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{V 000}	INITIAL COMMENTS A follow up survey was completed on 2/11/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability The survey sample consisted of two current clients.	{V 000}		
{V 109}	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall	{V 109}		

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{V 109}	Continued From page 1 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 observation, record review and interview one of one Qualified Professional (QP) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Review on 2/9/22 of the facility's public file maintained by the Division of Health Service Regulation revealed the following: - Statement of deficiencies dated 9/2/21 and 1/3/22 in which violation was cited for citations regarding oversight of treatment plans, protective devices, coordination of service and medication administration. - Plan of Correction dated 1/12/22 signed by the Quality Improvement Director (QID, also referred to as Director of Quality Management) the facility would be in compliance on 1/25/22. Corrective action for this violation included "The facility will ensure training to all staff and QP on goals and strategies identified in the treatment plans and behavior support assigned clients. The facility will ensure all persons functioning in the capacity of a QP, demonstrates knowledge, skills abilities required to serve the population to	{V 109}		

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{V 109}	Continued From page 2 include but not limited to the following..." Review on 2/11/22 of the QP's record revealed: - Hired: 1/14/22 - QP's job duties dated 1/25/22 and signed by the QP revealed: "Responsible for the psychosocial active treatment delivered to the consumers in a manner commensurate with the vision, mission, and values of Victor & Associates, Inc. (Licensee) Provide direct intervention and also arrange, coordinate and monitor services. Facilitate initial development and ongoing revision of individual Support Plan. Implementation of the consumer's individualized individual Support Plan. Shall initiate and oversee the process of assessment and reassessment of the individuals level of care and the review of the Individual Support Plan On-site training for paraprofessionals on an as needed basis (i.e. new hires, re-training) Orient and supervise employees that provide active treatment Mediate between the individuals and environment assuring the least restrictive environment is available to help the individual improve capabilities for independence (i.e., school, level of care, etc.)" "MARS (Medication Administration Record) oversight" - Training: 1/14/22 Behavioral Support Plan (BSP) and Medication Administration Record provided by the QID A. Cross-reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112). Based on record review and interview the facility failed to implement strategies	{V 109}		

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{V 109}	Continued From page 3 in a Treatment Plan for one of two clients (#1). B. Cross-reference: 10A NCAC 27G 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118). Based on observation, record review and interview the facility failed to ensure medications were administered on the written order of a physician and MARs were kept current for two of two audited clients (#1 and #2). C. Cross-reference: 10A NCAC 27G .5603 OPERATIONS (V291). Based on record review and interview the facility failed to coordinate services for one of two clients (#1). D. Cross-reference: 10A NCAC 27E .0105 PROTECTIVE DEVICES (V531) Based on record review and interview the facility failed to ensure a protective device was implemented by employees who were trained and demonstrated competence in the utilization of a protective device for one of two clients (#1). Interview on 2/9/22 the QP stated: - Prior to her hiring, the Director of Operations (DOO) provided oversight to the group home. The DOO served as her immediate supervisor. - She was hired 1/24/22. Later she clarified upon reviewing some training paperwork, she started 1/14/22. - As part of her job duties, she reviewed and completed a log of areas she monitored at least twice a week. These areas included monitoring BSPs and medications. - She provided trainings as needed or identified. - On 1/14/22, she was trained by the QID and immediately trained staff on BSPs Interview on 2/11/22 the DOO stated:	{V 109}		

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{V 109}	Continued From page 4 - No time lapsed between when the Former QP transitioned to another role and when the current QP was hired. - She did not serve as interim QP. Interview on 2/11/22 the QID stated: - The current QP's training was "ongoing" and shared between he and the DOO. - Group Home staff were newly hired and training was "ongoing." Review on 2/11/22 of the facility's Plan of Protection dated 2/11/22 signed by the QID revealed the following: - "What immediation action will the facility take to ensure the safety of the consumers in your care? The QPs will be in-service on the behavior support plan by the Director of Quality Management for all clients in the home, and with special emphasis on the application of protective helmet for client as outlined in the BSP. The QPs for the group home and day program will monitor in the home and in the day program and during van transport-at least 3 times weekly and provide training to all staff on the BSPs to include but not limited to the application of the protective helmet and documentation requirements. QPs for the group home and day program will monitor in the home and in the day program to ensure that all staff document on the MAR with initials that all medications are present in the home and are administered in accordance with the physician's orders. The monitoring will occur at least 3 times weekly and the QPs will provide training to all staff on the administration of medications to ensure compliance with physician's orders. The Director of Operations and Director of	{V 109}		

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{V 109}	Continued From page 5	{V 109}		

Quality Management will conduct weekly monitoring at the day program and the group to ensure continued compliance.

