Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-833	A. BUILDING: _____ B. WING _____	R 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE HOMES	926 EDISON ROAD RALEIGH, NC 27610

(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 000}	INITIAL COMMENTS A follow up survey was completed on October 13, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	{V 000}		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) 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. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110	V110 / Type B / Must be corrected in 45 days Corrective Measures Following the deficiencies cited, effective 10/29/2021 Staff #1 has been replaced at the facility. The behaviors observed and described by the surveyors are inconsistent to the values of CareOne as well as the on-boarding briefing/ orientation staff receive when coming on board New staff has been trained on clients' needs, history and treatment plans Clients have been informed that facility has no policy regarding loss of TV privileges Staff will continue to receive supervision with weekly touch points by the QP/RN Correction Completion Date Friday, October 29, 2021 Preventative Measures QP/RN will ensure via weekly monitoring of Staff interraction with clients that Staff addresses clients with respect, courtesy and in a non threatening manner Monitoring Responsibility QP/RN Monitoring Frequency Weekly	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Facility Director	November 08, 2021

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V 110	Continued From page 1	V 110		

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to ensure 2 of 2 staff (#1 & #2) demonstrated the knowledge, skills and abilities required by the population served. The findings are:

Review on 10/12/21 of staff #1's job description revealed:
- dated 6/19/21
- job title: Habilitation Technician I
- "Nature of work: responsible for providing residential/in-home services to consumers of varying ages, diagnoses and needs."
- "Duties and responsibilities:"
" implement service plans"
"assists consumers with personal care and activities of daily living "
"assist consumers in achieving and maintaining their specified individual goals"
"assist consumers with participation in recreation/leisure activities"
"completes necessary paperwork"
"other duties as assigned"

During interview on 10/11/21 staff #2 reported:
- started August 2021
- was live-in staff
- worked with clients on their independent living skills

During interview on 10/12/21 & 10/13/21 the Co-Licensee/Qualified Professional/Administrator/Registered Nurse

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V 110	Continued From page 2 (CL/QP/AD/RN) reported: - the personnel records were not kept at the facility - would fax staff #2's job description - job description was not received by the end of business day on 10/13/21 The following are examples of how staff#1 failed to demonstrate competence: A. Observation on 10/7/21 at 12:02pm revealed: - client #1 asked staff #1 for a cigarette. She responded "just because these people (State surveyors) here do not mean I'm going to give you a cigarette. So please stop asking!" B. Observation on 10/7/21 at 12:12pm revealed: - client #1 asked "what appointment I have today?" (10/7/21) - she responded "your psych (psychiatrist) doctor and do not talk to me like that, you know where you going today!" C. Review on 10/7/21 & 10/13/21 of clients #1 - #5s' record revealed: - diagnoses such as Paranoid Schizophrenia, Hypertension, Epilepsy, Mild Cognitive Impairment & Diabetes - there were no clients in the facility with unsupervised time, however staff #1 left clients without doctor appointments alone in the facility - staff #1 also reported something happened to client #1 when he was in the community but she could not recall what happened. The CL/QP/AD/RN reported staff #1 told her she was contacted in August 2021 to pick client #1 up in the neighborhood. Client #1 was almost attacked because he asked someone in the neighborhood for a cigarette	V 110		

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V 110	Continued From page 3 D. During interview on 10/11/21 staff #1 reported: - clients were not allowed to have cups in their bedrooms. She observed client #4 in his bedroom with a cup of water on 10/10/21. She asked for the cup of water and he refused to give it to her. She took the cup from his hand and it spilled on a wall in his bedroom. He called her a "sleezy b***h." He lost his television (TV) privileges on Sunday (10/10/21). - on 10/11/21 he did not make his bed or sweep his bedroom and she (staff #1) completed his chores - he could not watch television on 10/11/21 - that was the only time a client lost privileges - clients could loose TV privileges if chores were not completed - chores switched weekly and were not written down - she (staff #1) came up with the chores list - chores were to keep their bedrooms clean and take out the trash E. Observation on 10/11/21 at 12:06pm revealed: - 2 bathrooms in the facility, one upstairs and the other downstairs - client #3 & #5's bedroom were downstairs - staff #1's sleeping quarters were downstairs - clients lined up to wash their hands in the upstairs bathroom for lunch - CL/QP/AD/RN told clients they could use either bathroom, it was their facility During interview on 10/11/21 staff #1 reported: - when she worked clients used the bathroom upstairs due to her being a female in an all male facility - staff #2 was male and clients could use the bathroom downstairs when he worked - if it was an emergency, the clients could ask if they could use the downstairs bathroom	V 110		

