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V 000	INITIAL COMMENTS An annual and complaint survey was completed on February 4, 2022. The complaint was unsubstantiated (Intake# NC00184889). 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 3 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	V 109		

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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 interview and record review, the facility failed to ensure the Residential Team Lead/Qualified Professional (QP) demonstrated knowledge, skills and abilities for the population served for 1 of 1 QP. The findings are: Review on 1/27/22 of the Residential Team Lead/QP's employee file revealed: -Hired 3/16/20. -Job title Residential Team Lead/QP. The following are examples of competency failures of the Residential Team Lead/QP: -to assess and/or re-assess clients capabilities of smoking safely, self-administering medications, suicidal risks, and unsupervised time. -to update client treatment plans that reflect their current status and/or changes. -to ensure direct care staff were aware and following expectations of monitoring clients who were in need of increased checks. Refer to V110 for additional examples of	V 109		

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competency information.

Interview on 1/26/22 with the Residential Team Lead/QP revealed:
-She was on-site at the facility 1-2 times a week.
-She was responsible to complete all clinical assessments to include admission and risk assessments.
-She or the Residential Manager could complete the unsupervised and medication self-administration assessments.
-The above assessments would only need to be done one time; they would not do them annually unless there was a change.
-Examples of changes included if found out client wasn't taking their medications as prescribed, or if there was a change in behavior, or if the client was in the hospital for a long period of time and came back.
-They did not have a smoking assessment or any other means to determine if a client could smoke independently.
-They had a designated smoking area and made sure clients abided by this rule.
-If they showed signs of danger and self-harm she would take it to Client Rights Committee to evaluate if cigarettes and lighters needed to be managed by staff.
-It would fall on the direct care staff who were at the facility daily and the Residential Manager to notice if the client was not smoking safely.
-Clients who had unsupervised time were not required to sign in and out when they left the facility; " ...but we probably should and will do that...."
-She was responsible for developing and updating goals and strategies for the client's Person-Centered Profiles (PCPs).
-She worked with staff, the Residential Manager, the client and the client's guardian to determine

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V 109	Continued From page 3 what goals to put in the PCP. -The PCP was reviewed and updated every 90 days to determine if the client was making progress and if there were any changes that needed to be made. -Anytime changes needed to be made to the PCP it could be done; it was a revolving document and could change as the client needs changed. -She documented PIE (Problem, Intervention and Effectiveness/Evaluation) notes every month on each client regarding progress on their goals. This deficiency is cross referenced into 10A NCAC 27G.0205 Assessment and Treatment/Habilitation or Service Plan (V112) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
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;	V 110		

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V 110	Continued From page 4 (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on observation, interview and record review, 4 of 4 staff (Staff #1, #2, #3 and the Residential Manager) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 1/25/22 of the Residential Manager's employee file revealed: -Hired 2/28/21. -Job Title - Residential Manager. Review on 1/25/22 of Staff #1's employee record revealed: -Hired 12/13/20 as a Behavioral Specialist. Review on 1/27/22 of Staff #2's employee record revealed: -Hired 2/11/19 as a Behavioral Specialist. Review on 1/27/22 of Staff #3's employee record revealed: -Hired 12/13/21 as a Behavioral Specialist.	V 110		

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V 110	Continued From page 5 Review on 1/25/22 of Client #1's record revealed: -Admitted 7/1/20 - 62 years old. -Diagnoses of Major Depressive disorder, recurrent, moderate; Anxiety disorder, unspecified and Intellectual Developmental Disorder, mild. Review on 1/24/22 of an incident report in the North Carolina Incident Response Improvement System (IRIS) revealed: -Level II incident dated 1/6/22 at 6:00 p.m. for Client #1. -Client behavior - destructive and suicide attempt. -Incident comments - Client #1 "...used a cigarette lighter to set his clothes on fire in an attempt to end his life. Another resident saw what was happening and yelled for staff to help as he continued to put the fire out...." -Cause of incident - Client #1 "...had a plan to take his own life and acted on the plan." -Incident prevention- "...will be seeing a therapist for counseling...anything in his room that could be used to harm himself has been removed...Staff will monitor [Client #1] closely once he is released from the hospital...." Observation 1/24/22 at 3:50 p.m. of Client #1's room revealed: -No lighters, matches or other harmful objects were seen. -At 4:04 p.m. of the kitchen - Cooking knives in the drawer next to the stove and steak knives in the utensil drawer. -Both drawers were unlocked. Interview on 1/24/22 with Client #1 revealed: -He had lived at the facility for 2 years. -He did not like living at the facility because he didn't get along with other people.	V 110		

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-There were no person(s) he could say he did not like; He denied fighting/arguing with anyone.
-He set his shirt on fire because he was "Just upset about living here..." He was trying to "...end my life because I don't like it here."
-He did not get hurt or burned after he set his shirt on fire.
-He no longer had any lighters or matches in his possession.

Review on 1/25/22 of Client #1's Comprehensive Clinical Assessment (CCA) dated 4/24/20 (prior to admission) revealed:
-"Client reports that he is experiencing some unresolved issues with grief, depression and anxiety...that he miss his parents a lot, expresses he feels depressed because he misses his parents and he thinks about them, he could not recite time line of them dying..."
-He denied any history or current suicidal thoughts.

Review on 1/25/22 of Client #1's admission assessment dated 7/1/20 revealed:
-Three categories: General Information, Self-Care/Financial and Family/Social.
-The assessment did not address any psychosocial or mental health needs.

Review on 1/26/22 of a Risk Assessment for Client #1 dated 10/13/20 revealed:
-A suicide severity rating scale which indicated Client #1 was at no risk.
-Completed by the Residential Team Lead/QP.
-This was the only Risk Assessment in the client record.

Review on 1/26/22 of an Unsupervised Time assessment for Client #1 dated 6/30/21 revealed:
-Two questions involving abilities to smoke

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unsupervised.
-"If the person smokes, can they do so in a designated area, without supervision?: Yes"
-"Do they know how to properly dispose of cigarette butts into approved containers?: Yes"
-The team agreed the client could have unsupervised time of 4 hours in the home and 4 hours in the community.
-There were no other assessments that addressed the ability to smoke safely and carry smoking paraphernalia.
-The assessment was not updated to reflect the client no longer had unsupervised time.

Review on 1/26/22 of a Physician Order for Client #1 dated 5/18/21 revealed:
-The purpose of the visit was for a routine check-up.
-"Please call back + let us know if he has psychiatrist - needs psychiatrist if not continue [medications listed]..."

Review on 1/26/22 of a Physician note (undated) from Client #1's record revealed:
-It was written by the same Physician Assistant above.
-Discussion: "Try to spend more time out of bed. Let me know if there is a psychiatrist helping manage meds ...Also will need a follow-up Telehealth with me for psychiatric management...Plan follow up in 3 months..."
-There was no follow-up visit with this physician documented in the client's record.

Interview on 1/28/22 with the Residential Manager revealed:
-A request for any documentation of psychiatric services for Client #1.

Review on 2/1/22 of Client #1's "Appointment

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History" provided by the Residential Manager revealed:
-9/24/21 - "Psych (Psychiatric) Attended" 45 minutes with a local consulting associate.
-12/17/21 - "Follow-up. No Show." With the same local consulting associate.
-There were no other notes from any psychiatry appointments.

Review on 1/26/22 of Client #1's PCP dated 6/18/21 included:
-Description: Client #1 "...has a history of obsessively thinking about what might happen, to the extreme that he thinks he is sick all the time calling 911 and going to the hospital for non emergency reasons. Staff should assure him and assist him in processing his thoughts and problem solve to reduce his anxiety."
-"What's Working/What's Not Working: Guardian: [Client #1] has too much time on his hands and needs structured activities to participate in ...Working: QP: [Client #1] has been doing well living at Parkland and after consulting his Guardian we have increased his unsupervised time to 4 hours..."
-Long Range Outcome: Client wants to be healthy. "[Client #1] has improved and no longer calls 911 when he is alone. He is taking his medication consistently. [Client #1] needs to work on being active in the community and participate in recreational activities that staff plan."
-Goal: "...would like to manage his depression and learn the necessary coping skills so that he doesn't feel the need to call 911...will improve his mental health as evidenced by taking all medications, attending all doctors appointments and using coping skills to decrease the need to call 911."
-How (Support/Intervention)- "...take all his prescribed medication, attend medical and

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psychiatric appointments, communicate with staff when he feels depressed or anxious. Staff will: Support, encourage and assist [Client #1] as needed. Educate and model various coping skills, Educate [Client #1] about calling 911 (when it is appropriate, when it isn't)."
-Goal: - "...will participate in physical activity of his choosing at least 3 times per week for 90 days."
-How - Client #1 "...will choose and participate in a physical activity. Staff will: Provide choices of activities to choose from, Educate [Client #1] on the importance of physical activity and his mental health, Support and assist [Client #1] as needed."