The Director of Operations has scheduled a staff meeting on 2/15/21 to discuss the survey findings relative to implementation of BSP and administration of medications and MAR documentation.

*This provider contends that the findings do not support a need for a plan of protection as there was no evidence present to represent a threat to a client's safety and health.

-Describe your plans to make sure the above happens.

[Person's Name] Quality Management Director and the Director of Operations will monitor to assure the actions are in place and documented accordingly."

This deficiency constitutes a re-cited deficiency and must be corrected.

The facility served clients diagnosed with Mild Intellectual Developmental Disability (IDD), Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder, Type II Diabetes, Autistic Spectrum Disorder, Profound IDD and Cerebral Palsy.

Client #1 had a BSP dated 9/10/21 to reflect the use of a soft protective helmet. The BSP outlined strategies of helmet usage for Self Injurious Behavior, 10 minute interval checks for compliance with maximum length of 1 hour and 50 minutes. Client #1 exhibited behavior at the day program on 2/9/22 and the group home on 2/8/22. Documents developed by the Licensee for use at the day program did not reference if or how long the helmet was applied. Although no data sheets were at the home for the 2/8/22

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{V 109}	Continued From page 6 incident, the completed incident report did not reflect the length of time client #1 was in the helmet. Newly hired group home staff #1 noted the helmet was to be used for ambulation due to unsteady gait and when she rode in the van. This targeted behavior of unsteady gait was not noted in the BSP. No documentation to support staff #1 and staff #4, hired since 1/25/22, had been trained on client #1's BSP. Interviews with day program and group home staff revealed client #1 entered the day program with her helmet on. This continued to be an ongoing issue prior to 1/25/22.. Client #2's 2/7/22 night and bedtime medications were still in the bubble packet, although the MAR reflected the medication was administered. Client #1's Lactose was not at the facility but initialed as administered on the MAR. The QP reviewed the medications on 2/7/22 without any concerns of the medication errors. This deficiency constitutes a Continued Failure to Correct Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day continues to be imposed for failure to correct within 23 days.	{V 109}		
{V 112}	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include:	{V 112}		

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{V 112}	Continued From page 7 (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement strategies for one of two clients (#1). The findings are: Review on 2/9/22 of client #1's record revealed: - Admission date of 6/25/18. - Diagnoses of Autistic Spectrum Disorder, Mood Disorder, Profound Intellectual Developmental Disability (IDD) and Cerebral Palsy. - Behavior Support Plan (BSP) dated 9/10/21 Review on 2/9/22 of the BSP for client #1 revealed: - "Self Injurious behavior, aggression, agitation and spitting...Contingent Restraint Device- if	{V 112}		

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{V 112}	Continued From page 8 [client #1] continues to exhibit SI (Self Injurious) behavior staff will immediately place the Protective Restraint Device on her head (Protective helmet)...The device will remain on her head until she has not exhibited any SI behaviors for ten minutes, the clock will be set for 10 minutes...The helmet will be removed... The maximum amount of time wearing the helmet is one hour and 50 minutes... At that time the helmet will be removed from her head and staff will remain with [client #1] one on one basis during this ten minute interval...All episodes will be documented..." Interview on 2/9/22 staff #1 stated: - She had been shadowing another staff in the facility since 2/4/22, but worked on her own 2/8/22. - Received no training on client #1's helmet and its use - Was told by staff #4 that client #1 self-harms and to apply the helmet. - She was not told to document any helmet use. - She put the helmet on client #1 every time they left the group home because she was unsteady. - She thought the BSP was for client #1's agitation and when she was walking. - On 2/8/22, when the van came to pick up client #1 for the day program, she put the helmet on her to walk to the van. The 2/9/22 interview with staff #1 was interrupted due to the corporate office closing for the day. Attempted continued interview on 2/10/22 with staff #1 was unsuccessful. Voice and text messages were unanswered by staff #1 at the time of exit.	{V 112}		