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V 110	Continued From page 4 F. Observation on 10/12/21 at 2:00pm reveal client #1 asked CL/QP/AD/RN for a cigarette and the CL/QP/AD/RN told client #1 to ask staff #1 for a cigarette. Staff #1 would not allow client #1 to have a cigarette because he had reached his limited amount of cigarettes for the day 2. Review on 10/7/21 of client #1's record revealed: - treatment plan dated 7/25/21 revealed client #1 "He did a recent walk off the group home was living in and was hit by a car leading to a bruise in his right arm, elbow area" - staff #1 & #2 reported they were trained on client #1's treatment plan - neither staff knew client #1 was hit by a car prior to admission During interview on 10/13/21 the Director reported: - clients' TV privileges should not be lost for chores not completed During interview on 10/13/21 the (CL/QP/AD/RN) reported: - both staff were trained on the clients' treatment plans and assessments - was not aware clients lost TV privileges for chores not completed - staff #1 "needed to be relieved of her job duties" Review on 10/13/21 of the facility's Plan of Protection dated 10/13/21 written by the CL/QP/AD/RN revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Staff will be trained more on the needs of clients and and the importance of reading into the treatment plans,	V 110		

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V 110	Continued From page 5	V 110		

understanding them and curving out all that is needed for the safety of the clients. Staff will also be thought to control the tone of their voice towards clients and co-workers."

"Describe your plans to make sure the above happens. Teach Teach till our goals are met and also we well engage staff/clients in what they need to know."

This facility served clients with diagnoses of Paranoid Schizophrenia & Intellectual Disability Disorder. Clients #1 - #5 were not approved for unsupervised time in the facility or the community. However, staff #1 took clients with appointments with her and the clients without appointments remained in the facility unsupervised. Client #1 left off the facility's property several times during the survey without staff. Staff #1 couldn't recall how often he wandered off the property, didn't know how long he was gone and threw up her hands and and said he was probably gone now. Staff #1 had a chore schedule for the clients and if chores were not completed, they lost TV privileges. Client #4 lost 2 days of TV privileges for his bedroom not being cleaned. Clients were observed lined up to wash their hands in the upstairs bathroom even though there were 2 bathrooms in the facility. Staff #1 didn't allow clients to use the bathroom downstairs unless it was an emergency, because this was the bathroom she used. On one occasion client #1 asked for a cigarette and she told client #1 she didn't care if the State surveyors were at the facility, he was not getting a cigarette. In August 2021, client #1 was almost attacked in the community for asking someone for a cigarette. Staff #1 was contacted to come get client #1. Staff #1 recalled something happened with client #1 in the community but she couldn't

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V 110	Continued From page 6 recall what. Client #1's treatment plan documented he was hit by a car at his previous facility which resulted in injuries. Staff #1 & #2 reported they were trained on his treatment plan but wasn't aware he was hit by a car. These deficient practices were detrimental to the health, safety and welfare of the clients. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 7 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to develop and implement strategies to address needs and behaviors of 1 of 3 clients (#1). The findings are: Review on 10/7/21 of client #1's record revealed: -Admitted: 7/3/21 -Diagnoses: Mild Cognitive Impairment, Schizophrenia, and Chronic Obstructive Pulmonary Disease (COPD) -Admission assessment dated 7/5/21 revealed client #1 "should be always in eye view of the care giver always at least every 15 minutes" -Treatment plan dated 7/25/21 revealed client #1 "He did a recent walk off the group home was living in and was hit by a car leading to a bruise in his right arm, elbow area" and "is always ready to leave the home so the care givers eye should always be on him" -no goals or strategies to address wandering away from the group home Observation on 10/7/21 at 11:41am revealed: -Client #1 walked over to the neighbor's home approximately 200 feet (ft) away from the front porch of the group home - Speed limit on the neighborhood street was 20 miles per hours (mph) Observation on 10/13/21 @ 2:00pm revealed client #1 walked to the neighborhood park with no	V 112	V 112 /Type A1 - Cross / Must be corrected in 23 days Corrective Measures Facility developed and was implementing strategies to address Client #1 wandering tendencies. These policies were verbalized to surveyors at the time of the visits. Surveyors acknowledged the efforts in place to help Client #1 with these tendencies but encouraged the strategies be documented and placed in his file Effective 10/29/2021 strategies are documented and attached to client's file New staff has been trained on clients' needs, history and treatment plans Staff will continue to receive supervision with weekly touch-points by the QP/RN Correction Completion Date Friday, October 29, 2021 Preventative Measures QP/RN will ensure via weekly monitoring of Staff interaction with clients that Staff address clients with respect, courtesy and in a non-threatening manner Monitoring Responsibility QP/RN Monitoring Frequency Weekly	