Review on 1/26/22 of the Residential Team Lead/QP PIE notes for Client #1 revealed:
-The most recent note was dated 11/3/21.
-Goals addressed included "...will improve his mental health as evidenced by taking all medications, attending all doctors appointments and using coping skills to decrease the need to call 911...will participate in physical activity of his choosing at least 3 times per week for 90 days."
-Comments: "...continues to need support...staff have to provide a list of activities for [Client #1] to choose from, and then he is not interested in going to any of them. [Client #1] prefers to just stay at home...he will communicate to staff when he feels like he needs to call 911. [Client #1] is now claiming to be sick in order to not go out in the community..."

Interviews on 1/24/22 and 1/27/22 with Client #3 revealed:
-On 1/6/22 around 8:00 or 8:30 p.m. he happened to walk by Client #1's room.
-He saw Client #1 had the bottom of his shirt pulled out and he was lighting it up with his lighter.
-Client #1 was just sitting there, in his room,

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watching the fire.
-He ran into the room and put the fire out with his hands.
-He described the client's shirt as being burnt from the bottom up as the shape of a half circle - approximately 5 inches in diameter.
-He did not get hurt when he put the fire out.
-Someone had gone to get Staff #1 who was in the facility office.
-Client #1 had carried his own cigarettes and lighter since he had been there - until after the incident.
-He had not seen Client #1 smoke since the incident.
-He felt Client #1 didn't really smoke that much; He only came out to smoke because he and the other clients did.
-He heard Client #1 say he didn't want to be there but had never heard him say he wanted to kill himself.

Review on 1/25/22 of Client #2's record revealed:
-Admitted 12/4/20.
-Diagnoses of Anxiety Disorder, Diabetes Mellitus, Gastro-Reflux, Bipolar disorder, Schizophrenia, Paranoid Ideation and Hyperlipidemia.

During interview upon entrance on 1/24/22 the Residential Team Lead/QP identified Client #2 as one of the clients who self-administered his medications.

Review on 1/26/22 of facility's level I incident reports from October 2021 through January 2022 revealed:
-1/11/22 - Consumer behavior - Client #2 called the Residential Manager (via his cell phone) and said he felt like hurting himself.
-Staff #3 and the Residential Team Lead/QP were

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listed as staff members involved; the Residential Manager was not on shift.
-Client #2 stated Staff #3 told him to clean his room and he felt like overdosing on his medications.
-Mobile crisis was called who suggested to call 911.
-Client returned to the facility that same afternoon and was found to be no risk of self-harm.
-Suicidal Behavior - "Does the person have a history of suicide attempts? Unknown. Has the person been placed on suicide watch? Yes."
-"Systemic/Preventive Measures RM [Residential Manager] and TL [Team Leader] have staff trainings to increase knowledge of the risks of suicide ..."

Interviews on 1/24/22 and 1/27/22 with Client #2 revealed:
-He lived at the facility for 6 years and wanted a place of his own.
-He used to self-administer his medication until 3-4 weeks ago when he said he wanted to commit suicide.
-Prior to the incident he had self-administered medications for about 6 months or so.
-Staff checked his medications but he didn't know how often.
-Currently a nurse from his ACTT (Assertive Community Treatment Team) checked his medications once or twice every 2-3 months.
-He felt better now and was not suicidal but was still on "suicide watch."
-He had no unsupervised time in the home or the community since the incident.
-He talked with his therapist with ACTT 1-2 times a month.

Review on 1/26/22 of Client #2's last Risk Assessment dated 9/29/21 and completed by the

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V 110	Continued From page 12 Residential Team Lead/QP revealed: -No risk was indicated of suicidal thoughts or behavior. Review on 1/26/22 of Client #2's most recent Self-Medication Administration assessment dated 4/30/20 revealed: -A former Residential Manager completed the assessment; the Residential Team Lead/QP was listed as being "...Involved in Review of Assessment." -The team recommended support of self-administration of medication and self-use of medical equipment. -"Team Recommendation for follow up assessment: Does not need to be repeated unless change in skill level is noted." Review on 1/26/22 of Client #2's most recent Unsupervised Time assessment dated 5/25/21 revealed: -Staff #1 signed as completing the assessment. -Unsupervised time was agreed upon for 1 hour at home and zero hours in the community. Review on 1/26/22 of Client #2's PCP dated 3/24/21 revealed: -"...He has 8 hours of unsupervised time and is able to manage his medications on his own..." -Goal: "...he will maintain his mental health as evidenced by a reduction in symptoms of anxiety and depression (isolation). -How - "Communicate to staff when feeling anxious, take medications as prescribed. Work with staff to make and attend all appointments. Utilize coping skills recommended by Therapist. Staff will process with [Client #2] when he is feeling anxious. Provide medication education and diagnosis education. Encourage [Client #2] to take all medications and attend all appointments.	V 110		

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V 110	Continued From page 13 Educate and model coping skills that therapist recommends. -There was no documentation he had a history of suicidal ideations. Review on 1/26/22 of Client #2's Crisis Intervention and Prevention Plan dated 12/8/21 revealed: -"What are some events or situations that have caused me trouble in the past?...Being off meds and hearing voices. Panicking and going to hospital, worrying too much." -"What are the early warning signs that I am not doing well?...refusing meds, staying up late." Review on 1/27/22 of the Residential Team Lead/QP PIE notes for Client #2 revealed: -9/1/21 - "Personal Health: Supervised and prompted the Individuals medication needs: prescriptions, medication education, medication assistance. Provided education on self-medication skills: storage, dosage, purpose, side effects ...Provided support and prompting for Individual to make and keep needed appointments with health professionals. Comments: [Client #2] has made progress in this area keeping all medical and psychiatric appointments...." -11/3/21 - "Personal Health: Supervised and prompted the Individuals medication needs: prescriptions, medication education, medication assistance...Comments: ...he stays on top of his medication and staff assists [Client #2] to ensure that he attends all his doctors appointments. He engages with his ACTT [Assertive Community Treatment Team] team..." -12/6/21 - "Personal Health: he has maintained mental stability by taking all his medication and attending all doctors appointments..."	V 110		

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V 110	Continued From page 14 Observation on 1/24/22 from 11:33 a.m. to 2:15 p.m. revealed: -Staff #3 sitting in the office with the Residential Team Lead/QP as surveyor observed Client #1, #2, #3's medications. -The office door was shut and Staff #3 was not observed checking on the clients until after 2:15 p.m. Observations on 1/25/22 from the dining room table revealed: -From approximately 11:45 a.m. to 12:10 p.m. Client #1, who was sitting in the living room, came into the kitchen 2-3 times. He looked in the refrigerator and in the pantry. Staff #3 was in the office at this time. -At approximately 12:30 p.m. the Residential Manager came through the living room and asked Client #1 if he was hungry. They both walked to the kitchen to look for something to eat. Staff #3 remained in the office. -At approximately 1:33 p.m. Staff #3 was observed to walk through the living room and into the kitchen. -Client #1 and Client #5 were in the living room and she asked if they were okay and walked back into the office and shut the door. -At approximately 4:00 p.m. Client #2 and Client #4 were in the kitchen and started to cook frozen stir-fry for dinner. -There was no staff around; Staff #3 remained in the office with the door shut. -At approximately 4:15 p.m. Staff #1 came on shift, walked in the kitchen and asked the two clients what they were cooking. -Staff #1 read the directions out loud with the clients and advised they may want to add water to the pot. -Client #2 added water to the stir-fry.	V 110		

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V 110	Continued From page 15 Interviews on 1/25/22 and 1/27/22 with Staff #1 revealed: -During the incident on 1/6/22 regarding Client #1 he was in the office logging in medications. -Client #1 came to him and said " ...I set myself on fire." -Client #3 then came around the corner and had Client #1's burnt shirt in his hand. -He asked Client #1 why did he do that and he said "I just want to kill myself." -He then called the Residential Manager and 911; the client stayed overnight in the hospital and returned 1/7/22. -He described the burned area the same - like a half moon shape at the bottom of the shirt. -Both clients had no burn marks or injuries. -He saw no "red flags" prior to the incident and Client #1 never talked about suicide. -Client #1's ability to smoke independently had been approved with "everybody and the guardian" and he did not monitor for safety since it was approved. -He checked to make sure he was in the smoking area and never had a problem with this. -Client #1 did not smoke a lot; he only saw the client smoking once since being at the facility. -That same evening he ensured all lighters, pens, extension cords etc. were out of Client #1's room. -He did not look for and remove other potentially hazardous items within the facility. -He was aware that kitchen knives were easily accessible in the drawers; he felt the knives should always be locked up except during meal times. -He had not received additional suicide training since the incident. -Clients #1 and #2 were still on "suicide watch" which meant they had to go everywhere with staff when they left the facility. -Both clients had no unsupervised time at home	V 110		

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V 110	Continued From page 16	V 110		

or the community.
-They needed to be checked on every 30 minutes to see where they were and what they were doing.
-Client #2 " ...loves attention ...he is not very responsible."
-Client #2 never talked about wanting to die; he had been to many trainings and did not see any signs with Client #1 or Client #2.
-Felt like he saw Client #1 getting attention due to his suicidal acts and Client #2 wanted the same attention.
-Client #2 had been self administering his medications since he had worked there (about 2 years).
-Staff checked Client #2's medication, "not in depth ...check it periodically ...not highly prioritized."
-He was not given any direction to monitor clients who self-administered.
-The clients let them know if they felt like they were having problems.