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{V 112}	Continued From page 9 Attempted interview on 2/10/22 at 9:45am and 2:00pm with staff #3 was unsuccessful due to a wrong phone number provided by the Qualified Professional (QP). Interview on 2/9/22 staff #5 stated: - Started working at the facility 2/6/22 - Client #1 arrived home today, 2/9/22 with her helmet on. - She did not know why she had it on or how long it was on. - She thought the BSP stated that the helmet was used when client #1 "was hitting herself and when she was walking." Interview on 2/9/22 the QP stated: - She was hired 1/24/22. Later she clarified upon reviewing some training paperwork, she started 1/14/22. - She completed a training on client #1's BSP 1/2022. - Would need to go over client #1's BSP again with staff to make sure everyone understood why and when to apply the helmet - She also needed to train staff on documenting the helmet use and times. - May have to revise the current form to include when client #1 came out of her helmet which is not on the form they are using - Client #1 had an incident report from 2/8/22 showing the helmet was applied but nothing showing the time it came off. - It "should be" on the tracking form but it wasn't in the group home - She didn't know where the form was and why it wasn't in the group home. Multiple attempted interviews on 2/10/22 with the QP both in text and voice message were unsuccessful with no response. A few moments	{V 112}		

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{V 112}	Continued From page 10 before the exit survey, the QP indicated she had left her phone in the car on 2/10/22 due to appointments and late work hours. Interview on 2/9/22 the Quality Improvement Director stated: - All staff had been trained on the BSP. - The staff are following the BSP and understand the "parameters" of the helmet. - BSP was only for self-injurious behaviors and not for unsteady walking. - Client #1 was going to be assessed for her unsteady walk but it wouldn't go in the BSP. - It was not true that client #1 was wearing the helmet every time she left the home with staff #1. - The staff did not relay information correctly so the QP should have been answering these questions. This deficiency constitutes a re-cited deficiency and must be corrected. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for failure to correct Type A1 rule violation.	{V 112}		
{V 118}	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.	{V 118}		

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{V 118}	Continued From page 11 (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure medications were administered on the written order of a physician and MARs were kept current for two of two audited clients (#1 and #2). The findings are: Review on 2/9/22 of the facility's public file maintained by the Division of Health Service Regulation (DHSR) revealed the following: - Statement of deficiencies dated 9/2/21 and 1/3/22 in which violation was cited for Medication (meds) Requirements in which meds were not	{V 118}		

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{V 118}	Continued From page 12 available and the MAR was not current - Plan of Correction dated 1/12/22 signed by the Quality Improvement Director (QID) the facility would be in compliance on 1/25/22. Corrective action for this specific violation included "The facility will ensure..medications are administered in compliance with physician's orders and documentation is complete and accurate on the MAR. For Client #1 and #2 the QP (Qualified Professional) will monitor 2 times weekly to ensure documentation on the MAR...The QP will in-service all staff ...documentation on the MAR for all clients during medication administration...The Director of Quality Management (same as QID) will monitor the MAR...weekly to ensure continued compliance." I. Examples regarding client #2's meds not administered as written and the MAR not current Review on 2/9/22 of client #2's record revealed: - Admitted: 6/15/17 - Diagnoses: Mild Intellectual Developmental Disability (IDD), Mood Disorder, Psychotic Disorder, Schizoaffective Disorder, Intermittent Explosive Disorder and Type II Diabetes - FL-2 dated 3/3/21 listed meds that included the following with instructions for night or bedtime administration: Klonopin 2mg (milligram) one tablet (tab) three times a day (panic/anxiety disorders) Pravastatin Sodium 20mg one tab at night (high cholesterol) Centrum Melatonin 3mg two tabs at night (hormone to sleep) Prazosin HCL 2 mg three tabs at nights (high blood pressure) Metformin HCL 500mg one tab three times a day (diabetes)	{V 118}		

