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	MHL092-751	A. BUILDING: _____ B. WING _____	R-C 01/10/2022

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 1/10/22. The complaint was substantiated (Intake #NC00183509). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The survey sample consisted of audits of 4 current clients and 3 former clients.	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	V 110		

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V 110	Continued From page 1 develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

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

Review on 1/10/22, staff #1's record revealed:
- Hired: 1/27/15
- Job description listed title "Supervised Living Facility Worker"

Review on 12/9/21 of Former Client (FC) #7's record revealed:
- Admitted: 10/29/21
- Discharged: 11/14/21
- Diagnoses: Schizophrenia, Right Hip replacement, Arthritis, Hypertension and Hypothyroidism

a. Review on 12/10/21 of a police report dated 11/7/21 at 6:20 AM revealed:
- "Paraphrased statement of [staff #1]. [FC #7] woke up this morning and said he wanted some coffee and his medication. He got upset that I did not get them quick enough and he started getting aggressive. I heard something breaking and then I looked outside, he had a piece of glass or something in his hand while walking around in the front yard.

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V 110	Continued From page 2 - [FC #7] said he was frustrated with the staff because he was not getting his schizophrenia medications and feels that they treat him 'like a dog.' [FC #7] said he broke the window out of frustration." Interview on 1/6/22, the Officer who responded on 11/7/21 reported: - He did not witness any inappropriate interaction between staff #1 and FC #7. - FC #7 was agitated each time staff #1 came near him. FC #7 "huffed or frowned" each time staff #1 came around during the visit. - He did not spend a lot of time at the facility. He just took the report and transported the client to the emergency room (ER). b. Review on 12/13/21 of a EMS (Emergency Management System) report dated 11/14/21 at 4:59 PM revealed the following from the First Medic: - "Patient (FC #7) is a 67 YOM (year old male), sitting on the front porch. When we arrive on scene he gets up and begins to walk towards the ambulance. We meet him in the front yard. He is A&Ox4 (alert and oriented). He has a diagnosis of paranoid schizophrenia. He is aware of his diagnosis and will agree that he feels paranoid. He admits that he was at the hospital twice yesterday. When asked why he called 911 today he states, 'the medication they gave me at the hospital yesterday wore off.' When asked if he has had pain today he states, 'well the medication wore off this morning, I've just been laying in bed all day.' When asked if he took his medication this morning he states, 'no I did not. They don't work like the medications at the hospital.' Patient struggles to understand reason, and refuses to believe that he was given the same medications at the hospital as prescribed at the group home.	V 110		

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V 110	Continued From page 3 - From previous encounters with the patient it is noted that he is agitated by the group home staff member (staff #1). She is noted to come outside while we are speaking with the patient, he becomes very agitated and irate. EMS has to split up to speak with the group home staff member and move the patient away from the situation. - Patient is asked if he has a medical complaint or if he just wants to get away from the staff member and he states, 'both.' When asked what his current complaint is again he states, 'well my hip hurts, my chest hurts when I move and take deep breaths, and my back hurts.' He denies having asked for his PRN (as needed) pain medications stating, 'it doesn't work like the stuff at the hospital.' Patient also informs EMS, 'I don't take my medications everyday because they make me constipated.' Patient is also prescribed a stool softener. We informed that he is prescribed a stool softener patient states, 'I'm just going to stop talking, you aren't listening to me.' Patient continues to engage when asked questions. He is able to walk to the ambulance and sit on the bench seat. Vitals are obtained and as noted. Patient noted to be hypertensive. He does complain of a headache, and states that he did refuse his medications this morning and last night. - [Second Medic] arrives on scene, she knows of the patient and his current status. She attempts to speak with the patient as well, but with same outcome. After [Second Medic] is informed of the multiple altercations with the staff members she advises that she will be informing [guardian] and sending an email. Patient does appear grateful of this news, but we do inform him that he has to come back to this group home until something else can be worked out. He is informed that this is the home he is currently assigned to, and we cannot change that by	V 110		

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ourselves. Patient is also informed that if he is having issues at the group home he needs to contact his appointed guardian and let her know."

