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	MHL092-850	A. BUILDING: ______ B. WING ______	R 12/10/2021

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ACCESS HEALTH SYSTEM 2, INC	5208 COUNTRY PINES COURT RALEIGH, NC 27616

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V 000 INITIAL COMMENTS — V 000

An annual, follow up and complaint survey was completed on 12/10/21. The complaint was substantiated (NC Intake # 00183751). Deficiencies were cited.

The facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness

The survey sample consisted of six current clients.

V 109 27G .0203 Privileging/Training Professionals — V 109

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

Provider's Plan of Correction:

V 109 The facility has contracted with a QP for clinical supervision and monitoring of services for clients. The QP has experience with Substance Abuse, Mental Health, I/DD, Crisis Response and Intervention, PCP Development, Treatment Team Facilitation, Care Coordination, Culture Competence, supervision of group homes and staff, etc. The QP will provide ongoing supervision/training to the clinical, administrative and group home staff on a monthly basis. These include: incident reporting, recognizing and reporting abuse, neglect and/or exploitation, reporting procedures (to include reporting protocols-incident reporting, HCPR reporting and notification, guardians, , etc..), Incident Reporting, documentation, Workplace Behavior Ethics, Client Rights, Client Safety, Conflict Resolution Skills, Decision Making and any other trainings deemed appropriate/necessary by the QP and/or Treatment Team as needed.

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V 109	Continued From page 1 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. (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 record review and interview two of two Qualified Professionals (QP) (QP/Licensee #8 and QP/ Licensee #9) failed to demonstrate knowledge, skills and abilities required for the population served. The findings are: Review on 12/7/21 of the QP/Licensee #8's record revealed: -Date of Hire 10/16/09 Review on 12/7/21 of the QP/Licensee #9's record revealed: -Date of Hire 7/16/12 A. Cross Reference: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (V 132) Based on record review and interview the facility failed to make every effort to protect residents from harm while the investigation of abuse was in progress for one of one former staff (FS #7). B. Cross Reference: 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH	V 109	V109 continued: Additionally, fire/disaster drills will be conducted monthly and supervised by the administrator, director or CEO for the next 90 days. Following the 90 day period the administrator, director or CEO will follow up with staff on a monthly basis to ensure that the fire and disaster drills have been conducted as required. This would mean that each month during the quarter a fire drill will be conducted on a different shift. QP will ensure that all protocols are followed. In the event that an issue arises that requires immediate attention the residential QP will work with the team, guardian, etc.. to implement emergency goals/strategies until a full team can be assembled. QP will provide updates as needed. The facility administrator/licensee will no longer function in the role of QP as of 12/11/21 until the facility is brought back in compliance by the DHSR.	

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V 109	Continued From page 2	V 109		

CARE PERSONNEL (V 318) Based on record review and interviews the facility failed to ensure a report to Health Care Personnel of abuse was completed within 24 hours.

C. Cross Reference: 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V 366) Based on record review and interview the facility failed to implement written policies governing their response to incidents as required.

D. Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V 367) Based on record review and interview the facility failed to report Level III incidents within 72 hours of becoming aware of the incident affecting one of six clients (#3).

E. Cross Reference: 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (V 114) Based on record review and interview the facility failed to ensure fire and disaster drills were completed quarterly for each shift.

Review on 12/10/21 of "Plan of Protection" completed by the QP/ Licensee #8 on 12/10/21 revealed the following,
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
-QP and Director (QP/Licensee #8 and QP/Licensee #9) will contact the cross covering QP to assist in identifying and setting plan of actions to prevent similar indent happening, today.

- Describe your plans to make sure the above happens.

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V 109	Continued From page 3 -I will call the relieve QP immediately to set up a time to immediately address this." Client #3 was diagnosed with Schizoid Personality Disorder, Obsessive Compulsive Disorder (OCD), Hypertension, Hyperlipidemia and Hyperthyroidism. Following an allegation against FS #7 regarding a physical altercation on 11/24/21, she was allowed to work to work as the full time live in staff with the other clients during the investigation. There were no safety measures put in place to protect the other clients from FS#7 during her investigation. The QP/Licensee #8 only interviewed clients #4, #5, & #6 regarding the abuse allegations on FS #7 on 11/25/21. The QP/Licensee #9 did not complete a Health Care Personnel Report until 11/29/21 and did not complete a Level III incident report, only a Level II on 11/29/21. FS #7 was terminated on 11/29/21 due to client #3's sister refusing to return her to the home until FS #7 was no longer employed. The QP/Licensee #8 and QP Licensee #9's failure to protect the clients from futher abuse after allegations were made regarding FS #7 was detrimental to their health, safety and welfare. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. 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 109		
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	V 114		

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V 114	Continued From page 4	V 114		

shall be approved by the appropriate local authority.
(b) The plan shall be made available to all staff 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 for each shift. The findings are:

Review on 12/6/21 of Fire and Disaster Drill Log revealed:
-Fire Drills were not completed for several months leaving a quarter where no drills performed.
-Disaster Drills were not completed for several months leaving a quarter where no drills performed.

Interviews on 12/6/21 clients #1, #2, #3, #4, #5, & #6 stated:
-They had done fire and disaster drills, but could not remember when.

During interview on 12/10/21 the Qualified Professional (QP)/Licensee #8 stated:
-They had been doing fire and disaster drills quarterly
-Made sure they did one a quarter

V 114 As of 12/18/21
All staff, QPs, admin, etc.. were inservicedon procedures and protocols for conducting fire & disaster drills. Each will be completed by the administrative staff during the next 90 day period. Following the 90 days, the residential staff will complete the drills on no less than a monthly basis and will be completely on all shifts within the quarter. The administrator will ensure drills have been completed on a monthly basis and will co-sign the form once completed.