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{V 118}	Continued From page 13 Depakote 500mg two tabs twice daily (bipolar/seizures) Observation on 2/9/22 between 1:15 PM -2:30 PM of client #2's meds revealed: - The meds were dispensed from the pharmacy monthly and placed in weekly packets for Sunday-Saturday administration. - Each day a bubble contained all the meds for administration times set for Morning, Noon, 7 PM and Bedtime. - Beside each day was a handwritten number that correlated the date of the day of the week. Review on 2/9/22 of client #2's record revealed the following for January 25, 2022 -February 9, 2022 MARs: - On the back of the MAR "2/6/22 7 PM...Refused all meds." - On the front of the MAR staff initials noted 2/6/22-2/9/22 as meds administered Observation on 2/9/22 between 1:15 PM -2:30 PM of client #2's meds revealed: - Sunday, 2/6/22 at 7 PM and bedtime dosages were not in the bubble packet. - Monday, 2/7/22 at 7 PM and bedtime dosages remained in the bubble packet. Interview on 2/9/22 with staff #5 stated: - She started working at the group home on Sunday (2/6/22) in the afternoon 3 PM-11 PM. - She shadowed with staff #3. Meds were given. - "She (client #2) refused her meds." Client #2 refused her meds three times, then said she would take it but in the end did not. - "I never pulled the meds out." She was off Monday and Tuesday and returned on Wednesday (day of the interview).	{V 118}		

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{V 118}	Continued From page 14 - Upon her return to work on 2/9/22, she did not see the meds from 2/6/22 in the bubble packet. Attempted interview on 2/10/22 at 9:45am and 2:00pm with staff #3 was unsuccessful due to a wrong phone number provided by the Qualified Professional (QP). Interview on 2/9/22 with staff #1 stated: - She worked on 2/7/22. - Client #2 refused her meds on 2/7/22. - She left the 2/7/22 meds refused by client #2 in the bubble packet. The 2/9/22 interview with staff #1 was interrupted due to the corporate office closing for the day. Attempted continued interview on 2/10/22 with staff #1 was unsuccessful. Voice and text messages were unanswered by staff #1 at the time of exit. Interview on 2/9/22, the QP stated: - She completed her weekly monitoring of meds on 2/7/22 without any concerns. - The errors on the MARs, medications in the weekly packet occurred after her monitoring visit. - She had not inserviced the staff as a group on meds but had spoken with them individually. - As staff #3's initials appeared on the MAR, she would discuss with staff #3 specifically and inservice her. Multiple attempted interviews on 2/10/22 with the QP both in text and voice message were unsuccessful with no response. A few moments before the exit survey, the QP indicated she had left her phone in the car on 2/10/22 due to appointments and late work hours.	{V 118}		

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{V 118}	Continued From page 15 Interview on 2/9/22, the QID stated: - On 2/9/22, the pharmacist was contacted regarding the 2/7/22 missed PM meds for client #2. - Although the meds were important, the pharmacist deemed the incident as "not significant." - He instructed the QP to complete an incident report. Interview on 2/11/22, the QID stated: - Client #2 "refused meds from time to time." - Staff could have either discarded the refused meds in the toilet or returned to the pharmacy. - He was not sure which process the staff utilized on 2/6/22 regarding the refused meds. - The refused meds from 2/7/22 were gathered by the QP and will be returned to the pharmacist. - Since the change in pharmacies a few months prior, he was not sure if the current pharmacist accepted returned meds. II. Example client #1's meds not available to administer and MAR not current. Review on 2/9/22 of client #1's record revealed: - Admitted: 6/25/18 - Diagnoses: Autistic Spectrum Disorder, Mood Disorder, Profound IDD and Cerebral Palsy - Physician's order dated 9/3/21 Lactulose 15 milliliters (ml) (equals 1 tablespoon) 3 times daily may increase to 2 tablespoons (30ml) 3 times daily if no bowel movement for 2 days. - February 2022 MAR listed staff initials that Lactulose was administered on the morning of 2/9/22. Observation on 2/9/22 between 1:15 PM-2:15 PM revealed no Lactulose at the group home.	{V 118}		

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{V 118}	Continued From page 16 Interview on 2/9/22, staff #1 stated: - She worked "triple shifts" on 2/8/22 until 8 AM on 2/9/22. - Verified she administered the morning medications for all clients on 2/9/22. - She did not remember signing off on the Lactulose. - She was informed by staff #5 via phone call this afternoon (2/9/22) that she signed off on the Lactulose but the medication was not in the home. Interview on 2/9/22 the QP stated: - Extra meds were maintained at the corporate office. - She was not notified that the medication was not in the group home. - Had she known the Lactulose was low or out, she would have brought the med over to the group home. Interview on 2/9/22 and 2/11/22, the QID stated: - The agency was in compliance as the previous DHSR med citation was about glucose strips and readings. - "There were plenty of strips at the facility and the glucose readings were documented." - The strips and documentation of the readings were the main focus of the training and monitoring provided by the agency for compliance. - The Lactulose "that's not a big deal." This deficiency constitutes a re-cited deficiency and must be corrected. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for continued failure to correct Type A1	{V 118}		