Review on 12/13/21 of an EMS report completed by the Second Medic dated 11/14/21 at 7:51 PM revealed:

- "Today the patient called EMS for hip pain and headache, patient also stated he did not want to be in this group home because the caregiver provokes him. Patient admits he refused his prescribed medications yesterday (but received them at [hospital]). States he refused them today because he does not feel like they work and he admits he refused his prescribed medications yesterday (but received them at [hospital]). States he refused them today because he does not feel like they work and he does not want to be constipated. Patient was advised of the importance of being compliant with his medications and that he does have pain medications in his med (medication) list PRN (as needed). He advised it did not work. The patient was complaint with assessment questions and was not delusional at this time. He was agitated, when asked why he felt agitated he stated that the caretaker refuses to take him to the store to get personal items and she has taken his cigarettes and will only give him 3. States that when he is on the phone with the VA (Veterans Administration) representative she will pick up another phone in the home and begin talking and he can not continue the conversation with the VA representative. He states he does not know why she has done this. He states that caretaker advised him he could not be seen at the [nearby] VA because his paperwork has not been transferred. He was advised that not liking the caretaker was not a reason to be transported to the ER and that he needs to make his Guardian

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aware of his concerns. He stated he understood, but is fearful she will not listen.

- EMS [local unit number] stated they had a poor interaction with the caretaker on their arrival, they stated she was rude, antagonizing the patient to the point they had to move him to the truck. Stated she was not receptive when they were explaining the assessment process and would interrupt them while they were trying to assess him. States that every time the patient began to speak she would interrupt the patient. States they had to ask for copies of his paperwork several times and that she was short and dismissive. States she shut the door on them multiple times when they were trying to ask her questions concerning the patient and his current behavior. She advised them that he was just diagnosed at [local hospital] with Schizophrenia and that he needs mental help and needs to go back to [hospital] His Group Home chart clearly states his history and he is on Psych (psychiatric) medications.
- Spoke to [staff #1] the group home caretaker, when asked about the patients current behavior she was unable to explain any concerns and wanted to talk about other residents. She stated he needed mental help and does not need to stay there. When asked if she is supposed to take the patient to the store to get personal items she stated 'he does not need to go anywhere.' When asked who gets his personal items she stated 'he does not need to go anywhere'. She did not appear to be able to understand the questions she was being asked. When asked about his care through the VA she stated he could not be transported to the VA because of his paperwork being transferred. She was asked about the cigarettes and she stated 'they told me to only to give him 3', When asked who 'they' are she would only state 'they.' She was evasive when asked

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questions and would state call the owner of the group home and that he knows.
- Spoke to [name] the on call SW (Social Worker) for the [guardian agency], she stated she was not familiar with the patient and she advised transport to the ER for evaluation because she was not aware of his history or current situation. She was made aware of the EMS crews concerns and [Second Medic's] interaction with the patient and care taker. While speaking to her, the caretaker walked up to the [Second Medic] vehicle and stated that the patients problem was that he was to idle that the residents do nothing but eat, sleep and take medications. Stated 'they are men, they need to be men and be doing something.' The guardian was able to hear the conversation with the caretaker. The guardian stated she was documenting everything and was sending it to the patients guardian so she can follow up the care taker situation and on the VA situation because she does not understand why he can not be evaluated at the VA."

Interview on 12/15/21 the EMS driver reported:
- Staff #1 came up to the EMS and FC #7 was getting agitated.
- "The lady (staff #1) was agitating [FC #7]. She was basically complaining because he wanted to go the hospital and she would have to go pick him up later and it needed to stop. It would take time out of her day. Basically, an inconvenience because she had done it once. I'm paraphrasing."

Interview on 1/5/22 the guardian on-call for FC #7 reported:
- She could not recall specifics of the calls regarding FC #7 during her on call time.
- She did recall communications with the EMS worker. The EMS worker expressed concerns

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V 110	Continued From page 7 regarding the interactions between FC #7 and the on duty staff (#1). The EMS worker expressed that staff #1 was "evasive, hard to get anything out of her, she only gave him (FC #7) 3 cigarettes." - The EMS worker was on speaker phone and she did hear staff #1 say "men need to be men and they need something to do." Interview on 1/7/22 staff #1 reported: - She did not recall any concerns with her interactions with FC #7. Interview on 1/10/22 the Licensee/QP #1 reported: - She was not aware of concerns regarding staff #1's interactions with clients. - She needed to discuss with staff #1 concerns expressed.	V 110		
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 8 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 record review and interview the facility failed to ensure 1 of 4 current clients' (#2) and 1 of 3 former clients' (FC #7) 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		

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a. Review on 12/9/21 of client #2's record revealed:
- Admitted: 11/5/21
- Diagnoses: Bipolar, Hypertension, Neurogentic disorder, brain injury, Attention Deficit Disorder and Ataxia.
- No documentation of an assessment for unsupervised time.