Interview on 1/27/22 with Staff #2 revealed:
-She had worked at the facility for 3 years.
-She heard Client #1 say he didn't want to be at the facility, but saying he wanted to die was new.
-She saw Client #1 maybe smoke one time since he had been at the facility.
-If he saw someone had a stomach ache, his stomach would hurt too.
-She had never heard Client #2 say he wanted to die.
-She believed this happened because Client #2 wasn't taking his medications right.
-All staff were required to check self-administered MARs 2 times a week.
-It was "a while" since she had checked Client #2's MARS due to getting "distracted" doing other things.

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V 110	Continued From page 17 -She returned to her shift 2 days after Client #2's incident and his tub of medications were in the office. -This was when it was determined he wasn't taking his medications appropriately. -Clients #1 and #2 had no unsupervised time; they went everywhere with them if staff had to leave and take someone to work. -Since the incidents the requirement was to check on them every hour. -She had no additional training regarding suicide since the incidents; she made sure she kept an eye on them. Interview on 1/27/22 with Staff #3 revealed: -She worked at the facility for approximately a month and a half and had only worked by herself for 2 shifts. -She worked Sunday through Tuesday. -She checked on Clients #1 and #2 every time she had a free moment, usually every 30 - 40 minutes. -She was not told to do this by anyone, she did this for herself, she was just told not to leave them by themselves. -Even if she took another client to work, Client's #1 and #2 had to go with her. -She had not received any training on suicide behavior but had been in the field for a long time. -She was told to interact with the clients, talk about their goals with them, and she cooked with them. -She watched Client #1 cook scrambled eggs (date unknown). -She monitored cooking to make sure the clients were doing it right and no one got burned. -There was no set time to eat, the clients went in and out of the kitchen at all times. -She had not seen Client #1 smoking since the incident.	V 110		

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V 110	Continued From page 18 -The only monitoring she did for clients who smoked was to make sure they were not smoking in the house. -When she didn't see them for a while she would look outside in the smoking area to make sure they were there. -Prior to the incident Client #1 told her he would rather die than stay at the facility; He hasn't said anything about dying since the incident. -Client #2 said one time he was going to hurt himself, he said he wanted attention. -She "felt like it was a domino effect" for Client #2 because of what Client #1 did. -She was not told to monitor Client #2's self-administration or to monitor his MARs every so often. -Only thing she was told to monitor was when he did his insulin shots, which he did that in the office, his other medications were in his room. -When asked about the amount of time observed in the office she stated she did shut the door and stayed in the office. "They all want attention." Interview on 1/26/22 with the Residential Manager revealed: -After the incidents involving Clients #1 and #2, their unsupervised privileges were taken away and they now had zero hours at home and in the community. -They asked the guardian if the client could smoke independently and then allowed them to smoke. -If client's wanted to smoke they could not take that right away. -Staff #1 checked on them periodically; when clients were smoking he went outside and talked with them. -Since Client #1 and #2's incidents staff did 15 minute checks and were to "lay eyes" on them and see what they were doing.	V 110		

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V 110	Continued From page 19 -This was told to staff verbally and they did not have to document these checks. -She did additional training on suicide and what to watch for. She would obtain this documentation. -Client #2 called her on 1/11/22 and said he had thoughts of suicide and would overdose on his medications. -She tried to call ACTT (Assertive Community Treatment Team) and they wouldn't do anything so 911 was called. -The client went to the hospital and returned to the facility the same day. -Since Client #2 was thinking about suicide and especially by overdosing staff took his medications out of his room that same day. The documentation of additional training on suicide was not given prior to exiting the survey. Interviews on 1/26/22 and 1/27/22 with the Residential Team Lead/QP revealed: -Clients #1 and #2 had no unsupervised time at home or in the community. -When she updated the PCP she would just remove the unsupervised time portion. -Client #1 was not seeing a psychiatrist or therapist prior to the incident. -He just started seeing a psychiatrist (after the incident) and would probably go one time a month. -She offered him grief counseling (in the past - date unknown) and he refused to go. -Approximately two months ago Client #1 just starting saying he wasn't happy at the facility. -She had been working with the client's guardian on a different facility; now the guardian wants to relinquish his guardianship. -After Client #1's incident they removed his lighters and other potentially hazardous items from his room.	V 110		

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V 110	Continued From page 20 -Other hazardous items around the facility were not checked. -Regarding knives being in the drawer in the kitchen - if a client was in the kitchen, staff needed to be in the kitchen supervising them. -No one should be in the kitchen after 10:00 p.m. -When Client #2 threatened suicide by overdosing on his medications on 1/11/22 his medications were taken to the office and he was no longer self-administering. -They did not think he was serious because he wanted to make sure his bag was packed before 911 was called. -However, they still treated it as a serious threat. -The updates to self-administration privileges should be documented in PIE notes, an updated risk assessment as well as updated PCP. "...Which I know I did not do..." Interview on 1/31/22 with the Vice President of Long-Term Services and Support revealed: -She was the direct supervisor for the Residential Team Lead/QP who supervised the Residential Manager who supervised the support staff. -She communicated with the Residential Team Lead/QP monthly, at a minimum and was on-site once every couple of months. -They did not have an assessment to conduct the safety of a client smoking unsupervised. -There was no such protocol as "suicide watch." This deficiency is cross referenced into 10A NCAC 27G.0205 Assessment and Treatment/Habilitation or Service Plan (V112) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan	V 112		

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V 112	Continued From page 21 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement goals and strategies to address the treatment needs for 2 of 3 audited clients (Client's #1 and #2). The findings are:	V 112		

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V 112	Continued From page 22 CROSS REFERENCE: 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on observation, interview and record review, the facility failed to ensure the Residential Team Lead/Qualified Professional (QP) demonstrated knowledge, skills and abilities for the population served for 1 of 1 QP. CROSS REFERENCE: 10A NCAC 27G.0204 Competencies and Supervision of Paraprofessionals (V110). Based on observation, interview and record review, 4 of 4 staff (Staff #1, #2, #3 and the Residential Manager) failed to demonstrate the knowledge, skills and abilities required by the population served. Review on 2/2/22 of the first Plan of Protection (POP) dated and signed by the Vice President Long Term Services and Support (LTSS) on 2/2/22 revealed: "What Immediate action will the facility take to ensure the safety of the consumers in your care? ACTION 1. Current Person Centered Plans (PCP) for [Client #2] and [Client #3] will be updated to reflect revocation of self administration status and/or unsupervised time. FOLLOW UP/PERSON RESPONSIBLE Review for completion/accuracy [Vice President Long Term Services and Supports DATE 2/3/22 ACTION 2. Current PCP and Comprehensive Crisis Plans for [Client #1] and [Client #2] will be updated to reflect recent suicidal ideation/attempt and strategies for prevention and actions needed. FOLLOW UP/PERSON RESPONSIBLE Review for completion/accuracy [Vice President Long Term Services and Supports	V 112		

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V 112	Continued From page 23 DATE 2/3/22 ACTION 3. Team Leader (Residential Team Lead/QP) will be retrained on clinical documentation requirements/expectations. FOLLOW UP/PERSON RESPONSIBLE Training by [Vice President Long Term Services and Supports DATE 2/4/22" "Describe your plans to make sure the above happens. 1. Inform Team Leader of necessary changes and review them for accuracy once completed in the electronic medical record. 2. Arrange meeting with Team Leader and provide training on documentation requirements and expectations of the agency." Review on 2/2/22 of the second Plan of Protection (POP) dated and signed by the Senior Vice President LTSS on 2/2/22 revealed: "What Immediate action will the facility take to ensure the safety of the consumers in your care? How will staff monitor suicidal ideations of clients (long-term or on-going)? Each individual is screened for suicide risk at admission, and annually thereafter at a minimum. Agency policy also requires that individuals be screened upon release from hospitalization or referral for psychiatric services. (see policy). Monitoring also occurs via staff presence and observation of the individuals on a daily basis. Although in this particular situation the staff did observe suicidal behavior and ensured he received a higher level psychiatric assessment,	V 112		

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V 112	Continued From page 24 the QP failed to implement the policy follow-up. How will ensure strategies being implemented for staff to be proactive of managing suicidal ideations, monitoring signs and symptoms etc. and documenting this? The staff here did detect the ideations and responded to them for higher level of assessment. The QP failed to completed the required follow-up information. This QP will be disciplined and retrained with increased supervision put in place. In addition, as part of the plan of correction we will add to our policy that if someone is at a moderate or high level of risk then their risk, or absence of, will be documented in daily notes. Documentation will be monitored through the LTSS peer review system. How will ensure psychiatric recommendations are followed and interventions are successful (i.e. client actively participating and going to appointments)? Who will monitor staff compliance of this? Monarch Residential Manager tracks appointments and follow-up appointments. If someone is refusing to attend or participate this is brought to the Team Leader (QP). The QP would work with the team to put goals or further interventions in the plan. How will determine clients are safe to smoke independently and how will monitor on-going compliance? How and who will ensure this is happening?	V 112		