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V 112	Continued From page 8	V 112		

staff checking approximately 1000 ft away from the the front porch of the group home.

Interview on 10/11/21 client #1 reported he:
-Had gotten hit by a car at previous group home
-Had walked to the local corner store while at current group home a couple of times
-Was picked up by the police while at the local corner store, police brought him back to the group home
-Had asked strangers for cigarettes
-Does have unsupervised time, doesn't remember how much
-Had walked to the stop sign in the neighborhood and to the park next door
-Sometime will let staff know, sometime will not let staff know and will walk away for not long "maybe 20 or 30 minutes"

Interview on 10/11/21 staff #1 reported:
-Not aware of any goals or strategies for client #1 wandering away
-She is aware that client #1 should have eyes on him every 15 minutes

Interview on 10/11/21 with the next door neighbor reported:
-Client #1 had come over to ask for cigarettes or a lighter
-Doesn't know how often he comes over to ask for cigarettes
-Had given him a couple sometime when he gets on their nerves

Interview on 10/11/21 the Co-Licensee/Qualified Professional/Administrator/Registered Nurse (CL/QP/AD/RN) reported:
-Responsible for putting the strategies and goals in the treatment plans
-Acknowledged there were no strategies or goals

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V 112	Continued From page 9 in place for client #1 wandering away from the group home This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living -Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
{V 289}	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;	{V 289}	V 289 /Type A1 - Multiple Cross / Must be corrected in 23 days Corrective Measures Addressed in individual cross references	

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

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{V 289}	Continued From page 11 A. 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 and implement strategies to address needs and behaviors of 1 of 3 clients (#1). B. Cross reference 10A NCAC 27G .5602 SUPERVISED LIVING -STAFF (V290). Based on observation, record review and interview the facility failed to ensure 5 of 5 clients (#1, #2, #3, #4 & #5)'s treatment plan documented when the client was capable of remaining in the home or community without supervision for specified periods of time. C. Cross reference 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS (V366). Based on record review and interview the facility failed to develop and implement written policies governing their response to level I and II incidents. D. Cross reference 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS (V367). Based on record review and interview the facility failed to ensure Level I & Level II incident reports were submitted to the Local Managed Entity and Managed Care Organization (LME/MCO). E. Cross reference 10A NCAC 27E .0101 CLIENT RIGHTS-LEAST RESTRICTIVE ALTERNATIVE (V513). Based on observation, record review and interview the facility failed to promote a respectful and least restrictive environment for one of five clients (#1).	{V 289}		

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{V 289}	Continued From page 12 Review on 10/13/21 of the facility's Plan of Protection dated 10/13/21 written by the CL/QP/AD/RN revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? All assessments and treatment plans will be addressed to specific areas as is needed for individual client and staff will show strictly to compliance. Incident reports will be reviewed (recorded) and (put up to the authorities) LME as required. Unsupervised time for clients will be adequately addressed. Incident reporting system will be put in place are one policies. Client will be given whatever they demand without the rights restricted. Describe your plans to make sure the above happens. I will do a retraining and practice religiously to ensure compliance with all the teaching and if not we will have to relieve staff of their duties." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. Clients with diagnoses of Mild Cognitive Impairment, Paranoid Schizophrenia, and Epilepsy resided in the facility. Client #1 was hit by a car at his previous facility which resulted in injuries to his arm and elbow. He was not approved for any unsupervised time, however he wandered from the facility on several occasion. He walked along a busy highway to the local convenience store that was 10 minutes away. The police brought him back to the facility on two separate occasions, because the staff at the convenience store noticed him panhandling for cigarettes and call the police. Client #1 also walked to the neighbor's house to get cigarettes without staff's knowledge. On another occasion, he left the facility unsupervised and was almost	{V 289}		