Review on 1/10/22 of client #2's record revealed:
- Unsupervised time assessment completed by the Qualified Professional dated 11/26/21 for 1-2 hours daily in the home or community.
- Signature of the client noted on the assessment.

Interview on 1/10/22 of client #2's guardian reported:
- He did not recall having discussion about unsupervised for his son with Licensee/Qualified Professional (QP) #1.
- He would not have a problem if his son had unsupervised time.

Interview on 1/10/22, Licensee/QP #1 reported:
- She did not know why staff #1 could not locate client #2's unsupervised time assessment on 12/9/21.
- She recalled talking with client #2's guardian about unsupervised time for him to exercise.
- She was not sure why the guardian did not recall the telephone call.
- The client signed the unsupervised time assessment form because "the client would be responsible for following the rule."

b. Review on 12/9/21 of FC #7's record revealed:
- Admitted: 10/29/21
- Discharged: 11/14/21
- Diagnoses: Schizophrenia, Right Hip

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replacement, Arthritis, Hypertension and Hypothyroidism
- No documentation of an assessment for unsupervised time.

Review on 12/10/21 of the local Emergency Management System (EMS) reports between 11/13/21 and 11/14/21 revealed the following about FC #7:
- 11/13/21: PSAP (public safety answering point- when an emergency call center initiated per a subscriber ends)
8:32 AM, EMS on scene at the facility
8:40 AM, accessed due to complaints of chest pains
9:22 AM, transported to hospital per his request
- 11/13/21: PSAP-1:38 PM,
2:50 PM, EMS enroute
3:00 PM, EMS on scene
3:12 PM, EMS transport to hospital

Review on 1/6/22 of local hospital records between 11/09/21 and 11/14/21 revealed FC #7 was seen in the emergency room on 11/13/21:
- At 8:44 AM and discharged at 12:03 PM. Unsuccessful attempts were made to contact group home using three different numbers, Guardian and Licensee/Qualified Professional (QP) #1. Messages were left during each attempt. FC #7 was transported back to the group home by a ride sharing service.
- For a second visit at 3:40 PM and discharged at 6:18 PM. At 5:30 PM, contact was made with staff #1 to make aware client would be sent back to the group home. He was transported back to the group home by a ride share service.

Interview on 12/9/21 staff #1 reported:
- All clients (#1, #2, #3, FC #5, FC #6 and FC

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V 290	Continued From page 11 #7) admitted to the group home between 11/1/21 and 12/9/21 had unsupervised time. - "[Client #2] he just got here, I don't know how much time he has. I don't know how much [Licensee/QP #1] gave him." - "[FC #7] has unsupervised time I don't know" how many hours. - She had always been home and never left clients in the home unsupervised. - She did not recall a time when EMS (Emergency Management System) arrived and she was at the group home or arrived while they were on site. Interview on 12/10/21, staff #1 reported: - After she looked through the clients' records and talked with the Licensee/QP #1, FC #7 and client #2 did not have unsupervised time. Interviews between 12/9/21 and 12/15/21, client #2 and client #1 verified staff was always home when EMS arrived for FC #7. Client #2 reported during one occasion, he was in bed when EMS arrived. He was asleep and was not able to provide any information on that visit. Interview on 12/17/21, the local police officer reported the following about 11/13/21: - He was the first emergency personnel on the scene. "This was around 3:00-4:00 PM." - "It took awhile for EMS to arrive." He estimated 45 minutes before EMS arrived at the facility. - Upon arrival, FC #7 was outside on the steps and reported no staff was inside. - Police never went inside the home. - Police rung doorbell and at least two different clients confirmed no staff were inside the home.	V 290		