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V 114	Continued From page 5 -Always made sure they did a fire and disaster drill when the staff changed so they would know what to do. -FS #7 was a full time live in staff. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a type B rule violation and must be corrected within 45 days.	V 114		
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).	V 132		

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V 132 Continued From page 6

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.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to make every effort to protect clients from harm while the investigation of abuse was in progress for one of one former staff (FS #7). The findings are:

Review on 12/7/21 of FS #7's record revealed:
-Hire date of 11/2/20

Interview on 12/6/21 the Qualfied Professional (QP)/Licensee #8 stated FS #7 was the full time live in staff for the last few months.

Review on 12/7/21 of Police Report dated 11/24/21 regarding client #3 revealed:
-"on 11/24/21 at approximately 1600 (4:00 PM) hours, I responded to 5208 Country Pines Ct for a check on a welfare of resident named [client #3].

V 132

V132 Healthcare Personnel Registry
V132 – HCPR Notification.
Effective immediately, the QP will be informed of all allegations of abuse, neglect or exploitation by the staff person receiving the information. The QP has inserviced QPs, administrator, direct care staff on reporting procedures and provided examples of situations necessitating investigation. The administrator will ensure that the QP has been made aware of an allegation immediately upon receiving the information. Once notified of an allegation the staff person will be put on leave immediately and will not be allowed to return to the facility pending outcome of the investigation. The investigation will begin immediately by the QP and any allegations will be reported to the HCPR immediately. All information will be entered into IRIS and the notification section for HCPR will be submitted within 24 hours.

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V 132	Continued From page 7 [Client #3] reported her care taker had abused her and she wanted assistance in being escorted out of the home. Prior to arriving on scene, she also reported that she had been hit in the head and her hair had been pulled by the caretaker. Upon arrival, I was met by the care taker, [FS #7] and she escorted me to [client #3's] room. I asked to speak with [client #3] privately, but [FS #7] would not go back to the living room area and would stand in the hallway directly adjacent to the bedroom. [Client #3] reported the following: -On today's date, shortly prior to calling police, [client #3] had been hit in the head and in the side of the head by her left ear by [FS #7]. [FS #7] then grabbed her satchel and ripped it from her body causing the strap to break. [FS #7] denied ever striking [client #3], but did admit to taking her bag after [client #3] handed it to her. [FS #7] reported [client #3] is a hoarder and is not allowed to have certain things, so she wanted to check the bag and take out certain items before giving it back...I then spoke with [client #3's sister] ...who advised [client #3] has been telling her [FS #7] has recently become more verbally abusive towards [client #3] and she no longer felt safe in the home. She also reported [client #3] has been called a racist by [FS #7] and has been threatened by her...She also reported [client #3] has no issues in the home until recently...During the time I spoke with [client #3's sister] on the phone, [client #3] reported [FS #7] hit her again with her bag after giving it back to her. [FS #7] denied hitting her with the bag. I checked [client #3] for injuries upon arriving on scene and coming back into the home, but did not see any signs of assault..." Review on 12/6/21 of Level II Incident Report of Incident Response Improvement System (IRIS) provided by the QP/Licensee #8 dated 11/29/21	V 132		

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revealed regarding client #3's incident on 11/24/21:
-"Consumer alleged that staff got mad with her for opening front door and later alleged that staff pulled her hair."

Review on 12/6/21 of "Progress Note" regarding client #3 completed by the QP/Licensee #8 dated 11/25/21 revealed:
-"Client complained that staff was upset with her for telling on her and letting her sister in the house. So feels that she is not safe. Her sister asked her to call 911 if she felt threatened and notifying the directors. So client called 911 and [the QP/Licensee #8's husband] also responded. On interview client said staff was forcing at her and pulled on her hair, but staff denied that. Client's sister took her home for Thanksgiving and said that she will only bring her back if staff (FS #7) leaves. No witness saw anything."
-Interview with client #4- "Interviewed [client #4] regarding her feeling safe with staff [FS#7] working here at Access or if she has any concerns. 'I like [FS #7], she cooks good and don't bother nobody. I feel safe around her.'"
-Interview with client #5- "I don't have any issues with [FS #7]. I am fine."
-Interview with client #6 -"I like [FS #7]. I don't have problems with her. I feel safe."
Interview with FS #7 -"[QP/Licensee #8] my thing is this, you know these client are going to say anything to get their way. I did not touch [client #3]. She said that to make her sister take her home for Thanksgiving because [client #2 and #5] are going home. I was asking her why she lied on me. I went to the store to buy a few things I needed. You know [client #3] lies"

Review on 12/6/21 of "Progress Note" regarding client #3 completed by the QP/Licensee #8 dated

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11/29/21 revealed:
-"Staff was sent home and client returned to facility, reassured her that she is safe and that staff will not return to the facility."

Interview on 12/7/21 FS #7 stated:
-After the incident on 11/24/21 she continued to work alone with the clients until 11/29/21 when client #3 returned.
-Told the QP/Licensee #8 she did not touch client #3.
-"If I am so bad, why did they keep me there?"

Interviews on 12/6/21 clients #1, #2 & #4 stated:
-Did not recall the QP/Licensee #8 asking them any questions about FS #7 and client #3's altercation
-The QP/Licensee #8 had not spoken to them about FS #7 leaving.

