struck and moved - after the fall, she tried to stay away from client #1 in the hope it would help de-escalate her behaviors - "[client #1] came back the following day (8-20-21) and said I pushed her" - "[client #1] was saying, ' that b***h pushed me, that b***h pushed me ' " - on 8-20-21, she completed her part of the incident report document, but there was no discussion about a 24-hour report to the Health Care Personnel Registry (HCPR)	V 132		

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V 132	Continued From page 11 Interview on 9-14-21 with the PM revealed: - he was present when the incident occurred with client #1 and the QP - he saw client #1 the next day and her face and eye looked worse than it had the day before - there was no talk or discussion about completing the 24-Hour HCPR report - "That was a ball drop on my part. I wasn ' t aware of that report. Anytime an accusation is made I ' ll make sure that ' s down, and follow that all the way to [Facility Licensee] ' s desk. I ' ll see to it. I felt bad because that ' s a ball drop on my part"	V 132		
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;	V 367		

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V 367	Continued From page 12 (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 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	V 367		

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V 367	Continued From page 13 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 meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility staff failed to report all level II incidences that occurred during the provision of billable services or while clients were on the provider ' s premises, to the LME (Local Management Entity) responsible for the catchment area where services were provided, within 72 hours of becoming aware of the incident. The findings are: Review on 9-10-21 of client #1 ' s facility record revealed: - admitted 8-19-19	V 367		

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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 367	Continued From page 14 - 24 years old - diagnosed with: - Intellectual Disability, Mild - Unspecified Impulse Control Disorder - Intermittent Explosive Disorder - Major Depressive Disorder, Recurrent and Severe with Psychotic Symptoms - Morbid Obesity Review on 9-10-21 of an internal report of an event that occurred on 8-19-21 revealed: - client #1 was involved in an incident that occurred on the premises at approximately 1:00 pm - the client ' s agitation increased until her behavior became aggressive toward multiple staff - intervention by staff to attempt to prevent injury to the client and staff, resulted in an altercation where the client fell - "[client #1] was physically attacking staff [Qualified Professional] and lost her balance causing her to fall striking her head on a table that she was standing by" Review on 9-14-21 of a video recording of the event, time/date-stamped 8-19-21 from 1:57 to 1:58 pm revealed: - the event occurred in a space approximately 10 feet by 10 feet - in that area was a sofa, two tables and 3 chairs - there was an exit door with a floor mat/rug in front of the door - Program Manager (PM) was struck by client #1 - PM was attempting to block client #1 ' s strikes towards his head - Qualified Professional (QP) approached	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-375	A. BUILDING: _____ B. WING _____	09/15/2021

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V 367	Continued From page 15	V 367		

client #1 from her left, placing herself between client #1 and a sofa
- client #1 directed her aggression toward the QP, and began striking towards her head
- the QP attempted to block client #1 ' s strikes towards her head
- client #1 appeared to grab the QP and pull her down
- as the two fell, client #1 struck the table with her head and landed next to a chair, while the QP went down to her knees beside client #1

Interview on 9-13-21 with the QP revealed:
- she was involved in the incident
- she was expected to document what happened
- on 8-20-21, the day after the incident, she completed her incident report documentation and forwarded it to be reviewed by other agency staff
- she was expected to submit her report to other staff, who entered it into the "North Carolina Incident Response Improvement System" (IRIS)

Review on 9-10-21 of the, "Morgan Support Services Internal Incident Report" which was dated 8-20-21 at 1:08 pm revealed:
- the incident occurred while client #1 was on the premises receiving services
- occurred at 1:00 pm on 8-19-21
- "Type of incident ...":
  - "Verbal Aggression/Threats"
  - "Property Destruction"
  - "Trip/Fall"
- "Was anyone injured during or as a result of this incident?"
  - "Yes"
- "Was physical restraint used on the person in this incident?"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-375	A. BUILDING: _____ B. WING _____	09/15/2021

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V 367	Continued From page 16 - "Yes" - "This incident is determined to be a Level II" - the report was completed by the QP - reviewed by the agency Quality Assurance staff on 8-20-21 at 1:58 pm Interview on 9-10-21 with the Facility Licensee revealed: - he was aware of the incident involving client #1 on 8-19-21 - he knew it was a Level II incident - he knew it was supposed to be entered and submitted to the Local Management Entity (LME) through the IRIS system - he has a designated staff person that submits reports to IRIS - The designee had been attempting unsuccessfully to submit the report from 8-20-21 through 8-22-21 - further interview failed to reveal why, as stated in, "10A NCAC 27G .0604 (a) ...The report may be submitted via mail, in person, facsimile (fax) or encrypted electronic means ..." the LME had not received the report. Review on 9-9-21 and 9-15-21 of the "North Carolina Incident Response Improvement System" (IRIS) failed to reveal any Level II incident report completed or submitted by the facility staff regarding the event between client #1, the QP or the PM, where client #1 was injured	V 367		