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V 290	Continued From page 12 Interview on 12/10/21, Advanced Practice Medic reported the following about 11/13/21: - He was the second emergency personnel on site after the local police. - Earlier in the week, he had responded to several calls that involved FC #7. - During prior calls, group home staff was available on site. - Upon arrival, no staff was on site. He walked through the home and asked clients about staff. - He could not recall how many clients were home. He recalled one was in the bed. Interview on 12/15/21, the EMS Driver on 11/13/21 reported: - Due to an overwhelming number of calls, her unit was not initially cleared to respond. - Estimated a 30 minute time lapse between when the Advance Practice Medic arrived and her arrival. - A van pulled up at the group home simultaneously as she arrived with the EMS vehicle. - The van driver/staff #1 was asked to move the van because it blocked EMS's access to the driveway. Interview on 12/17/21 staff #1 reported: - She now recalled not being at home when the EMS arrived to pick up FC #7 - The morning of 11/13/21, FC #7 was taken to the hospital. - Later that afternoon, she had to leave the home to "run an errand." - When she left the home, FC #7 was not at the home. - Upon her arrival, EMS was at the group home to take FC #7 back to the hospital. - She was not sure how or whom returned FC #7 to the group home.	V 290		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	Continued From page 13 Interview on 12/10/21, FC #7's guardian reported: - She became his guardian in April 2021. - Before admission to this group home, he had been in a psychiatric hospital since July 2021. - "I don't think he can have unsupervised time." - "I would be concerned because he might do something to someone else or be taken advantage of...I can see him getting agitated or getting beat up or harmed." - "From what I remember, they (psychiatric hospital and group home) did an assessment on him and they would've known that he was not to be left alone." - FC #7 had a history of elopement and property destruction. Interviews between 12/17/21 and 1/10/22 the Licensee/QP #1 reported: - Although the EMS had been contacted on more than 5 occasions for FC #7, she thought the incident occurred on 11/14/21 not 11/13/21. - FC #7 did not have unsupervised time. - The hospital discharged FC #7 without speaking to a staff. - She discussed the occurrence with staff #1 after 12/17/21. Staff #1 disclosed the "errand" she performed was to the local grocery store. - She did not agree the group home should be cited when the hospital did not make contact directly with the staff. - She did not recall receiving a missed call or any communication from the hospital of his discharge. Review on 12/17/21 of the facility's Plan of Protection dated 12/17/21 submitted by the Licensee/QP #1 revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care?	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-751	A. BUILDING: _____ B. WING _____	R-C 01/10/2022

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V 290	Continued From page 14 All clients in our facility are supervised by our staff while under their care except if they have unsupervised time approved. QP will complete an unsupervised time assessment on every new client into the facility to determine need as per supervision rule not later than 30 days of admission - Describe your plans to make sure the above happens. QP will ensure that all new clients assessments are done by checking their chart and reviewing with staff at the facility every month and complete any unsupervised assessment due. The new client [FC #7] in question had an assessment started but already indicated he is not staying and 30 day notice to vacate facility was already served." Clients #2 and FC #7 who were diagnosed with Bipolar and Schizophrenia respectively, resided at the group home on 11/13/21. Both had been admitted to the facility less than 30 days. Neither client had been assessed and deemed capable of unsupervised time. FC #7 contacted emergency management systems and complained of chest pains. Upon arrival of Police and EMS, no staff was available on site at the group home. An estimated 45 minutes to an hour time lapsed without staff at the home. The lack of staff available in an emergency situation 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 290		

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V 736	Continued From page 15	V 736		
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, record review and interview the facility was not maintained in a safe, clean and attractive manner. The findings are: a. Observation 12/9/21 at 10:07 AM revealed the following: - Client #1 peeled back the cardboard and yelled out the window - Living room window broken: Shards of glass pieces broken in the 3 window panes Fitted card board pieces taped against the broken window from inside Review on 12/10/21 of the facility's IRIS (incident response improvement system) report submitted 11/9/21 revealed - on 11/7/21 6:00 AM Former Client (FC) #7 "had a verbal altercation with another resident night before, calmed down, next morning, woke up early and told staff he was up and asked for coffee. Next thing he went to the living room and started breaking the front glass windows, pieces all over the floor." Review on 12/10/ 21 of a police report dated	V 736		

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V 736	Continued From page 16 11/7/21 at 6:20 AM revealed: - "Paraphrased statement of [staff #1]. [FC #7] woke up this morning and said he wanted some coffee and his medication. He got upset that I did not get them quick enough and he started getting aggressive. I heard something breaking and then I looked outside, he had a piece of glass or something in his hand while walking around in the front yard." Interview on 12/9/21 staff #1 reported: - FC #7 broke the window in the living room. - She deferred questions about the incident to the Qualified Professional (QP) #2 who was the Licensee/QP #1's husband. Interviews between 12/9/21 and 12/10/21, the QP #2 reported: - He had attempted to secure a company to fix the living room glass. - The first glass company canceled the appointments or never came. - Difficult to secure a glass company due to issues with supplies and work demands. - He called a second glass company and an appointment was scheduled for 12/10/21. Interview on 12/10/21, the first glass company representative provided by QP #2 reported: - Per their records, they had not received any inquiry regarding the address, QP #2's name or telephone numbers related to this group home. Interview on 12/10/21, the second glass company representative provided by QP #2 reported: - Company was contacted on Monday 12/6/21 regarding the broken window. - Between Monday 12/6/21 and Tuesday 12/7/21, an onsite estimate and assessment was conducted. Friday 12/10/21 between 10 AM -12	V 736		