Interview on 12/6/21 client #5 stated:
-The QP/Licensee #8 had told her that FS #7 would not be coming back, but not sure why.
-Don't recall the QP/Licensee #8 speaking with her about FS #7's behaviors

Interview on 12/6/21 the QP/Licensee #8 stated:
On 11/24/21 client #3 called 911 because she said she did not feel safe
-Client #3 had gone out with her sister and when she returned FS #7 was "furious" that client #3 had told her sister she was at the store and she allowed her sister in the facility.
-While staff is gone, clients were not allowed to let people in the facility.
-Client #3 told her sister she was scared of FS #7 and she (FS #7) was going to do something to her.
-Client #3 had called the police and told them FS #7 was mad at her and pulled her hair.

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-The police responded and called the QP/Licensee #9 and he went to the home as well.
-The police stated they did not believe client #3 and she had no visible marks.
-Client #3's sister arrived and took her home for the Thanksgiving holidays.
-The QP/Licensee #9 ensured client #3's sister that FS #7 would be gone by her return on 11/29/21.
-FS #7 was a full time live in staff.
-Spoke with all the clients and they stated they felt safe with FS #7 working until client #3 returned.
-FS #7 was" PRN (as needed)" due to "staffing crisis" and had just turned into full time
-They can't find staff to work anymore
-They continued to allow FS #7 to work after client #3 left with her sister until 11/29/21 when client #3 was to return.
-The other clients were "OK," and said they didn't see anything happen with FS #7 and client #3
-Did her investigation by speaking with the clients regarding the incident.
-Didn't feel she needed to remove her from the other clients as they did not express concern.
-Completed an incident report and Health Care Personnel Registry (HCPR) on 11/29/21
-The QP/Licensee #9 assured client #3's sister FS #7 would be gone by client #3's return.
-Client #3's sister brought her back on Monday 11/29/21
-On 11/29/21 they terminated FS #7
-They had to call the police because FS #7 had "rough handled" the van and they were thinking of pressing charges on her.

Interview on 12/9/21 the QP/Licensee #9 stated
-Client #3 called him on 11/24/21 and said FS #7 was angry with her because she had opened the door for her sister while FS #7 was gone to the

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V 132	Continued From page 11 store. -FS #7 had gone to the store and she told the clients not to open the door to anyone. -Client #3 called him upset telling him FS #7 was going to be mad at her -Told client #3 not to worry about it and let him know if anything happened. -Client #3 called her sister who told her to call the police if staff #7 did something to her -Client #3 then called the police and the police called him -Arrived at the facility and spoke with the police and told them he would have FS #7 leave -Client #3 told him that FS #7 had pulled her hair -Asked FS #7 about this and she said she did not touch client #3 -Asked the other clients in the home and no one saw the incident -At that point client #3's sister arrived and took client #3 with her because she did not feel she was safe at the facility. -Told the sister he would have someone else to work there when she returned in a few days. -Client #3's sister called and said client #3 would stay the full weekend at their house -Client #3's sister brought her back on Monday (11/29/21) and he "let [FS #7] go" -Clients had never told him FS #7 said threatening things or cursed at them -Allowed FS #7 to work for that week because client #3 was not there -The other clients had not complained, so he didn't think it would be a problem -Clients were in full support of FS #7 staying. -Had no reason to believe the other clients were threatened -FS #7 was loud with him on that night (11/24/21) because he told her that weekend would be her last one -"If I had someone to replace her, I would have let	V 132		

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
	MHL092-850	A. BUILDING: ______ B. WING ______	R 12/10/2021

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V 132 Continued From page 12 V 132

her go immediately."
-Arrived that day (11/29/21) and saw the damage to the van that was not there the day before
-FS #7 was upset on 11/29/21 and "messed" up the dash board and broke the windshield of the van because he had fired her
-He called the police and charged her with property damage
-FS #7 had never acted like that, but she had "talked back" to him when he was redirecting her, but not heard it toward the clients.

This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V 109) for a type B rule violation and must be corrected within 45 days.

V 318 13O .0102 HCPR - 24 Hour Reporting V 318

10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL
The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).

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V 318	Continued From page 13 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure a report to Health Care Personnel of abuse was completed within 24 hours. The findings are: Refer to V132 for information regarding incident of 11/24/21 with client #3 and Former Staff (FS) #7 Review on 12/6/21 of Level II Incident Report dated 11/29/21 provided by the Licensee/Qualified Professional (QP) #8 revealed: -"Consumer alleged that staff got mad with her for opening front door and later alleged that staff pulled her hair." Interview on 12/9/21 the Customer Service Rights Team Leader with Incident Response Improvement System (IRIS) stated: -The incident report dated 11/29/21 was entered by the QP/Licensee #9 but was not complete -No information on the consumer -The provider did not click on the "consumer report needed" -Did not click on the "Licensed Services" which is why it can not be viewed by the Division of Health Service Regulation (DHSR) -Did not put any comments in for the incident -No comments in supervisor actions or provider actions -Allegations for abuse was checked, but no information under Health Care Personnel Registry (HCPR) tab to report -Was not sent to the Local Management Entity (LME) only to the private health care provider -Clicked on no consumer report needed -There are no comments in the incident comment section	V 318	V 318 – HCPR - 24 Hour Reporting Effective 12/18/21, the Administrator, Director/CEO and direct care staff have been in-serviced on reporting requirements. Going forward, all allegations of abuse, neglect or exploitation will be reported to the Qualified Professional by the staff person who witnessed the incident immediately. If the administrator receives the information this should be reported to the QP immediately. The QP will report the allegation to the HCPR by way of entering the information into IRIS within 24 hours of receiving information of an allegation of abuse, neglect or exploitation. Subsequent investigation will be conducted and entered into the HCPR via IRIS within 5 working days.	