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{V 118}	Continued From page 17 rule violation.	{V 118}		
{V 291}	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview the facility	{V 291}		

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{V 291}	Continued From page 18 failed to coordinate services for one of two clients (#1). The findings are: Review on 2/9/22 of client #1's record revealed: - Admission date of 6/25/18 - Diagnoses of Autistic Spectrum Disorder, Mood Disorder, Profound Intellectual Developmental Disability (IDD) and Cerebral Palsy Review on 2/9/22 of the Behavior Support Plan (BSP) for client #1 dated 9/10/21 revealed: - "Self Injurious behavior, aggression, agitation and spitting...Contingent Restraint Device- if [client #1] continues to exhibit SI (Self Injurious) behavior... staff will immediately place the Protective Restraint Device on her head (Protective helmet)...The device will remain on her head until she has not exhibited any SI behaviors for ten minutes, the clock will be set for 10 minutes...The helmet will be removed... The maximum amount of time wearing the helmet is one hour and 50 minutes... At that time the helmet will be removed from her head and staff will remain with [client #1] one on one basis during this ten minute interval...All episodes will be documented..." Review on 2/9/22 of the facility's behavior tracking form used at the group home revealed: - "Date/time, type of behavior, interventions used, duration, describe behavior incident, staff's initials" - "Behavior Interventions: Redirection (R), NCI (blocking), Correction (C), verbal prompts (VP), partial prompts (PP), Protective Helmet (PH)." Review on 2/9/22 of the facility's behavior tracking form used at the day program revealed: - "Behaviors, date/time, intervention by staff,	{V 291}		

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{V 291}	Continued From page 19 incident report y/n (yes/no), staff signature, injury or bruise y/n, who notified" - "Intervention - Gentle teaching = GT, Rubbing =R, Holding hands = HH, Talk Low & Soft = TLS - Form did not have if the helmet was used, the duration of the helmet use and did not list protective helmet as an intervention Interview on 2/9/22 staff #1 stated: - She put the helmet on client #1 each day they went out - "I'm not with her at the day program but I think they take it off, I don't know what they do at the day program." - She didn't say anything to the day program staff about what time she put the helmet on client #1 in the mornings when she took her to the day program. The 2/9/22 interview with staff #1 was interrupted due to the corporate office closing for the day. Attempted continued interview on 2/10/22 with staff #1 was unsuccessful. Voice and text messages were unanswered by staff #1 at the time of exit. Interview on 2/9/22 client #1's worker at the day program stated: - Had been working with client #1 for 3 years. - Client #1 arrived daily with her helmet on. - She was previously told by group home staff that they put the helmet on client #1 because she was drowsy in the van and leaning forward as if she was going to fall - Staff from the group home never told her what time the helmet was put on each morning Interview on 2/9/22 the QP for the day program stated: - He just started about a month ago	{V 291}		

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{V 291}	Continued From page 20 - He had not spoken with any group home staff about client #1 coming to the program in her helmet - Client #1's day program worker would know if she was in her helmet when she arrived to the day program Multiple attempted interviews on 2/10/22 with the QP both in text and voice message were unsuccessful with no response. A few moments before the exit survey, the QP indicated she had left her phone in the car on 2/10/22 due to appointments and late work hours. Interview on 2/11/22 the Quality Improvement Director stated: - "This is not true" that client #1 went to the day program every day with her helmet on. - Staff did not relay information correctly and this should be asked of both the QP's (day program and facility) and "not just rely on the staff saying this." - The BSP was not for client #1's unsteady walking. - "As long as they are documenting the behavior and the helmet use, then they are okay with that. It doesn't matter the form, only the contents." This deficiency constitutes a re-cited deficiency and must be corrected. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for Failure to Correct Type A1 rule violation.	{V 291}		