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	MHL092-833	A. BUILDING: _____ B. WING _____	R 10/13/2021

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CARE ONE HOMES	926 EDISON ROAD RALEIGH, NC 27610

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{V 289}	Continued From page 13 attacked in the neighborhood because he asked someone for a cigarette. There were no goals or strategies in his treatment plan to address his wandering and panhandling behaviors. No incident reports to address the police calls or his wandering behaviors. Also, no incident report policy on when to complete an incident report. Client's #1-#5 were left unattended at the facility while staff escorted other clients to doctor's appointments. Client #1 was allotted only 6 cigarettes a day because his previous facility only allotted him 6 cigarettes a day. This constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	{V 289}		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the	V 290		

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V 290	Continued From page 14 following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 5 of 5 clients' (#1, #2, #3, #4 & #5) treatment plans documented when the client was capable of remaining in the home or community without supervision for specified periods of time. The findings are:	V 290	V 290 /Type A1 - Cross / Must be corrected in 23 days Corrective Measures Following the deficiencies cited, effective 10/29/2021 Staff #1 has been relieved of her duties as live in staff at CareOne Homes. The behaviors observed and described by the surveyors are inconsistent to the values of CareOne as well as the on-boarding briefing/ orientation staff receive when coming on board as Staff New staff has been trained on clients' needs, history and treatment plans particularly around clients supervision Staff will continue to receive supervision with weekly touch-points by the QP/RN Correction Completion Date Friday, October 29, 2021 Preventative Measures QP/RN will ensure via weekly monitoring of Staff interaction with clients ensuring Staff is aware and adheres to the supervision requirements of each client Monitoring Responsibility QP/RN Monitoring Frequency Weekly	

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V 290	Continued From page 15 Review on 10/7/21 & 10/13/21 of clients #1 - #5's record revealed: - diagnoses such as Paranoid Schizophrenia, Hypertension, Epilepsy, Mild Cognitive Impairment & Diabetes - no unsupervised time documented in clients' #2 - #5's record - client #1's record - unsupervised time in the community dated 7/30/21: "...[client #1] always ready to leave the the home so the caregivers eye is always on him." - "team met on 8/2/21 and recommends requires addition training and is not capable of unsupervised time." (no signatures documented) - "9/20/21 - [client #1] is allowed to have 1 hour unsupervised time in the community as its observed that he goes and come home safely in less than 30 minutes of him leaving the house. The house manager still have an eye on him just to ensure he is on time back home. " signed by the Co-Licensee/Qualified Professional/Administrator/Registered Nurse (CL/QP/AD/RN) Review on 10/12/21 of an email sent by the CL/QP/AD/RN on 10/11/21 revealed: - "When QP must be contacted..." "client left resident and whereabouts are unknown (client ran away)" "police /paramedics responded to incident on the home" Review on 10/11/21 of a police call service log revealed: - "9/21/21 - 11:57am - Missing Person - Adult" Review on 10/11/21 of Google maps revealed: - convenience store was 10 minutes from the facility walking about .6 miles	V 290		

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V 290	Continued From page 16 Observation on 10/11/21 at 9:55am revealed: - the convenience store was on a 2 lane highway with a turning lane in the middle - a speed limit sign posted 35 miles per hour - multiple cars in both lanes Observation on 10/7/21 between 12:04pm & 12:10pm revealed: - client #1 walked outside without staff - staff #1 threw up her hands and stated "he's probably gone now" - staff #1 did not get up to locate him - 12:10pm client #1 came inside the facility Continued observation and interview on 10/11/21 with staff #1 between 10:53am & 11:50am revealed: - small white (sports utility vehicle) SUV in the yard with a driver and passenger seat, one long seat in the rear of the SUV - client #1 on the front porch - client #1 entered the facility to get staff #1 - staff #1 reported client #1 & client #4 had 12pm appointments - 5 clients were at the facility - 11:41am client #1 walked to the neighbor's home & knocked...nobody answered the door - 11:50am staff #1 had not left for the appointments - reported CL/QP/AD/RN requested she wait her arrival - staff #1 reported clients would "just be late" to their appointment During interview on 10/11/21 & 10/13/21 client #1 reported: - he walked to the park and back to get away from the facility for exercise - the police had brought him back to the facility - did not get hit by a car at the previous facility,	V 290		