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V 318	Continued From page 14 -The report says "filed in error" -From what she can tell this is an incomplete report and there was no report sent to HCPR Interview on 12/10/21 the Qualified Professional/Licensee #8 stated: -The QP/Licensee #9 had completed the IRIS on 11/29/21 and completed on 11/29/21 regarding the abuse allegations. -She had completed her investigation prior to completing the incident report -They did not complete the IRIS report within the 24 hours due to the holidays and staffing issues. -Not aware the incident report in IRIS was not completed correctly This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V 109) for a type B rule violation and must be corrected within 45 days.	V 318		
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 15 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		

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V 366	Continued From page 16 (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 17 This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement written policies governing their response to incidents as required. The findings are: Review on 12/10/21 of facility's policy on Incident Reports revealed: -"The CEO (Chief Executive Officer) ensure that Level I, II or III incidents are responded to by assigning staff directly involved with the person and the Qualified Professional to: a. Immediately attend to the health and safety needs of persons involved in the incident b. Determine the cause of the incident c. Develop and implement corrective measure d. Develop and implement measure to prevent similar incidents, which will be monitored by the Human Rights Committee e. Be responsible for implementation of the corrections and preventative measure and f. Maintain documentation of a-e above." Refer to V132 for information regarding incident of 11/24/21 with client #3 and Former Staff (FS) #7 Review on 12/6/21 of Level II Incident Report provided by the Qualified Professional (QP)/Licensee #8 dated 11/29/21 revealed: -"Consumer alleged that staff got mad with her for opening front door and later alleged that staff pulled her hair."	V 366	V366 Incident Response Requirements The Interim QP has provided extensive training to the administrator and Director on requirements. Going forward all protocols will be followed. Incident will be entered into IRIS for HCPR notification within 24 hours. (The investigation will begin immediately once QP is notified and will be completed within 5 calendar days). All level II and III incidents will be entered into IRIS within 72 hours.	

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V 366	Continued From page 18 Review on 12/6/21 of "Progress Note" regarding client #3 completed by the QP/Licensee (QP) #8 dated 11/25/21 revealed: -"Client complained that staff was upset with her for telling on her and letting her sister in the house. So feels that she is not safe. Her sister asked her to call 911 if she felt threatened and notifying the directors. So client called 911 and [the QP/Licensee #8's husband (QP/Licensee #9)] also responded. On interview client said staff was forcing at her and pulled on her hair, but staff denied that. Client sister took her home for Thanksgiving and said that she will only bring her back if staff (FS #7) leaves. No witness saw anything." -Interview with client #4- "Interviewed [client #4] regarding her feeling safe with staff [FS#7] working here at Access or if she has any concerns. 'I like [FS #7], she cooks good and don't bother nobody. I feel safe around her.'" -Interview with client #5- "I don't have any issues with [FS #7]. I am fine." -Interview with client #6 -"I like [FS #7]. I don't have problems with her. I feel safe." Interview with FS #7 -"[QP/Licensee #8] my thing is this, you know these client are going to say anything to get their way. I did not touch [client #3]. She said that to make her sister take her home for Thanksgiving because [client #2 and #5] are going home. I was asking her why she lied on me. I went to the store to buy a few things I needed. You know [client #3] lies," Review on 12/6/21 of "Progress Note" regarding client #3 completed by the QP/Licensee #8 dated 11/29/21 revealed: -"Staff was sent home and client returned to facility, reassured her that she is safe and that staff will not return to the facility."	V 366		

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V 366	Continued From page 19	V 366		

Interview on 12/7/21 FS #7 stated:
-After the incident on 11/24/21 she continued to work alone with the clients until 11/29/21 when client #3 returned.
-Told the QP/Licensee #9 she did not touch client #3.
-"If I am so bad, why did they keep me there?"

Interviews on 12/6/21 clients #1, #2 & #4 stated:
-Did not recall the QP/Licensee #8 asking them any questions about FS #7 and client #3 altercation
-The QP/Licensee had not spoken to them about FS #7 leaving.

Interview on 12/6/21 client #5 stated:
-The QP/Licensee #8 had told her that FS #7 would not be coming back, but not sure why.
-Didn't recall the QP/Licensee #8 speaking with her about FS #7's behaviors

Interview on 12/6/21 and 12/10/21 the QP/Licensee #8 stated:
-QP/Licensee #9 had completed the Incident Report in Incident Response Improvement System on 11/29/21 regarding the abuse allegations.
-They did not get it completed in the time frame due to the holidays and staffing issues.
-She had completed her investigation prior to completing the incident report
-The QP/Licensee #9 had assured client #3's sister that FS #7 would be gone by her return on 11/29/21.
-Spoke with all the clients and they stated they felt safe with FS #7 working until client #3 returned.
-FS #7 was" PRN (as needed)" due to "staffing crisis" and just turned into full time

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V 366	Continued From page 20 -They can't find staff to work anymore -Continued to allow FS #7 to work after client #3 left with her sister -The other clients were "OK," and said they didn't see anything happen with FS #7 and client #3 -Did her investigation by speaking with the clients -Talked to clients and they did not take her off until 11/28/21 -Didn't feel she needed to remove FS #7 from working with the other clients -Completed an incident report and Health Care Personnel Registry (HCPR) on /11/29/21 -Client #3's sister brought her back on Monday 11/29/21 and FS #7 left because client #3 was coming back that day -On 11/29/21 they terminated FS #7 -Hired a new staff on 11/29/21 for a full time live in. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V 109) for a type B rule violation and must be corrected within 45 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	V 367		

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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 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

V367 Incident Reporting Requirements
As of 12/18/21 the Interim QP has provided an extensive training to all people on the staff of Access Health Systems (direct care, administrator, Director, etc..). Training included examples of level I, II and III incidents. Level of reporting will be decided by the Interim QP until the previous QPs have been cleared to resume as QPs. All incidents will be completed & entered into IRIS within 72 hours. HCPR notification must be submitted within 24 hours of learning of the incident.