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V 112	Continued From page 25 When we screen for services smoking is discussed. Any past history of issues or current issues would be part of the initial planning process with goals or restrictions put in place to respond to the need. For others with no past/current issues then they maintain this right unless a safety issue occurs, and then it would be re-evaluated by the team. How will ensure clinical documentation/expectations training successful, remains reflective of the client's current status, who and how often will this be monitored? (Not sure I fully understand this question, so let me know if I do not answer your question) Success of training will be monitored through ongoing record reviews in our peer review system. In March, 2022 we will be changing our sample to 1 record per QP in our agency per quarter." Review on 2/3/22 of the third Plan of Protection (POP) dated and signed by the Senior Vice President LTSS on 2/2/22 revealed: "What Immediate action will the facility take to ensure the safety of the consumers in your care? How will staff monitor suicidal ideations of clients (long-term or on-going)? Each individual is screened for suicide risk at admission, and annually thereafter at a minimum. Agency policy also requires that individuals be screened upon release from hospitalization or referral for psychiatric services. (see policy). (No policy received with Plan of Protection.) Monitoring also occurs via staff presence and observation of the individuals on a daily basis.	V 112		

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V 112	Continued From page 26 Although in this particular situation the staff did observe suicidal behavior and ensured he received a higher level psychiatric assessment, the QP failed to implement the policy follow-up. We are currently looking at our policy on suicide and post-hospitalization to see if updates/revisions need to be made. QP will notify Senior VP of any risk issues that occur at Parkland immediately. Senior VP will monitor the situation, follow-up, and documentation and provide active coaching to the QP until Senior VP feels confident in her skills. The QP will be retrained by the VP or Senior VP on : post-hospitalization, follow up to harm risk, documentation, and medication requirements. Training to be completed by 02-28-22. The Manager will receive training on completion of the monthly medication checks. 02-28-22. How will ensure strategies being implemented for staff to be proactive of managing suicidal ideations, monitoring signs and symptoms etc. and documenting this? The staff here did detect the ideations and responded to them for higher level of assessment. The QP failed to completed the required follow-up information. This QP will be disciplined and retrained with increased supervision put in place. In addition, as part of the plan of correction we will add to our policy that if someone is at a moderate or high level of risk then their risk, or absence of, will be documented in daily notes.	V 112		

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V 112	Continued From page 27 Documentation will be monitored through the LTSS peer review system. How will ensure psychiatric recommendations are followed and interventions are successful (i.e. client actively participating and going to appointments)? Who will monitor staff compliance of this? The Residential Manager is responsible for tracking appointments. If a person refuses an appointment, or new recommendations are made, the Residential Manager will notify the QP verbally and will document the notification in the record (progress note). The QP will document their follow-up actions in the record (QP PIE [Problem, Intervention, and Effectiveness or Evaluation] Note). Records will be monitored via the peer review process. The agency is currently adding a compliance position who will follow-up on all hospitalizations. Until this position is filled, this will be completed by the Senior VP. [Following paragraph was struck through] Monarch Residential Manager tracks appointments and follow-up appointments. If someone is refusing to attend or participate this is brought to the Team Leader (QP). The QP would work with the team to put goals or further interventions in the plan. How will determine clients are safe to smoke independently and how will monitor on-going compliance? How and who will ensure this is happening? When we screen for services smoking is	V 112		

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discussed. Any past history of issues or current issues would be part of the initial planning process with goals or restrictions put in place to respond to the need. For others with no past/current issues then they maintain this right unless a safety issue occurs, and then it would be re-evaluated by the team.

How will ensure clinical documentation/expectations training successful, remains reflective of the client's current status, who and how often will this be monitored?

(Not sure I fully understand this question, so let me know if I do not answer your question) Success of training will be monitored through ongoing record reviews in our peer review system. In March, 2022 we will be changing our sample to 1 record per QP in our agency per quarter."

This is a 6 bed residential facility for adult clients with mental illness to include Major Depressive Disorder, Anxiety Disorder, Bipolar Disorder, Schizophrenia, and Paranoid Ideation. Client #1, who had a history of Major Depressive disorder, expressed suicidal ideations because he no longer wanted to stay at the facility and therefore wanted to end his life. On 1/6/22 he acted on this ideation by using his cigarette lighter to set his shirt on fire. Another client happened to be walking by, saw this, and kept Client #1 from catching himself on fire or being burned. The client was never assessed as to his ability to smoke safely and manage his own smoking paraphernalia. In May of 2021 it was recommended Client #1 see a psychiatrist. Client #1 attended one psychiatric appointment in September 2021 and refused the other in December 2021. No other efforts were made for

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V 112	Continued From page 29 the client to receive any mental health services. The facility environment was not checked for safety, leaving kitchen knives easily accessible in the kitchen drawers. Client #2, who had multiple mental health diagnoses, stated he felt like hurting himself on 1/11/22 and would do so by overdosing on his medications which he self-administered at the time. Both Clients #1 and #2 had no unsupervised time and were expected to be observed every 15 minutes due to these recent suicidal ideations and actions. Clients #1 and #2 were not observed to be checked every 15 minutes. Staff were inconsistent as to what the expectations were regarding how often Clients #1 and #2 needed to be monitored. One staff checked on them every hour, one every 30-40 minutes and another whenever they had a free moment. After the above incident Client #2 no longer self-administered his medications. Assessments and treatment plans were not revised to reflect the clients current status on being unable to self-administer and his doctor was unaware of this change. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	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	V 118		

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V 118	Continued From page 30 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. (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, interview and record review, the facility failed to ensure 5 of 5 staff (Staff #1, #2, #3, Residential Manager and Residential Team Lead/Qualified Professional (QP)) who administered medications were trained; failed to ensure medications were administered only on the written order of a person	V 118		

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authorized to prescribe drugs; failed to ensure the MARs were kept current and recorded immediately after administration and failed to assess and ensure authorized physician's order to self-administer for 2 of 2 clients (Clients #2 and #3). The findings are:

Finding #1:

Review on 1/28/22 of the facility's policy for "Self Administration of Medications" last revised 5/29/19 revealed:
-"...All individuals who self-administer medications are evaluated, educated, and deemed competent to do so by a staff member qualified in medication administration..."
-"...A member of the team, competent in medication administration, will complete the agency form, Assessment for Self-Administration of Medication form..."
-"...Reassessments will be conducted as determined by the team...'
-"...The person's Qualified Professional will be responsible for working with the person on storage and locking options for the medication...."
-"People living in residential settings...will be requested to maintain a Medication Administration Record (MAR) of all administrations of medications..."

Review on 1/27/22 of the Residential Team Lead/QP's employee file revealed:
-Hired 3/16/20.
-Medication Administration training certificate 3/23/20 - not signed by the trainer.
-Education history reflected no medical education.

Review on 1/25/22 of the Residential Manager's employee file revealed:

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V 118	Continued From page 32 -Hired 2/28/21. -Medication Administration Observation checklist 1/10/22 completed by the Residential Team Lead/QP. -There was no documentation to verify Medication Administration training was conducted by a legally qualified person to administer medications. Review on 1/25/22 of Staff #1's employee record revealed: -Hired 12/13/20 as a Behavioral Specialist. -Medication Administration Observation checklist 10/11/21 completed by the Residential Manager. -There was no documentation to verify Medication Administration training was conducted by a legally qualified person to administer medications. Review on 1/27/22 of Staff #2's employee record revealed: -Hired 2/11/19 as a Behavioral Specialist. -Medication Administration Observation checklist 2/2/21 completed by the Residential Team Lead/QP. -There was no documentation to verify Medication Administration training was conducted by a legally qualified person to administer medications. Review on 1/27/22 of Staff #3's employee record revealed: -Hired 12/13/21 as a Behavioral Specialist. -Medication Administration Observation checklist 1/3/22 completed by the Residential Manager. -There was no documentation to verify Medication Administration training was conducted by a legally qualified person to administer medications.	V 118		

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V 118	Continued From page 33 Interview on 1/28/22 with the Residential Team Lead/QP revealed: -Her medication administration training was completed by a Registered Nurse (RN). -Human Resources did not have any certificates of training for her or the other staff to determine the qualifications of who trained them. Interview on 2/2/22 with the Vice President of Long-Term Services and Support revealed: -The education department confirmed the initial medication administration trainings for all staff were completed by an RN. -Since COVID-19 they now had online trainings conducted by their current Nursing Director. -The observation checklist was completed on-site, after the initial medication training, by a person who had already been through the process and had demonstrated competency. -The observation checklist was done annually by the staff member's supervisor to ensure continued competence. -The education department did not provide certificates for the initial medication administration training conducted by an RN. Finding #2: Review on 1/25/22 of Client #2's record revealed: -Admitted 12/4/20. -Diagnoses of Anxiety disorder, Diabetes Mellitus, Gastro-Reflux, Bipolar disorder, Schizophrenia, Paranoid Ideation and Hyperlipidemia. Upon entrance on 1/24/22 the Residential Team Lead/QP identified Client #2 as one of the clients who self-administered his medications. Review on 1/26/22 of Client #2's most recent Self-Medication Administration assessment dated	V 118		

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4/30/20 revealed:
-A former Residential Manager completed the assessment; The Residential Team Lead/QP was listed as being "...Involved in Review of Assessment."
-The team recommended support of self-administration of medication and self-use of medical equipment.
-"Team Recommendation for follow up assessment: Does not need to be repeated unless change in skill level is noted."