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{V 531}	Continued From page 21	{V 531}		
{V 531}	27E .0105(a) Client Rights - Protective Devices 10A NCAC 27E .0105 PROTECTIVE DEVICES (a) Whenever a protective device is utilized for a client, the governing body shall develop and implement policy to ensure that: (1) the necessity for the protective device has been assessed and the device is applied by a facility employee who has been trained and has demonstrated competence in the utilization of protective devices; (2) the use of positive and less restrictive alternatives have been reviewed and documented and the protective device selected is the appropriate measure; (3) the client is frequently observed and provided opportunities for toileting, exercise, etc. as needed. When a protective device limits the client's freedom of movement, the client shall be observed at least every hour. Whenever the client is restrained and subject to injury by another client, a facility employee shall remain present with the client continuously. Observations and interventions shall be documented in the client record; (4) protective devices are cleaned at regular intervals; and (5) for facilities operated by or under contract with an area program, the utilization of protective devices in the treatment/habilitation plan shall be subject to review by the Client Rights Committee, as required in 10A NCAC 27G .0504. Copies of this Rule and other pertinent rules are published as Division publication RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES, APSM 30-1,and may be purchased at a cost of five	{V 531}		

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{V 531}	Continued From page 22 dollars and seventy-five cents ($5.75) per copy. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a protective device was implemented by employees who were trained and demonstrated competence in the utilization of a protective device for one of two clients (#1). The findings are: Review on 2/9/22 of client #1's record revealed: - Admission date of 6/25/18. - Diagnoses of Autistic Spectrum Disorder, Mood Disorder, Profound Intellectual Developmental Disability (IDD) and Cerebral Palsy. Review on 2/9/22 of the Behavior Support Plan (BSP) for client #1 dated 9/10/21 revealed: - "Self Injurious behavior, aggression, agitation and spitting...Contingent Restraint Device- if [client #1] continues to exhibit SI (Self Injurious) behavior... staff will immediately place the Protective Restraint Device on her head (Protective helmet)...The device will remain on her head until she has not exhibited any SI behaviors for ten minutes, the clock will be set for 10 minutes...The helmet will be removed... The maximum amount of time wearing the helmet is one hour and 50 minutes... At that time the helmet will be removed from her head and staff will remain with [client #1] one on one basis during this ten minute interval...All episodes will be documented..." Interview on 2/9/22 staff #1 stated: - She had been shadowing another staff in the facility since 2/4/22, but worked on her own	{V 531}		

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{V 531}	Continued From page 23 2/8/22. - Received no training on client #1's helmet and its use - Was told by staff #4 that client #1 self-harms and to apply the helmet. - She was not told to document any helmet use. - She put the helmet on client #1 every time they left the house because she was unsteady. - She also put the helmet on because of the other clients being aggressive towards client #1 on the van. - She thought the BSP was for client #1's agitation and when she was walking. Interview on 2/9/22 client #1's worker at the day program stated: - Had been working with client #1 for 3 years. - Client #1 arrived daily with her helmet on. - She was previously told by group home staff that they put the helmet on client #1 because she was drowsy on the van and leaning forward as if she was going to fall The 2/9/22 interview with staff #1 was interrupted due to the corporate office closing for the day. Attempted continued interview on 2/10/22 with staff #1 was unsuccessful. Voice and text messages were unanswered by staff #1 at the time of exit. Attempted interview on 2/10/22 at 9:45am and 2:00pm with staff #3 was unsuccessful due to a wrong phone number provided by the Qualified Professional (QP). Interview on 2/9/22 staff #5 stated: - Started working at the facility 2/6/22 - She thought the BSP stated that the helmet was used when client #1 "was hitting herself and	{V 531}		

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{V 531}	Continued From page 24 when she was walking" Interview on 2/9/22 the QP stated: - Not aware of client #1 wearing the helmet to the day program every day - Staff were already trained on the use of the helmet and client #1. - Will speak with and re-train staff on the use and documentation of the helmet. Multiple attempted interviews on 2/10/22 with the QP both in text and voice message were unsuccessful with no response. A few moments before the exit survey, the QP indicated she had left her phone in the car on 2/10/22 due to appointments and late work hours. Interview on 2/11/22 the Quality Improvement Director stated: - All staff were trained on the "parameters" of the helmet. - The BSP was for self-injurious behavior and not for client #1's unsteady gait. - The QP was the "core monitor" of the home to monitor the helmet use. - Client #1 was not going to the day program every day with a helmet on. - "This is not true" if they said that client #1 went to the day program with her helmet on daily. - The staff did not relay information correctly so this should be asked of both QP's (day program and facility) and "not just rely on the staff saying this." This deficiency constitutes a re-cited deficiency and must be corrected. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals	{V 531}		

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{V 531}	Continued From page 25 (V109) for Failure to Correct Type A1 rule violation.	{V 531}		