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V 367	Continued From page 22 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 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 report Level III incidents within 72 hours of becoming aware of the incident affecting one	V 367		

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of six clients (#3). The findings are:

Refer to V132 for information regarding incident of 11/24/21 with client #3 and Former Staff (FS) #7

Review on 12/6/21 of Level II Incident Report dated 11/29/21 provided by the Qualified Professional (QP)/Licensee #8 revealed:
-"Consumer alleged that staff got mad with her for opening front door and later alleged that staff pulled her hair."

Review on 12/7/21 of the Incident Response Improvement System (IRIS) did not reveal the incident report dated 11/29/21.

Interview on 12/9/21 the Customer Service Rights Team Leader with IRIS stated:
-The incident report dated 11/29/21 was completed by the QP/Licensee #9 was not complete
-No information on the consumer
-They did not click on the "consumer report needed"
-Did not click on the "Licensed Services" which is why it can not be viewed by the Division of Health Service Regulation (DHSR)
-Did not put any comments in for the incident
-No comments in supervisor actions or provider actions
-Allegations for abuse was checked, but no information under Health Care Personnel Registry (HCPR) tab to report
-Was not sent to the Local Management Entity (LME) only to the private health care provider
-Clicked on no consumer report needed
-There are no comments in the incident comment section
-The report says "filed in error"

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V 367	Continued From page 24 -From what she can tell this is an incomplete report and there was no report sent to HCPR Interview on 12/9/21 the QP/Licensee #8 stated: -The QP/Licensee #9 had completed the IRIS on 11/28/21 and completed on 11/29/21 regarding the abuse allegations. -She had completed her investigation prior to completing the incident report This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V 109) for a type B rule violation and must be corrected within 45 days.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.	V 512		

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(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.

This Rule is not met as evidenced by:
Based on interview and record review one of one former staff (FS #7) abused six of six clients (#1, #2, #3, #4, #5, & #6). The findings are:

Review on 12/7/21 of FS #7's record revealed:
-Hire date of 11/2/20

Interview on 12/6/21 the Qualfied Professional (QP)/Licensee #8 stated:
-FS #7 was a full time live in staff for the last three to four months.

Review on 12/6/21 of client #1's record revealed:
-Admission date of 7/30/18
-Diagnoses of Schizoaffective and Neurocognitive Disorder
-Age 65

Review on 12/6/21 of client #2's record revealed:
-Admission date of 5/28/14
-Diagnoses of Schizophrenia and Hypertension
-Age 67

Review on 12/6/21 of client #3's record revealed:
-Admission date of 8/31/18
-Diagnoses of Schizoid Personality Disorder, Obsessive Compulsive Disorder (OCD), Hypertension, Hyperlipidemia and Hyperthyroidism
-Age 64

Review on 12/6/21 of client #4's record revealed:
-Admission date of 3/27/20

V 512-All clients will be free from abuse, negligence and harm. Reassessment of client's treatment goals/PCP and current needs occurred on 12/15 and 12/16/21. Client's health and safety will be primary. All clients have access to the QP and the role of QP has been fully explained to each client. The contracted QP has provided training in the areas of needs as identified in assessments, Treatment/PCP goals, Mental Health and Substance Abuse Diagnoses (as they apply to population served), Client Rights, Client Health and Safety, Incident and Behavior Reporting Procedures, Incident Reporting Requirements, Documentation, Cultural Competence, Workplace Behavior Ethics, Counter Productive Workplace Behaviors, Conflict Resolution Skills, Establishing Rapport, Self Coping/Identifying and utilizing appropriate coping skills, Steps for Mental Wellness, Preventing & Reporting Abuse, Neglect and Exploitation and reporting procedures and protocols including notifying DSS, Deescalating behaviors, Using the least restrictive intervention to diffuse a behavior, . QP will provide training on client rights on a monthly basis for the next quarter and then at least quarterly thereafter.

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-Diagnoses of Major Depression , Post Traumatic Stress Disorder (PTSD), Cocaine and Cannabis Use and Diabetes
-Age 65

Review on 12/6/21 of client #5's record revealed:
-Admission date of 8/19/19
-Diagnoses of Schizoaffective Disorder, Bi-polar Disorder and Type II Diabetes
-Age 60

Review on 12/6/21 of client #6's record revealed:
-Admission date of 6/23/21
-Diagnoses of Schizophrenia, Depression, Anxiety, Intellectually Disabled Disability (IDD), Subarachnoid hemorrhage/Traumatic Brain Injury and right eye blindness
-Age 37

Below are examples of FS #7 physically abusing clients.