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V 290	Continued From page 17 but was in traffic and the police told him to get out of traffic - walked on a side walk when there was one but doesn't think there was a sidewalk where he currently walked - walked with client #3 sometimes to the park - sometimes left for about an hour - walked next door to get to a cigarette, but not everyday - he was not attacked while unsupervised in the neighborhood - he asked a female for a cigarette and her male friend got upset. The female gave him the cigarette. Nothing happened During interview on 10/11/21 client #3 reported: - he had unsupervised time in the facility and community - mostly walked for exercise - will sometimes walk to the convenience store - does not keep up with the time he spent in the facility and community unsupervised - walked 3 times in the morning and 3 times in the evening - no curfew - does not sign in or out - some clients could remain at the facility without staff - all the clients could not get in the staff #1's vehicle when there were appointments - he, client #2 and client #5 were sometimes left at the facility without staff - does not keep up with the time staff #1 was gone - when at the facility without staff he laid around or took a walk in the community - client #1 does not walk with him in the community - client #1 walked his way and he (client #3) went another way	V 290		

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V 290	Continued From page 18 - he (client #3) walked alone, "that's the best way to walk" During interview on 10/11/21 staff #1 reported: - all the clients had unsupervised time in the facility and community except client #5 - client #1 had one hour of unsupervised time in the community - she planned to leave client #2 & client #3 at the facility today (10/11/21), while the other 3 clients went with her to the appointment, but the CL/QP/AD/RN asked her to remain at the facility - client #1's unsupervised time consisted of him walking with client #3 - he could walk where he wanted to go within the one hour - had to be in eyesight after he used the 1 hour of unsupervised time - aware client #1 walked to the neighbor's home next door to get a cigarette or a light - the neighbor had not complained that client #1 went to their home for cigarettes - didn't know how often he went to the neighbor's home - when she witnessed client #1 at the neighbor's home, she redirected him back to the facility - sometimes he went without her knowledge - client #1 was supposed to sign in and out when he left the property but refused - supposed to notify staff of his whereabouts prior to departure from the facility - had walked to the convenience store on 2 different occasions without her knowledge - client #3 was not with him - workers at the convenience store was made aware to contact the police if client #1 came to the convenience store - he panhandled for cigarettes when at the convenience store	V 290		

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V 290	Continued From page 19 - the police brought him back to the facility on 2 different occasions because the workers at the convenience store called the police - does not recall the day the police returned client #1 to the facility - does not know how long he was gone - she contacted the CL/QP/AD/RN whenever client #1 left the facility - he wandered from the facility because he liked to smoke - something happened one time with client #1 while he was in the community but she does not recall - client #1 had not been injured by a car while in the community previously or while at the facility - client #1 & client #3 were the only clients that used the unsupervised time - does not know how much unsupervised time client #3 had in the community or facility During interview on 10/11/21 staff #2 reported: - started at the facility the beginning of August 2021 - he was live-in staff - client #1 liked to smoke - he would leave the facility when he could not smoke - was not gone for long periods of time - followed him long enough to keep eyesight on him and the facility - only allowed client #3 to walk to the nearby park so he could keep eyesight of him - the clients did not have unsupervised in the facility or community - not aware of any clients being left alone in the facility - informed the CL/QP/AD/RN client #1 walked to neighbor's home to ask for cigarettes - also made the CL/QP/AD/RN he ran up to cars in the neighborhood to ask for cigarettes	V 290		

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V 290	Continued From page 20 - CL/QP/AD/RN informed him client #1 liked to have been attacked in the neighborhood because he asked someone for a cigarette During interview on 10/11/21 a neighbor next door reported: - an older white gentlemen (client #1) came daily to ask for a cigarette - staff requested cigarettes not to be given to client #1 - when he (client #1) got on their nerves, they gave him a cigarette During interview on 10/11/21 a worker at the convenience store reported: - a white older gentlemen (client #1) used to come to the store - had not seen him since the end of September 2021 - she had not witnessed him panhandling - a staff requested they call 911 if they saw him at the store - a list of facility's staff names and numbers were given to them if client #1 was seen at the store - no photo description was given but she knew who he was - she had not called 911 or staff about client #1 During interview on 10/12/21 client #1's guardian reported: - was not aware client #1 had unsupervised time - depended on the group home to provide supervision - aware of previous behaviors of panhandling for cigarettes - CL/QP/AD/RN made her aware he wandered from the facility on 9/21/21 - was not aware he was picked up from the	V 290		