Review on 1/26/22 of facility's level I incident reports from October 2021 through January 2022 revealed:
-1/11/22 - Consumer behavior - Client #2 called the Residential Manager (via his cell phone) and said he felt like hurting himself.
-Client #2 stated Staff #3 told him to clean his room and he felt like overdosing on his medications.

Review on 1/26/22 of Client #2's Physician's order revealed:
-5/1/20 - "Patient to administer his own medications, except for insulin which still requires supervision."

Review on 1/27/22 of an undated Physician order (different physician from above) for Client #2 revealed:
-Staff to administer the client's medications.

Attempted interview on 1/31/22 for the Physician above regarding the undated order. A message was left, however a return call was not received prior to exiting the survey.

Interviews on 1/24/22, 1/25/22 and 1/27/22 with Client #2 revealed:

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V 118	Continued From page 35 -He used to self-administer his medication until 3-4 weeks ago when he said he wanted to commit suicide. -Prior to the incident he had self-administered medications for about 6 months or so. -Staff checked his medications but he didn't know how often. -The medications he took were Coreg, Aspirin low dose 81 milligrams (mg), Hydrochlorot, fluid pill, Prilosec, Naproxen for fluid and inflammation on his knew and Atorvastatin - he had " ...no idea what it's for." -He no longer had any paper MARs from when he self-administered, including the one for this month. -Staff checked them but he had no idea how often. Interview on 1/31/22 with the ACTT (Assertive Community Treatment Team) Behavioral Health Director revealed: -The last note from Client #2's doctor was 1/25/22. -There was no mention in his records the client was not adhering to his medication regimen. -Requested for the doctor to call surveyor, however no call was received prior to exit. Review on 1/24/22 of Client #2's Physician's Orders dated 10/4/21 revealed: -Aspirin Low Tab - 81 mg - 1 tablet every day. -Atorvastatin (cholesterol) - 20 mg - 1 tablet daily. -Carvedilol (high blood pressure) - 3.125 mg - 1 tablet - 2x day. -Escitalopram (antidepressant) - 20 mg - 1 tablet every a.m. -Fish Oil - (supplement) 1000 mg - 1 capsule 2x day. -Hydrochlorot (high blood pressure) - 12.5 mg - 1 capsule every day.	V 118		

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-Pantoprazole (indigestion) - 40 mg - 1 tablet every day.
-Perphenazine (schizophrenia) - 16 mg - 2 and ½ tablets at bedtime.
-Risperidone (antipsychotic) - 3 mg - 2 tablets at bedtime.
-Risperidone - 0.5 mg - 1 tablet - as needed for voices.
-No order was found for Paliperidone (antipsychotic) ER (extended release) - 3 mg - 1 tablet daily.
-No order found for Neo/Poly/HC 1% Otic suspension (ear drops) - Instill 4 drops into affected ear 3x day.

Review on 1/24/22 of Standing Medications Orders dated 10/4/21 for Client #2 revealed:
-Robitussin CF 10 ml (millimeters) 4x day as need for nasal, chest congestion and cough suppressant.
-"May use generic substitution to brand name medications."
-There was no order for Ibuprofen (pain reliever) - 1 tablet 3 x day - as needed.

Review on 1/27/22 of a Physician's Order dated 11/16/21 for Client #2 revealed:
-Naproxen (anti-inflammatory) - 500 mg - 1 tablet - 2x day.

Observation on 1/24/22 at 11:53 a.m. of the facility medication cart that included Client #2's medications revealed:
-Paliperidone (antipsychotic) ER (extended release) - 3 mg - 1 tablet daily - dispensed 8/13/21 - (no order).
-Neo/Poly/HC 1% Otic suspension (ear drops) - Instill 4 drops into affected ear 3x day - dispensed 2/16/21 (no order).
-Ibuprofen (pain reliever) - 200 mg - 1 tablet 3 x

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day - as needed - dispensed 10/25/21 (no order).
-The following medications were not observed in the medication cart according to the above orders:
Aspirin Low Tab - 81 mg - 1 tablet every day.
Atorvastatin - 20 mg - 1 tablet daily.
Carvedilol - 3.125 mg - 1 tablet - 2x day.
Escitalopram - 20 mg - 1 tablet every a.m.
Fish Oil - 1000 mg - 1 capsule 2x day.
Hydrochlorot - 12.5 mg - 1 capsule every day.
Naproxen - 500 mg - 1 tablet - 2x day.
Pantoprazole - 40 mg - 1 tablet every day.
Perphenazine - 16 mg - 2 and ½ tablets at bedtime.
Risperidone - 3 mg - 2 tablets at bedtime.
Risperidone - 0.5 mg - 1 tablet - as needed for voices.

Observation and Interview on 1/24/22 at 2:15 p.m. in the staff office revealed:
-The Residential Team Lead/QP stated the rest of Client #2's medications were in his room since he self-medicated.
-Staff #3 stated at this time, no, his medications were there, and pointed to a large storage container on the floor.
-A large black storage container (approximately 30 gallon) was observed with a pad lock on it.
-Staff #3 opened the storage container.
-The Residential Team Lead/QP stated at that time the medications were brought back to the office to help him to better organize them as he was getting confused but that he did self-medicate.
-The following included Client #2's medications observed in the storage container.
-8 bubble packs with a rubber band wrapped around them and hand written at the top of the first pack was a.m.:
Aspirin Low Tab - 81 mg - 1 tablet every day -

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V 118	Continued From page 38 dispensed 12/21/21. Atorvastatin - 20 mg - 1 tablet daily - dispensed 10/22/21. Carvedilol - 3.125 mg - 1 tablet - 2x day - dispensed 12/21/21. Escitalopram - 20 mg - 1 tablet every a.m. - dispensed 12/21/21. Fish Oil - 1000 mg - 1 capsule 2x day. - dispensed 10/22/21. Hydrochlorot - 12.5 mg - 1 capsule every day - dispensed 12/21/21. Naproxen - 500 mg - 1 tablet - 2x a day - dispensed 12/21/21. Pantoprazole - 40 mg - 1 tablet every day - dispensed 12/21/21. -6 bubble packs with a rubber band wrapped around them and hand written at the top of the first pack was bedtime: Carvedilol - 3.125 mg - 1 tablet - 2x day - dispensed 10/22/21. Fish Oil - 1000 mg - 1 capsule 2x day. - dispensed 7/24/21. Naproxen - 500 mg - 1 tablet - 2x a day - dispensed 12/21/21. Perphenazine - 16 mg - 2 tablets at bedtime (order was for 2 and ½ tablets at bedtime) - dispensed 12/21/21. Risperidone - 3 mg - 2 tablets at bedtime (total of 6 mg) - dispensed 11/28/21. Risperidone - 3 mg - 1 tablet at bedtime with 6 mg (total of 7 mg) - dispensed 4/25/21. -There was no order for a total of 7 mg of Risperidone; The ordered 0.5 mg - 1 tablet - as needed for voices was not observed. -5 bubble packs with a rubber band wrapped around them (no notations written at the top): Aspirin Low Tab - 81 mg - 1 tablet every day - dispensed 1/20/22.	V 118		

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V 118	Continued From page 39 Atorvastatin - 20 mg - 1 tablet daily - dispensed 1/20/22. Carvedilol - 3.125 mg - 1 tablet - 2x day - dispensed 1/20/22. Escitalopram - 20 mg - 1 tablet every a.m. - dispensed 1/20/22. Pantoprazole - 40 mg - 1 tablet every day - dispensed 1/20/22. -3 bubble packs with a rubber band wrapped around them with bedtime at the top of the first pack: Fish Oil - 1000 mg - 1 capsule 2x day. - dispensed 1/20/22. Naproxen - 500 mg - 1 tablet - 2x a day - dispensed 1/20/22. Perphenazine - 16 mg - 2 tablets at bedtime (order was for 2 and ½ tablets at bedtime) - dispensed 1/20/22. -2 bubble packs wrapped together - one with a.m. sticker and one with p.m. sticker: Fish Oil - 1000 mg - 1 capsule 2x day. - both dispensed 12/21/21 - all capsules remained. -2 additional bubble packs wrapped together - one with a.m. sticker and one with p.m. sticker: Fish Oil - 1000 mg - 1 capsule 2x day. - both dispensed 11/21/21 - all capsules remained. -1 bubble pack with a rubber band around it: Fish Oil - 1000 mg - 1 capsule 2x day. - dispensed 7/24/21 - all capsules remained.. -1 additional bubble pack with a rubber band around it: Fish Oil - 1000 mg - 1 capsule 2x day. - dispensed 10/22/21 - all capsules remained.. -1 bubble pack at bottom of the container:	V 118		