A. Review on 12/7/21 of a Police Report dated 11/24/21 regarding client #3 revealed:
-"on 11/24/21 at approximately 1600 (4:00 PM) hours, I responded to 5208 Country Pines Ct for a check on a welfare of resident named [client #3]. [Client #3] reported her caretaker had abused her and she wanted assistance in being escorted out of the home. Prior to arriving on scene, she also reported that she had been hit in the head and her hair had been pulled by the care taker. Upon arrival, I was met by the care taker, [FS #7] and she escorted me to [client #3's] room. I asked to speak with [client #3] privately, but [FS #7] would not go back to the living room area and would stand in the hallway directly adjacent to the bedroom. [Client #3] reported the following:
-On today's date, shortly prior to calling police, [client #3] had been hit in the head and in the side

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of the head by her left ear by [FS #7]. [FS #7] then grabbed her satchel and ripped it from her body causing the strap to break. [FS #7] denied ever striking [client #3], but did admit to taking her bag after [client #3] handed it to her. [FS #7] reported [client #3] is a hoarder and is not allowed to have certain things, so she wanted to check the bag and take out certain items before giving it back...I then spoke with [client #3's sister] ...who advised [client #3] has been telling her [FS #7] has recently become more verbally abusive towards [client #3] and she no longer felt safe in the home. She also reported [client #3] has been called a racist by [FS #7] and has been threatened by her...She also reported [client #3] has no issues in the home until recently...During the time I spoke with [client #3's sister] on the phone, [client #3] reported [FS #7] hit her again with her bag after giving it back to her. [FS #7] denied hitting her with the bag. I checked [client #3] for injuries upon arriving on scene and coming back into the home, but did not see any signs of assault..."

Interview on 12/6/21 client #3 stated:
-Had to call the police a few weeks ago on FS #7 because she did not feel safe
-FS #7 had been getting upset with her for a while because she was telling her sister about FS #7 leaving and going to the store and to her home in nearby city.
-Her sister had come by several times and FS #7 was not present
-On 11/24/21 her sister came by and she allowed her sister to come in the home
-FS #7 had always told them while she was gone, not to answer the door to anyone.
-She knew FS #7 would be upset when she got back from the store because she allowed her sister in the home

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-FS #7 arrived and began to get close to her and pointed her finger close to her face, "you could tell she was upset."
-Then went to her bedroom to lay on the bed and realized she did not feel safe
-FS #7 came to her room and grabbed her hair on the side and pulled it and ripped off her "fanny pack" and hit her in the head with it.
-She (client #3) then put her coat on as she was going to leave
-She called her sister and told her what happened and her sister told her to call 911 if she did not feel safe and she was on her way back to the house.
-Called 911 several times to let them know she didn't feel safe and was threatened
-While the police were outside FS #7 then came back to her room and "assaulted" her again by hitting her with the "fanny pack" and breaking the strap on it.
-Spoke to two police officers and told them what happened
-Not sure if any of the other clients had seen what happened
-Police spoke to FS #7 who denied hitting her
-Her sister arrived so she left with her sister for the Thanksgiving holiday.
-When she returned on Monday 11/29/21, FS #7 was still at the house
-The police came back that day because FS #7 had done something to the group home van
-FS #7 had said if the QP/ Licensee #9 did not pay her, she would set the van on fire.
-FS #7 left that day and has not returned to work.
-Had seen her hit client #6, somewhere in the face or chest and had "dragged" her down the hall a few months ago.
-Never told anyone about seeing FS #7 hitting client #6

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Interview on 12/6/21 client #5 stated:
-On 11/24/21 FS #7 was upset with client #3 due to client #3's sister coming over.
-Heard FS #7 tell client #3 to go to her room stating, "I don't want to see your face."

During interview on 12/6/21 client #4 stated:
-FS #7 had punched her in the arm once while at a restaurant because she was nervous and FS #7 was trying to get her attention.
-Did not have a bruise from it
-Did not tell anyone about it
-Once in the van she hit client #6 in the face with an open hand because she was "acting out" and FS #7 couldn't take it anymore.
-Client #6 was having one of her behaviors.
-Client #6 then hit FS #7 back in the face
-FS #7 did hit client #3 in her face with a closed hand right before she went to her sister's home a few weeks ago.
-Client #3 called the police on FS #7 and she left to go to her sister's home

B. Below are examples of FS #7 verbally abusing clients

Interview on 12/6/21 client #3 stated:
-In the past FS #7 would get upset with her and call her a "snitch" and tell her she would have her "people" get her one day at the bus stop.
-FS #7 would curse at the clients a lot and never been physical until that day (11/24/21)

Interview on 12/6/21 client #5 stated:
-FS #7 was "rough around the edges"
-She would say, "I don't give a d**n, call the state, I don't give a f***k."
-She would get upset if they called the QP/Licensee #8 or the QP/Licensee #9 for

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anything
-FS #7 spoke like that to everyone in the home.
-Never told anyone because, 'that's just the way she is."
-She would always tell them she was from the "projects."
-Heard her once tell client #6 "I'm going to kick your a** and f**k you up"
-Never saw FS #7 hit anyone, just curse at them.

Interview on 12/6/21 client #2 stated:
-FS #7 cursed and yelled at them on a "regular basis."
-Had told her children about FS #7's tone and they called and told her not to "disrespect" their mother.
-FS #7 stated the clients were trying to get her fired and lied on her
-On occasion had heard her say to some clients, "I'm gonna beat the h#*l out of you."
-FS #7 could "blow up anytime" over stuff.
-She would tell them, "no one gonna put me under the bus."
-"She cursed a lot, and as soon as you meet her, she presents herself that way."
-Once "felt" like she was going to jump on her, but others were present in the home.
-FS #7 was upset and was walking real close behind her cursing at her.
-"Felt" like if she turned around FS #7 would have hit her.

Interview on 12/6/21 client #1 stated:
-FS #7 "has her ways, used lots of profanity, and treated some not so good."
-She would try to "intimidate us with profanity, and aggressive tone with her arms."
-"I don't miss her at all."
-She would curse at him a lot, "but I got numb to it."

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During interview on 12/6/21 client #4 stated:
-FS #7 can get "violent" and curse at them
-FS #7 had threatened to beat her up or fight her
-Was scared of FS #7
-"I'm glad she is gone."