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V 290	Continued From page 21 convenience store by the police Staff #1 was not available to be interviewed on 10/13/21 During interview on 10/11/21 & 10/13/21 the CL/QP/AD/RN reported: - client #1 had one hour of unsupervised time in the community - he was assessed by her and staff #1 - the guardian was verbally told client #1 had 1 hour of unsupervised time - when he left the facility, he was gone no more than 20 minutes - he was approved to only walk in the neighborhood - was not approved to walk to the convenience store - staff followed him one day and observed him panhandle cigarettes while in the community - the convenience store was located on a "busy highway" - staff was aware client #1 could not walk to the convenience store unsupervised - she informed the workers at the convenience store to call the police if they saw him there - he was supposed to sign in and out but he said he could not write - she has witnessed client #1 write - requested the neighbor not to give him cigarettes - staff #1 told her client #1 was almost attacked in the facility's neighborhood. Someone called staff #1 and she went to get client #1. He had asked someone for a cigarette. Thought the incident happened in August 2021 - client #3 had 8 hours of unsupervised time in the facility and community - she was not aware staff #1 left the clients in the facility unsupervised while she attended	V 290		

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V 290	Continued From page 22 appointments - client #3 could remain in the facility without staff - staff #1 usually contacted her CL/QP/AD/RN to relieve her (staff #1) to attend appointments with the clients - the facility's van was in the car shop, however she would follow up on the van today Continued review on 10/13/21 the CL/QP/AD/RN reported: - will send documentation of client #3's unsupervised time by close of business day on 10/13/21 - documentation of unsupervised time for client #3 was not received This deficiency is crossed referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 290		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider	V 366		

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V 366	Continued From page 23 specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:	V 366	V 366 /Type A1 - Cross / Must be corrected in 23 days Corrective Measures CareOne Incident Reporting guidelines are available at facility Correction Completion Date Preventative Measures QP/RN will ensure all Staff are trained and can provide guidelines on demand Monitoring Responsibility QP/RN Monitoring Frequency Weekly	

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V 366	Continued From page 24 (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 25	V 366		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to develop and implement written policies governing their response to level I and II incidents. The findings are:

During interview on 10/11/21 the Co-Licensee/Qualified Professional/Administrator/Registered Nurse (CL/QP/AD/RN) reported:
- she would locate the incident report policy and email it

Review on 10/12/21 of an email sent by the CL/QP/AD/RN on 10/11/21 revealed:
- "When QP (CL/QP/AD/RN) must be contacted..."
"client left resident and whereabouts are unknown (client ran away)"
"police /paramedics responded to incident on the home"
- no documentation of when an incident report needed to be completed

During interview on 10/13/21 the CL/QP/AD/RN reported:
- she was not able to locate an incident report policy
- staff are to follow the guidelines for when the CL/QP/AD/RN was to be contacted

During interview on 10/13/21 the Director reported:

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	MHL092-833	A. BUILDING: _____ B. WING _____	R 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE HOMES	926 EDISON ROAD RALEIGH, NC 27610

(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 366	Continued From page 26 - there was an incident report policy - it was requested by 5:00pm on 10/13/21 - the incident report policy was not received by the close of business day This deficiency is crossed referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding.	V 367	V 367 /Type A1 - Cross / Must be corrected in 23 days Corrective Measures CareOne Incident Reporting guidelines are available at facility Correction Completion Date Friday, October 29, 2021 Preventative Measures QP/RN and staff are have received refreshers on incident reporting guidelines and can provide CareOne Policy on demand All unusual occurrences will be reported to the LME through IRIS Monitoring Responsibility QP/RN Monitoring Frequency Weekly	

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V 367	Continued From page 27 (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 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;	V 367		