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V 118	Continued From page 40 Fish Oil - 1000 mg - 1 capsule 2x day. - dispensed 6/24/21 - all capsules remained. -3 bubble packs with rubber band wrapped together: Fish Oil - 1000 mg - 1 capsule 2x day. - dispensed 1/20/22. Hydrochlorot - 12.5 mg - 1 capsule every day - dispensed 1/20/22. Naproxen - 500 mg - 1 tablet - 2x a day - dispensed 1/20/22. -2 loose bubble packs: Atorvastatin - 20 mg - 1 tablet daily - dispensed 12/21/21. Atorvastatin - 20 mg - 1 tablet daily - dispensed 11/21/21. -10 loose prescription bottles at the bottom of the container: Risperidone - 4 mg - 1 tablet 2x day - bottle was empty - dispensed 1/14/22. Risperidone - 4 mg - 2 tablets at bedtime - 2 tablets remained - dispensed 5/10/21. Risperidone - 3 mg - 2 tablets at bedtime - quantity filled 180 tablets - bottle approximately ¾ full - dispensed 9/28/21. Perphenazine - 16 mg - 2 ½ tablets at bedtime - quantity filled 225 tablets - bottle full - dispensed 9/28/21. Hydrochlorothiazide - 12.5 mg - 1 capsule day - quantity filled 90 - bottle approximately ¼ full - dispensed 11/16/21. Escitalopram - 20 mg - 1 tablet every a.m. - quantity filled 60 - bottle approximately ¼ full - dispensed 9/28/21. Escitalopram - 20 mg - 1 tablet every a.m. - quantity filled 90 - bottle approximately ¼ full - dispensed 11/16/21. Atorvastatin - 20 mg - 1 tablet every day - quantity	V 118		

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filled 90 - bottle approximately ¼ full - dispensed 11/13/21.
Atorvastatin - 20 mg - 1 tablet every day - quantity filled 90 - bottle approximately ¼ full - dispensed 10/5/21.
Carvedilol - 3.125 mg - 1 tablet 2x a day - quantity filled 180 - bottle approximately 1/8 full - dispensed 11/13/21.

-3 bottles in a baggie:
Carvedilol - 3.125 mg - 1 tablet 2x day - quantity filled 180 - bottle approximately 1/8 full - dispensed 10/5/21.
Pantoprazole - 40 mg - 1 tablet every day - quantity filled 90 - bottle approximately ¼ full - dispensed 10/5/21.
Hydrochlorothiazide - 12.5 mg - 1 capsule every day - quantity filled 90 - approximately ½ full - dispensed 10/5/21.

-1 bottle in a baggie:
Pantoprazole - 40 mg - 1 tablet every day - quantity filled 90 - approximately ¼ full - dispensed 11/17/21.

-3 bottles of Tussin Mucus and Chest congestion - Over-the-Counter (OTC).
-21 bottles of One Daily Men's Health - OTC

Review on 1/24/22 of Client #2's MAR for January 2022 revealed:
-Aspirin Low Tab - 81 mg - 1 tablet every day.
-Atorvastatin - 20 mg - 1 tablet daily.
-Carvedilol - 3.125 mg - 1 tablet - 2x day.
-Escitalopram - 20 mg - 1 tablet every a.m.
-Fish Oil - 1000 mg - 1 capsule 2x day.
-Hydrochlorot - 12.5 mg - 1 capsule every day.
-Naproxen - 500 mg - 1 tablet 2 x day.
-Pantoprazole - 40 mg - 1 tablet every day.
-Perphenazine 16 mg - 2 tablets at bedtime.

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-Risperidone - 3 mg - 2 tablets at bedtime.
-Risperidone - 0.5 mg - 1 tablet - as needed for voices- not listed.
-In a box underneath each of the above medications read "Not given by facility."
-There were no initials to indicate staff were administering medications starting after the incident on 1/11/22.

Interviews on 1/25/22 and 1/27/22 with Staff #1 revealed:
-Client #2 had been self administering his medications since he had worked there (about 2 years).
-Staff checked Client #2's medication, "not in depth ...check it periodically ...not highly prioritized."
-He was not given any direction to monitor clients who self-administered.
-The clients let them know if they felt like they were having problems.

Interview on 1/27/22 with Staff #2 revealed:
-All staff were required to check self-administered MARs 2 times a week.
-It was "a while" since she had checked Client #2's MARs due to getting "distracted" doing other things.
-She returned to her shift 2 days after Client #2's incident and his tub of medications were in the office.
-This was when it was determined he wasn't taking his medications appropriately.

Interviews on 1/24/22, 1/27/22 and 2/1/22 with Staff #3 revealed:
-She was not told to monitor Client #2's self-administration or to monitor his MARs every so often.
-Only thing she was told to monitor was when he

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did his insulin shots, which he did that in the office, his other medications were in his room.
-The note next to the initial boxes read not given by facility because he was self-administering his medications.
-They were administering Client #2's medications since the 1/11/22 incident.
-The staff pulled the a.m. and p.m. medications from the storage container and wrapped them with a rubber band.
-Those were the ones staff were using once they started to administer the medications.
-The January MAR from 1/12/22 forward was not initialed by staff because the system still had him as self-administering; they were not able to put their initials into the system when they started administering.

Interview on 1/26/22 with the Residential Manager revealed:
-Since the 1/11/22 incident of Client #2 threatening suicide and especially by overdosing staff took his medications out of his room that same day.
-She was "flabbergasted" when she looked inside his storage container with all his medications.
-He was ordering his own medications through his insurance who dispensed medications differently.
-They were sending him a quantity of 90 pills, that didn't work with their current system.
-Their pharmacy and pharmacist was out of Raleigh.
-Current and discontinued orders were asked for medications found in the medication cart: Paliperidone ER - 3 mg; Neo/Poly/HC 1% Otic suspension; and Ibuprofen 200 mg.
-Discontinue orders were requested for Perphenazine - 16 mg - 2 and ½ tablets at bedtime and Risperidone - 0.5 mg - 1 tablet - as

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needed for voices.
-The above orders/discontinue orders were not provided prior to survey exit.

Interviews on 1/26/22 and 1/27/22 with the Residential Team Lead/QP revealed:
-When Client #2 threatened suicide by overdosing on his medications on 1/11/22 his medications were taken to the office and he was no longer self-administering.
-They notified his primary doctor and he was aware.
-His self-administration privileges would be revoked until a physician approved it again.
-Clients who self-administered medications had their own paper MARs they were responsible to complete.
-Staff were to check the client's MARs every day or at least every couple of days.
-She depended on the Residential Manager to look at MARs and let her know if there were any discrepancies.
-The pharmacist from Raleigh will come on-site and "periodically" check medications and QuickMar (electronic MAR) to ensure everything was correct.
-They were expected to come on-site Friday (1/28/22) to help sort out Client #2's medications.
-Current and discontinued orders were requested for medications found in the medication cart: Paliperidone ER - 3 mg; Neo/Poly/HC 1% Otic suspension; and Ibuprofen 200 mg.
-Discontinue orders were requested for Perphenazine - 16 mg - 2 and ½ tablets at bedtime and Risperidone - 0.5 mg - 1 tablet - as needed for voices.
-The above orders/discontinue orders were not provided prior to survey exit.

Interview on 1/31/22 with the Vice President of

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Long-Term Services and Support revealed:
-She was the direct supervisor for the Residential Team Lead/QP who supervised the Residential Manager who supervised the support staff.
-She communicated with the Residential Team Lead/QP monthly, at a minimum and was on-site once every couple of months.
-There was no nursing oversight at the facility; If there were no medical issues they did not assign a nurse.
-They recently hired a Director of Nursing who the facility could call anytime they had questions about medications.
-There was no policy to "spot check" clients who self-administered medications

Review on 1/25/22 of Client #3's record revealed:
-Admitted 4/4/20.
-Diagnoses of Persistent Depressive disorder (Dysthymia), Attention-Deficit Hyperactivity Disorder, and Intellectual Developmental Disability, mild.

Review on 1/26/22 of Client #3's Self-Medication Administration assessment dated 7/28/20 revealed:
-Self-Medication Administration was supported.
-Completed by the Residential Team Lead/QP.
-An updated Self-Medication Administration assessment was not found.

Review on 1/26/22 of Client #3's most recent Person Centered Plan dated 3/29/21 revealed:
-"What's Working/What's Not Working: ...is able to manage his own medication ..."

Review on 1/26/22 of Client #3's Physician's Orders dated 7/22/20 revealed:
-Client to self-administer all medication.
-There was no order to discontinue

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self-administration.