Interview on 12/7/21 Client #3's legal guardian stated:
-Was informed of the situation on 11/24/21 on 11/29/21 by client #3's sister.
-Client #3's sister arrived on 11/24/21 and FS #7 was gone
-Client #3 was not supposed to open the door to anyone but she allowed her sister to come in
-When client #3 returned from her outing with her sister, FS #7 began to confront her about allowing her sister in the home.
-Client #3 told her that FS #7 then pulled client #3's hair and grabbed her "fanny pack"
-Client #3 called her sister and told her what happened
-Client #3 was told by her sister she was on her way and if she did not feel safe to call the police.
-Client #3's sister returned client #3 on 11/29/21 and FS #7 was there along with the QP/Licensee #9 and the police.
-The QP/Licensee #9 was attempting to get FS #7 to leave and she was threatening to harm the van
-FS #7 is known to not be "professional" and she had complained on her in the past to the QP/Licensee #8 about her behavior.
-Was at the home a few weeks before the incident on 11/24/21 and FS #7 was complaining to her about working too much and needed clients gone during the day so she could get her stuff done.
-Had spoke to the QP/Licensee #8 in the past about how FS #7 spoke "reckless" and did not

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care what she said even in her presence as a county employee.
-Had issues with FS #7 lying to her at a sister facility about one of her clients and "knew how she operated."
-When she would visit client #3 she would always speak to her outside to have privacy, but FS #7 would continue to walk in and out as they spoke.
-Believed what client #3 told her about being hit by FS #7, she is always "truthful"

Interview on 12/7/21 Client #3's sister stated:
-On 11/24/21 went to the facility to take client #3 her cell phone.
-FS #7 was not in the home, she had left to go to the store
-Client #3 let her in and said that FS #7 would be upset if she knew she had been to the home while she was gone
-Two hours after she left, client #3 called her and said that FS #7 had hit her "upside" the head and "talked ugly to her."
-Told client #3 if she did not feel safe to call the police and she would be on her way to get her
-When she arrived, the police were there and said it was going to be client #3's word against FS #7 because no one else saw anything.
-While she was outside speaking with the police, FS #7 "started in on me" saying "I have never seen you over here, you don't understand these people."
-While the police were talking to her, FS #7 would come up to her yelling and the police had to redirect her multiple times to step back
-Client #3 told her the strap on her "fanny pack" that she always wore was broken from FS #7 ripping it off of her and hitting her with it.
-Sewed the strap back on her "fanny pack" because its very important to her.
-Client #3 said FS #7 had told her she was going

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to find her sister and get her
-She would tell the clients she is from "the projects" in nearby city and she is tough.
-Client #3 said that FS #7 told her she would have someone get her at the bus stop
-Client #3 stated FS #7 had put her finger in her face several times
-Client #3 stated FS #7 had called her a "snitch" in the past for telling her what was going on there.
-FS #7 told client #3 "snitches get stitches"
-Told the QP/Licensee #9 she would not bring client #3 back until FS #7 was no longer employed
-Client #3 is always "truthful"

Interview on 12/7/21 FS #7 stated:
-Was employed off and on for four years at the facility
-Had been working the last 3-4 months straight as a live in staff
-On 11/24/21 client #3 called the police saying she had hit her
-Client #3 "lied" because she was wanting to go home for Thanksgiving like two of the other clients.
-Never touched client #3, "she is White, if I hit her, she would have a mark."
-Client #3 and her sister think they are "above the law."
-Client #3 is a "racist" that's why she said that stuff.
-Told the police she did not touch her and they did not charge her.
-Client #3's sister took her home that day and returned her on 11/29/21
-The QP/ Licensee #9 was there too and he called the police on her.
-He told the police she wouldn't leave, and "I told him you need to pay me my money, or I will mess your stuff up."

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-Had all her stuff packed up and ready to go, he just needed to pay her.
-She was terminated that day
-"If I am so bad, why did they keep me there?"
-Never touched any of the other clients, "I wouldn't touch those people"
-Never cursed at the clients
-"They are lying if they say I did."
-"I am tired of answering all these questions, because people lying on me and making me lose my license."

Interview on 12/8/21 the Police Officer stated:
-Responded to a call at the facility on 11/24/21.
-Client #3 was "pleasant to deal with but just said she was afraid of [FS #7."]
-Anytime she tried to talk to client #3 alone, FS #7 would not give her space.
-Client #3 still spoke to her even with FS #7 still there
-Client #3 did not have any visible marks or bruises
-When they were outside with eveyone, FS #7 began to get "loud and aggressive" when client #3's sister and the QP/Licensee #9 arrived.
-FS #7 did not handle herself in a professional manner of someone that was caring for mentally ill adults.

Interview on 12/6/21 the QP/Licensee #8 stated:
-On 11/24/21 client #3 called 911 because she said she did not feel safe
-Client #3 had gone out with her sister and when she returned FS #7 was "furious" that client #3 had told her sister that she was at the store and had allowed her sister in the facility.
-While staff was gone, clients were not allowed to let people in the facility.
-Client #3 told her sister she was "scared" of FS #7 and she (FS #7) was going to do something to

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her.
-Client #3 had called and told the police FS #7 was mad at her and pulled her hair.
-The police responded and the QP Licensee #9 went to the home as well.
-The police stated they did not believe client #3 and she had no visible marks.
-Client #3's sister arrived and took her home for the Thanksgiving holidays.
-The QP/Licensee #9 assured client #3's sister that FS #7 would be gone by her return on 11/29/21.
-Spoke with all the clients and they stated they felt safe with FS #7 working until client #3 returned.
-On 11/29/21 they terminated FS #7
-They had to call the police because FS #7 had "rough handled" the van and they were thinking of pressing charges on her.