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V 367	Continued From page 28 (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 record review and interview the facility failed to ensure Level I & Level II incident reports were submitted to the Local Management Entity and Managed Care Organization (LME/MCO). The findings are: Review on 10/12/21 of an email sent by the Co-Licensee/Qualified Professional/Administrator/Registered Nurse (CL/QP/AD/RN) on 10/11/21 revealed: - "When QP (CL/QP/AD/RN) must be contacted..." "client left resident and whereabouts are unknown (client ran away)" "police /paramedics responded to incident on the home" Review on 10/11/21 of a police call service log	V 367		

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V 367	Continued From page 29	V 367		

revealed:
- "9/21/21 - 11:57am - Missing Person - Adult"

During interview on 10/11/21 staff #1 reported:
- had worked at the facility since June 2021
- client #1 had left on 2 different occasions to walk to the nearby convenience store
- the police returned client #1
- both times he went to the convenience store she was not aware he left the facility
- she was on shift both times client #1 left
- an incident report was completed when an incident happened
- she was supposed to document when client #1 wandered from the facility but she forgot
- didn't know how many times client #1 wandered from the facility
- could not give a time frame of how long he was gone from the facility
- notified the CL/QP/AD/RN when client #1 wandered from the facility
- CL/QP/AD/RN does not ask for incident reports to be completed
- did not complete an incident report when the police returned client #1
- someone at the convenience store called the police and not her (staff #1)

During interview on 10/11/21 & 10/13/21 the CL/QP/AD/RN reported:
- she was responsible for ensuring incident reports were completed
- an incident report was completed when something unusual happened
- an incident report was not completed when the police returned client #1 to the facility on two different occasions
- staff #1 told her client #1 was almost attacked in the facility's neighborhood because he asked someone for a cigarette. Someone called staff #1

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V 367	Continued From page 30 and she went to get client #1. - staff #1 documented the incident - she would locate the documentation and fax it * the documentation was not received by the close of business day on 10/31/21 This deficiency is crossed referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use.	V 513	V 513 /Type A1 - Cross / Must be corrected in 23 days Corrective Measures Client #1 has received PCP evaluation of cigarette consumption with 10 cigarettes/day recommended per doctor's orders. Client #1 now gets cigarettes when he asks for it with no time or count restriction. Correction Completion Date Friday, October 29, 2021 Preventative Measures QP/RN will continue to monitor to ensure no restrictions are placed on this poilcy Monitoring Responsibility QP/RN Monitoring Frequency Weekly	

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V 513	Continued From page 31 This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to promote a respectful and least restrictive environment for 1 of 5 clients (#1). The findings are: Review on 10/7/21 of client #1's record revealed: -Admitted: 7/3/21 -Diagnoses: Mild Cognitive Impairment, Schizophrenia, and Chronic Obstructive Pulmonary Disease (COPD) -No documentation for restriction of cigarettes Admission Assessment dated 7/5/21 revealed: Client #1 "should be given cigarette at designated times minimum of 6 sticks (cigarette) daily." Interview on 10/11/21 staff #1 reported: -Client #1 is allowed 6 cigarettes daily, he smoked 1 at 7:00am, 1 at 12:00pm, 2 at 2:00pm and 2 at 5:00pm -The previous facility came up with the smoke break times and made them aware -Doesn't know why he is restricted to 6 cigarettes daily Interview on 10/11/21 the Co-Licensee/Qualified Professional/Administrator/Registered Nurse (CL/QP/AD/RN) reported: -Client #1 is allowed 6 cigarettes daily -The allowance of 6 cigarettes came from the previous placement - Client #1's guardian was aware of the amount of cigarettes that he smoked daily - Kept the same times to smoke and the amount of cigarette available to smoke	V 513		

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V 513	Continued From page 32 Interview on 10/11/21 the guardian reported: -Had not given out any restrictions for limited cigarettes, unsure of where the restriction came from -The restriction of the cigarettes may be a group home rule however not aware of any daily amount of cigarettes to smoke -Was aware of the previous behaviors of pan handling and begging for cigarettes Observation on 10/12/21 Client #1 at 2:00pm asked CL/QP/AD/RN for a cigarette and CL/QP/AD/RN told client #1 that he should ask staff #1 for a cigarette, Staff #1 would not allow client #1 to have a cigarette stated client #1 had the limited amount of cigarettes for the day and was not allowed any at the time designated for a smoke break This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living -Scope (V289) deficiency for a Type A1 rule violation and must be corrected within 23 days.	V 513		