Review on 1/26/22 of facility level I incident reports from October 2021 through January 2022 revealed:
-Date of event: 10/21/21; Awareness date and time: 10/22/21 at 9:00 p.m.
-Incident type: Medications.
-Client #3, who was administering his own medications, noticed " ...he did not receive 2 of his morning medications ..."
-Staff #2 checked electronic MAR and found the medication had been reordered.
-Staff #2 called the pharmacy who stated " ...the medication was shipped and received by the facility on 10/21/2021."
-The medication listed as missing was Pantoprazole (indigestion) 20 mg.
-"Other medication event medication was delivered by pharmacy and checked in by staff but medication is missing."
-Team Leader and staff looked for medication.
-"Systemic/Preventive Measures ...when staff check in medication they will initial each medication and [client] will initial that the medication was received..."

Review on 1/25/22 of Client #3's Physician's Orders dated 9/16/21 revealed:
-Hydroxyzine HCl (anxiety)- 25 mg - 1 tablet 2x day as needed.
-Discontinue Depakote (typically used for seizures and off label use for behaviors) scripts.

Review on 1/25/22 of Client #3's Physician's Orders dated 10/4/21 revealed:
-Depakote ER - 250 mg - 1 tablet daily.
-Lopid (high cholesterol) - 600 mg - 1 tablet daily.
-Lopid - 600 mg - ½ tablet at bedtime.
-Metformin (diabetes)- 1000 mg - 1 tablet 2x day.

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V 118	Continued From page 47 Omega-3-Acid (supplement) - 1 gm (gram) - 2 capsules daily. -Pantoprazole - (indigestion) 20 mg - 1 tablet daily. -Risperidone (antipsychotic) - 3 mg - 1 tablet at bedtime with 4 mg dose. -Risperidone - 4 mg - 1 tablet daily with 3 mg dose (total 7 mg). -Zoloft (antidepressant) - 100 mg - 1 tablet day. -Trazodone (antidepressant and sedative)- 100 mg - 1 ½ at bedtime. Review on 1/25/22 of a signed physician note dated 12/8/21 for Client #3 revealed: -"To whom it may concerne ...This is to clarify that the medication Depakote has been stopped. The client is now taking Atarax [Hydroxyzine] 25 mg twice a day as needed." Observation on 1/24/22 at 12:10 p.m. of Client #3's medications in the facility medication cart revealed: -Depakote ER - 250 mg - 1 tablet daily - dispensed 11/21/21 - handwritten on top of bubble pack "Dc'd." -Omega-3-Acid - 1 gm (gram) - 2 capsules daily - not observed. -Atarax - 25 mg - 2x a day as needed - not observed. -All other medications were present as ordered. Interview on 1/24/22 and 1/27/22 with Client #3 revealed: -His medications were Risperidone, Lopid, Trazadone, Zofran and Metformin. -The facility taught him how to take his medications. -He was self-administering his medications, but the facility took them away from him about 3-4 months ago.	V 118		

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V 118	Continued From page 48 -They got "messed up" somehow, the staff thought he sold his medications, "I wouldn't sell my meds [medications]." -They handed him his medications when they arrived at the facility and when he went to take them it wasn't there - "Zoloft was gone." -He went to the hospital and was able to get more Zoloft that same day. Interview on 1/27/22 with Staff #2 revealed: -The pharmacy for Client #3 sent his medications to the facility monthly. -When she received the new medications, she compared them to what Client #3 had left over. -On 10/21/21 when it was time for him to take his medications, he didn't have 2 of the new bubble packs that had been logged as received. -She remembered Risperdal was one of them but could not remember the other one. -The pharmacy was contacted and replaced the medications; He did not miss any of his medications. -Staff had been administering his medications since this incident. -She remembered checking his MARs prior to the incident and "...they were good." Interview on 1/27/22 with Staff #3 revealed: -She took out the medications in the cart that had handwritten "Dc'd" on the bubble pack, but someone put them back in the client's active medications. Interview on 1/26/22 with the Residential Manager revealed: -She did not know anything about Atarax being ordered as needed and the client had never asked for this medication. -She was on vacation the day of the incident. -When asked for Client #3's order to discontinue	V 118		

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self-administration - "I don't know because I wasn't here."
-When asked if missing medications were refilled - "He was taken to the ER (emergency room) for the meds he misplaced. They were filled he did not miss any meds."
-Asked for the ER visit documentation, this was not received prior to the survey exit.

Interview on 1/26/22 with the Residential Team Lead/QP revealed:
-Client #3's self-administration was revoked as a direct correlation of the incident.
-There was suspicion Client #3 was selling his medications in the community and to his family.
-Client #3 had not been re-evaluated for self-administration per his guardian's wishes.

Interview on 1/31/22 with Client #3's guardian revealed:
-She was aware of incident on 10/21/21 of the client's missing medications.
-This kept him from being able to self-administer, she thought he was self-administering his medications now.

Interview on 1/31/22 with Client #3's psychiatrist office revealed:
-The last note found was 9/16/21 indicating the client could self-administer his medications.
-There was no note reflecting the client was no longer self-administering.

Review on 2/2/22 of the first Plan of Protection (POP) dated and signed by the Vice President Long Term Services and Support (LTSS) on 2/2/22 revealed:
What Immediate action will the facility take to ensure the safety of the consumers in your care?
"ACTION

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V 118	Continued From page 50 1. [Name of Pharmacy] Pharmacy representative came on site on 1/28/22, reconciled the current prescription medications stored in medication cabinet with current prescriptions and assisted group home manager [name] with packaging discontinued meds. FOLLOW UP/PERSON RESPONSIBLE [Name of Pharmacy] Pharmacy [Consultant Pharmacist] DATE 1/28/22 Discontinued meds were picked up by [Name of Pharmacy] pharmacy for disposal. FOLLOW UP/PERSON RESPONSIBLE [Name of Pharmacy] Pharmacy [Consultant Pharmacist] DATE 1/28/22 ACTION 2. LTSS [Long Term Services and Support] Nursing Director for Monarch will do a site visit to check medication storage and reconcile prescribed meds and onsite meds. FOLLOW UP/PERSON RESPONSIBLE [Nursing Director] DATE 2/4/22 ACTION 3. Team Leader and Manager will be re-trained on self administration policy. FOLLOW UP/PERSON RESPONSIBLE [Nursing Director] DATE 2/4/22 ACTION 4. A weekly online medication closet checklist will be completed weekly for 4 weeks and reviewed by Nursing Director. FOLLOW UP/PERSON RESPONSIBLE [Nursing Director] DATE Starting week of 2/7/22 through end of week 3/4/22. ACTION 5. Notifications will be made to prescribing doctors who initially signed orders for self administration that this has been revoked.	V 118		

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V 118	Continued From page 51 FOLLOW UP/PERSON RESPONSIBLE Documentation of notification done/reviewed by Credible record [Vice President of LTSS] DATE 2/2/22" Describe your plans to make sure the above happens. "Outlined above." Review on 2/2/22 of the second Plan of Protection (POP) dated and signed by the Senior Vice President LTSS on 2/2/22 revealed: What Immediate action will the facility take to ensure the safety of the consumers in your care? "How often will Nursing Director will be on-site to monitor medication storage and reconcile medications? Will this be on-going? The Nursing Director went to the home 02-02-22 to complete this monitoring. She will visit the home every 2 weeks until she is confident in the manager's skills to complete this process. The Nursing Director will not continue to do med reviews or reconciliation consistently, but will work with the home manager until she is confident of competency. It is the agency's expectation that these duties be fulfilled by the QP and Residential Manager. This home is not funded for any type of nursing support. When will direct care staff be retrained in medication administration/self-administration? Who will do this? 02-04-2022 How will staff monitor clients' capability to continue to self-administer per doctor orders? Who will ensure staff are monitoring this?	V 118		

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V 118	Continued From page 52 Self-administration is reassessed as part of the planning process annually. If incidents or issues occur, the team will re-evaluate the person's ability at that time. One thing we will include in our plan of correction is we are changing the forms for both unsupervised time and self-medication administration. We will add a formal revocation to the form to document when the team recommends stopping either unsupervised time or self-medication. This documentation will include: Date of team meeting; Reason for the change; Effective Date; and for self-medication, date physician withdrew order. How will the online medication closest checklist be checked for accuracy by the Nursing Director (if she will not be on-site)? How will ensure on-going compliance after the 4 weeks expired? As part of supervision the QP checks behind the residential manager on the compliance with the medication closet. The agency also conducts "tracers" which is an internal sampled review from the Monarch QM department where visual evidence is obtained of the accuracy of storage. Vice-Presidents also review medication closets during their site visits. How will ensure notification to the physician's on self-administration changes is communicated timely? How and who will monitor this for on-going compliance? In our plan of correction we will change our policy to ensure this is outlined as a need. The revised forms will outline the date the physician is notified. Overall compliance will be monitored through supervision and peer review audits."	V 118		