Interview on 12/9/21 the QP/Licensee #9 stated
-Client #3 called him on 11/24/21 and said FS #7 was angry with her because she had opened the door for her sister while FS #7 was gone to the store.
-FS #7 had gone to the store and told the clients not to open the door to anyone.
-Told client #3 not to worry about it and let him know if anything happened.
-Client #3 called her sister who told her to call the police if staff did something to her
-Client #3 then called the police and the police called him
-Arrived at the facility and spoke with the police and told them he would have FS #7 leave
-Client #3 told him that FS #7 had pulled her hair
-Asked FS #7 about this and she said she did not touch client #3
-Asked the other clients in the home and no one saw the incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-850	A. BUILDING: ______ B. WING ______	R 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH SYSTEM 2, INC	5208 COUNTRY PINES COURT RALEIGH, NC 27616

(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 512	Continued From page 36 -At that point client #3's sister arrived and took client #3 with her because she did not feel she was safe at the facility. -Told the sister he would have someone else to work there when she returned in a few days. -Client #3's sister called and said client #3 would stay the full weekend at their house -Client #3's sister brought her back on Monday (11/29/21) and he "let FS #7 go." -Clients had never told him FS #7 said threatening things or cursed at them -Allowed FS #7 to work for that week because client #3 was not there -The other clients had not complained, so he didn't think it would be a problem -Clients were in full support of FS #7 staying. -Had no reason to believe the other clients were threatened -FS #7 was "loud" with him on that night (11/24/21) because he told her that weekend would be her last one -"If I had someone to replace her, I would have let her go immediately." -Arrived on 11/29/21 day and saw the damage to the van that was not there the day before -FS #7 was upset and "messed up" the dash board and broke the windshield of the van because he had fired her -He called the police and charged her with property damage -FS #7 had never acted like that, she has "talked back" to him when he was redirecting her, but not heard it toward the clients. Review on 12/10/21 of "Plan of Protection" completed by the QP/Licensee #8 on 12/10/21 revealed the following, -"What immediate action will the facility take to ensure the safety of the consumers in your care? -Staff involved with the incident was	V 512		

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V 512	Continued From page 37	V 512		

terminated already. New staff hired after this incident was trained on abuse/neglect and harm. [QP/Licensee #8 and QP/Licensee #9] will pop in frequently during the week to observe staff and client interaction. We will have monthly meetings with the clients only.
-Describe your plans to make sure the above happens.
-Staff was already terminated and will not return. All staff hired in the future will continue to be trained in abuse, harm and neglect prior to starting job. Will have the cross covering QP monitor and provide staff supervision intermittently until we are back into compliance."

Clients diagnosed with Schizophrenia, Schizoaffective disorder, Bi-Polar, OCD, PTSD, Major Depression and IDD were all subjected to verbal abuse by FS #7. FS #7 had threatened several clients with violence along with daily cursing at them. All six clients were subjected to this violent behaviors through out the last few months as FS #7 was the only staff employed as the live in full time staff. On 11/24/21 client #3 called 911 to report FS #7 had pulled her hair and ripped off her fanny pack and hit her with it. The altercation occurred after client #3 had allowed her sister in the home while FS #7 had left to go to the store. FS #7 returned from the store and learned client #3 had let her sister in the home and began to argue with client #3 which was witnessed by client #4 who observed FS #7 hit client #3 in the head area. Client #3 and client #4 had witnessed FS #7 physically hit client #6 in the face a few months ago. FS #7 denied ever cursing/threatening or physically assaulting any of the clients. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days. An administrative penalty of $1,000.00 is imposed. If the violation is

Division of Health Service Regulation

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V 512	Continued From page 38 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 512		
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. This Rule is not met as evidenced by: Based on observation and interviews the facility was not maintained in a clean, safe and attractive manner. The findings are: Observation on 12/6/21 at 12:30 PM revealed: -Vent in the living area was covered in lint and dust -The wall in the hallway had areas of paint peeling back and several one inch size holes -Hallway bathroom had trash on the floor, the sink was clogged with water standing in it and the bath tub was dirty with black mildew -Client #4 and #6's bedroom had hair all over the floor, clothes stacked in piles around the room -Client #4 and #6's bathroom's sink was clogged with standing water and bathtub with black mildew -Back door blinds were broken and falling apart Interview on 12/6/21 client #4 stated:	V 736	V 736 – Facility Grounds and Maintenance. The facility administrator has started the process of making repairs and painting specific areas in the group home. Going forward the administrator and director will complete monthly inspections in the home and will make necessary repairs or modifications within a timely manner. Additionally, the QP will inspect at least quarterly and advise the administrator and director that repairs are needed. This will be monitored by the Facility Administrator monthly and QP at least quarterly.	

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V 736	Continued From page 39 -The hair on the floor was from her when she brushed her hair -Their sink has been clogged for a few days -They help clean the bathroom, but had not done so in a few days. Interview on 12/6/21 the Qualified Professional (QP)/Licensee #8 stated: -Had not been to the house in a few days. -The last time she was there it was clean -There is a new staff and not sure he has been making the clients clean up -Not aware of how long the sinks had been clogged as no one had old her about it Interview on 12/9/21 the QP/Licensee #9 stated: -He had a repair man that fixed things in the house -The staff was to let them know if something was broken so they could get the repair guy out. [This is a recited deficiency and must be corrected within 30 days]	V 736		

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