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V 736	Continued From page 17	V 736		

Noon was scheduled for the repair.
- If an inquiry had been made earlier, the company would have been able to repair the window sooner.

Interview on 1/10/22 the Licensee/QP #1 reported:
- QP #2 told her he had email exchanges of attempts made to get the window repaired.
- It was her understanding, the November 7-December 6 delay with fixing the broken window was due to the company not showing up as scheduled for the repair.
- She was not directly involved in the process of replacing the window.

b. Review on 12/14/21 of the facility's public file maintained by Division of Health Service Regulation revealed:
- Sanitation inspection report dated 11/19/21 listed demerits issued for areas throughout the home regarding baseboards and inadequate lighting

Observation and interview with staff #1 on 12/14/21 between 10:00 AM- 11:00 AM revealed the following:
- Outside Entrance:
  Burgundy car no license plate, located closest to the entrance of fence to the backyard
  Blue car with air bag inflated, passenger side front end torn, no license plate, located behind the Burgundy car
- Bottom Level:
  Open Office area-3 large brown stains on the ceiling. Stains were larger in size than a 10 inch plate
  Bedroom (formerly occupied by FC #8)-mattress sunken on left side
  Bedroom (formerly occupied by FC #10)-poor

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V 736	Continued From page 18	V 736		

lighting in the room, no covering on overhead light fixtures that used elongated fluorescent bulbs, small indention of sheetrock noted near electrical plug.

Bathroom- caulk missing, open gap around base of commode,

baseboards and corners had dirt build up

3 light vanity missing one bulb, second bulb blown

bathtub had dark stains and dirty inside, tile dirty

sink...cabinet separating leaving spacing between wall, missing caulk

- Upper Level:

Bathroom- sink cabinet separating leaving spacing between wall, missing caulk

Dining room- 4 of 6 chairs loose in nature when touched,

dusty shade on lamp located in the middle of the dining table

baseboards dirty

Interviews between 12/9/21 and 1/6/22, Licensee/QP #1 reported:

- The cars had been in the driveway for less than a year. A person was supposed to come pick up the cars but never did. She would discuss with her husband who was also QP #2.
- In regards to the missing bulbs, stains in bathtubs, caulking needed, she planned on repainting, deep cleaning and replacing items within the next few weeks.
- She was not aware the dining tables were loose.
- She was not aware the items identified during the 10/15/21 survey as she did not received the report until 12/20/21.

This deficiency has been cited 4 times since the

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V 736	Continued From page 19 original cite on 3/05/18. Review on 12/9/21 of the facility's Plan of Protection dated 12/9/21 submitted by the Licensee/QP #1 revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? All consideration was given towards the safety of all clients and staff of Access Health System I regarding the front upstairs windows broken by one of our former clients. The window was boarded with cardboard and sealed to prevent anyone accessing it pending glass company coming to fix it. Clients were instructed not to go there. Sign put up for danger, do not touch. - Describe your plans to make sure the above happens. All efforts were made to secure an earlier appointment to fix the window without success until 12/10/21 when it was fixed. It is interest of [Licensee/QP #1 and QP #2] to protect the interest and safety of all the clients under our care in any of our facilities." The facility served 4 adult males who had diagnoses that included Schizophrenia, Mild Intellectual Disabilities and Brain Injury. The facility had been cited by Division of Health Service Regulation multiple times since 3/5/18 regarding the living environment. Cleanliness, mattresses and lighting concerns had been noted during past surveys as well as sanitation reports. In November 2021, a 30 day time frame lapsed before the broken window was repaired. The broken glass still hanging in the window only covered by taped up cardboard for which a client was seen peeling back & looking out the window. This deficiency constitutes a Type A1 rule violation for serious neglect and must be	V 736		

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V 736	Continued From page 20 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 736		