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V 118	Continued From page 53 Review on 2/3/22 of the third Plan of Protection (POP) dated and signed by the Senior Vice President LTSS on 2/2/22 revealed: What Immediate action will the facility take to ensure the safety of the consumers in your care? "How often will Nursing Director will be on-site to monitor medication storage and reconcile medications? Will this be on-going? The Nursing Director went to the home 02-02-22 to complete this monitoring. She will visit the home every 2 weeks until she is confident in the manager's skills to complete this process. The Nursing Director will not continue to do med reviews or reconciliation consistently, but will work with the home manager until she is confident of competency. It is the agency's expectation that these duties be fulfilled by the QP and Residential Manager. This home is not funded for any type of nursing support. When will direct care staff be retrained in medication administration/self-administration? Who will do this? 02-04-2022 Current curriculum is introduction video, live Teams meeting with an RN, and competencies are verified by camera. In addition, the residential manager completes 3 on-site observations with each employee to verify competency. How will staff monitor clients' capability to continue to self-administer per doctor orders? Who will ensure staff are monitoring this? [The following two sentences were struck through.]	V 118		

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V 118	Continued From page 54 Self-administration is reassessed as part of the planning process annually. If incidents or issues occur, the team will re-evaluate the person's ability at that time. At Parkland, the DON [Director of Nursing] will be assessing capabilities on 02-02-22 and 02-04-2022. Going forward we will add checking self-medication storage, meds, and orders monthly on all individuals that self-medicate to our monthly medication check. The Residential Manager will be responsible for completing this form and submitting it to the DON. DON will track monitoring for all sites. Target date for completion is 02-11-22. One thing we will include in our plan of correction is we are changing the forms for both unsupervised time and self-medication administration. We will add a formal revocation to the form to document when the team recommends stopping either unsupervised time or self-medication. This documentation will include: Date of team meeting; Reason for the change; Effective Date; and for self-medication, date physician withdrew order. How will the online medication closest checklist be checked for accuracy by the Nursing Director (if she will not be on-site)? How will ensure on-going compliance after the 4 weeks expired? As part of supervision the QP checks behind the residential manager on the compliance with the medication closet. The agency also conducts "tracers" which is an internal sampled review from the Monarch QM department where visual evidence is obtained of the accuracy of storage.	V 118		

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V 118	Continued From page 55 Vice-Presidents also review medication closets during their site visits. How will ensure notification to the physician's on self-administration changes is communicated timely? How and who will monitor this for on-going compliance? In our plan of correction we will change our policy to ensure this is outlined as a need. The revised forms will outline the date the physician is notified. Overall compliance will be monitored through supervision and peer review audits." This is a 6 bed residential facility for adult clients with mental illness to include Major Depressive Disorder, Anxiety Disorder, Bipolar Disorder, Schizophrenia, and Paranoid Ideation. Client #2 was last assessed in April 2020 as being able to self-administer his medications. There was no process in place to ensure medications were being checked on a continuing basis. Staff were to check Client #2's MARs every day or every other day. Two of the staff never checked the client's MARs and one did periodically. The actual medications or bottles were never checked. There was no evidence the staff had been trained to administer medications by a legally qualified person to administer medications. The storage container where Client #2 kept his medications, currently in the staff office, was observed to have medications scattered throughout the container with no organization. A total of 48 bubble packs or prescription bottles were found in Client #2's storage container with one bottle dispensed on 4/24/21. Client #2 had a total of 11 medications prescribed that he was self-administering. Of the medications observed only one bottle was empty, the rest had all of the pills dispensed to approximately 1/4 of the pills remaining. His	V 118		

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V 118	Continued From page 56 prescriptions included 2 antipsychotic medications for schizophrenia and 1 antidepressant. It was unable to be determined how long Client #2 had not been taking his medications as prescribed. He did not keep his MARs current and staff were not monitoring his compliance. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	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	V 291		

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V 291	Continued From page 57 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 observation, interview and record review, the facility failed to have activity opportunities for 3 of 3 (Clients #1, #2 and #3) clients based on their choices, needs and the treatment/habilitation plan. The findings are: Observation on 1/24/22 from 11:00 a.m. to 4:45 p.m. revealed: -Staff #3 sitting in the office with the Residential Team Lead/QP from 11:33 a.m. to 2:15 p.m. as surveyor observed Client #1,#2, #3's medications. -The office door was shut and Staff #3 was not observed checking on the clients until after 2:15 p.m. -Client #1 remained in his room throughout the observation period with the exception of taking his medications around noon. -Client #2 remained in the living room throughout the day with the exception of walking in the kitchen a couple of times and going to the restroom. -Client #3 remained at the facility all day, either in his room, or outside smoking. Observations on 1/25/22 from the dining room table revealed: -At approximately 1:33 p.m. Staff #3 was	V 291		

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observed to walk through the living room and into the kitchen.
-Client #1 and a non-sampled client were in the living room and she asked if they were okay and walked back into the office and shut the door.

Observations on 1/26/22 from approximately 1:00 p.m. - 2:15 p.m. revealed:
-A non-sampled client asked Client #1 if he wanted to go for a walk at two different times.
-Client #1 was not heard responding to the non-sampled client.
-The same non-sampled client was heard asking the Residential Manager to go for a walk with him.
-The non-sampled client had not taken a walk yet at the time the surveyor left at approximately 5:15 p.m.

Review on 1/25/22 of Client #1's record revealed:
-Admitted 7/1/20 - 62 years old.
-Diagnoses of Major Depressive disorder, recurrent, moderate; Anxiety disorder, unspecified and Intellectual Developmental Disorder, mild.

Review on 1/26/22 of Client #1's PCP dated 6/18/21 included:
-"What's Working/What's Not Working: Guardian: [Client #1] has too much time on his hands and needs structured activities to participate in ...Working: QP: [Client #1] has been doing well living at Parkland and after consulting his Guardian we have increased his unsupervised time to 4 hours..."
-Goal: - "...will participate in physical activity of his choosing at least 3 times per week for 90 days."
-How - Client #1 "...will choose and participate in a physical activity. Staff will: Provide choices of activities to choose from, Educate [Client #1] on

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the importance of physical activity and his mental health, Support and assist [Client #1] as needed."

Review on 1/25/22 of Client #2's record revealed:
-Admitted 12/4/20.
-Diagnoses of Anxiety disorder, Diabetes Mellitus, Gastro-Reflux, Bipolar disorder, Schizophrenia, Paranoid Ideation and Hyperlipidemia.

Review on 1/26/22 of Client #2's PCP dated 3/24/21 revealed:
-Client "...will manage his diabetes independently as evidenced by adhering to a health diet, exercise and talking all medications as prescribed."
-How - "...participate in a physical activity at least 3 times a week...encourage [Client #2] to participate in physical activities."

Review on 1/25/22 of Client #3's record revealed:
-Admitted 4/4/20.
-Diagnoses of Persistent Depressive disorder (Dysthymia), Attention-Deficit Hyperactivity Disorder, Intellectual Development Disability, mild.

Review on 1/26/22 of Client #3's most recent Person Centered Plan dated 3/29/21 revealed:
-Client "...will participate in a physical activity of his choosing at least 3 times a week for 3 consecutive months."
-How - "...will choose an exercise/activity to participate in Monarch Staff will educate [Client #3] on the health benefits of exercise; encourage and support [Client #3]; educate [Client #3] on options for activities."

Interviews on 1/24/22 and 1/27/22 with Client #3 revealed:
-They could only go out on Wednesday's and

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Saturday's "due to budget cuts."
-They used to go to the park, Chimney Rock, Cherokee to hike and go to gift shops.
-The last time he remembered going on an outing was in December when they went to look at Christmas lights.

Interview on 1/27/22 with Staff #1 revealed:
-Due to budget cuts outings and events have been cut and the gas budget was cut about 3-4 months ago.
-They had one specific outing planned a week.
-Yesterday he took the clients for a ride in downtown Asheville.

Interview on 1/27/22 with Staff #2 revealed:
-They haven't been able to do activities due to budget cuts.
-They used to go bowling and would eat out once a month.
-They cannot do this anymore unless they use their own money - which she had done before.

Interview on 1/27/22 with Staff #3 revealed:
-She had never seen a facility that did not have an activity calendar.
-The only days they could take the clients out were Wednesday and Saturday.
-Those were shopping days so usually the outing consisted of Dollar General or Walmart.

Interview on 1/26/22 with the Residential Manager revealed:
-Activities had been planned in the past but the clients "...just don't want to go."
-Usually Saturday or Sunday they had a game activity.
-They were supposed to go fishing last Sunday, the clients didn't want to go.
-We just have to say, "okay, get in the van and

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V 291	Continued From page 61 don't tell them where we are going" to get them to go. Interviews on 1/26/22 and 1/27/22 with the Residential Team Lead/Qualified Professional revealed: -There used to be structured activities like the movies, bowling, or going to the lake but clients would refuse to go once the actual day came. -They currently did not have a schedule of activities planned, but they tried to do something monthly. -Staff #1 was from Asheville and knew the area very well so he took the clients for rides there. -There were ample activities they could do that didn't cost money. -Once a month the clients were asked what they wanted to do, they planned it, and when the day came they didn't want to do it.	V 291		