Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040-055	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS GROUP HOME #6	710 WEST HARPER STREET SNOW HILL, NC 28580

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on November 5, 2021. The complaints were substantiated (intake #NC00182382 and #NC00182500). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. A sister facility is identified in this report. The sister facility staff is identified as staff #A6. The Licensee/Director/Qualified Professional (QP)/Registered Nurse (RN) is hereinafter referred to as Licensee #1. The Licensee/President/QP/RN is hereinafter referred to as Licensee #2. Licensee #2 is the spouse of Licensee #1. The Community Support Team (CST) hereinafter referred to in this report is owned/managed by Licensee #1 and Licensee #2's daughter.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including:	V 105	The QP or designee will respond and report to the facility within a reasonable time frame after the survey notification is announced. The House Manager will document the beginning and end time of the survey.	12/18/21

PRINTED: 11/24/2021
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V 105	Continued From page 1 (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting	V 105		

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V 105	Continued From page 2 applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record review, observation and interviews, the facility failed to develop and implement written policies for the delegation of management authority. The findings are: Review on 10/28/21 of the Licensee #1's personnel record revealed : -Hire date of 1/1/00. -Registered Nurse, License valid through 12/31/22. Review on 10/28/21 of a sister facility's delegation of management authority policy for a licensee's sister facility revealed: "Name of Policy: Operating Authority...Effective Date 5/16/14...Purpose: To specify the delegated line of authority...Authority is the right or obligation to act on behalf of a department or agency..." Policy: I. The delegation of management authority for [Licensee of sister facility] is...A. the President delegated authority to the Director/QP...B the Director/QP delegates authority to the Habilitation Technicians... II. It is the policy of [Licensee of sister facility] to have available at all times a	V 105		

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V 105	Continued From page 3 Qualified Professional...responsible for assuring that all duties of the agency are carried out..." Observation between 10/28/21-11/5/21 the Division of Health Service Regulation surveyors did not receive a call from QP #1 or Licensee #2 prior to the end of the survey. Interview and observation of the facility on 10/27/21 between 9:30am - 2:00pm revealed: -No vehicle was at the facility. -No answer at the door. -Staff #A6 and 3 males arrived at the facility and left the facility. -1 of the males that accompanied staff #A6 went to the side of the facility and returned with a TV and placed it in the van. -Staff #A6 stated she was not able to allow surveyors access to the facility. -She did not have a key to the facility and had not been inside the facility in years. -She provided an envelope to surveyors from Licensee #1 but did not know what was inside. -She worked at a facility for Licensee #1 but surveyors could get that information from Licensee #1. -She did not have any additional information to provide to surveyors. Attempted contact on 10/27/21 with Licensee #1 resulted in a voice mail left at approximately 9:43am. Attempted interview on 11/3/21 with the Licensee #2 was unsuccessful and appeared to be a fax number. Attempted interview with the QP#1 on 11/1/21 - 11/3/21 were unsuccessful as messages were left but there was no return call to the surveyors.	V 105		

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V 105	Continued From page 4 Interview on 10/27/21 - 11/5/21 Licensee #1 stated: -She was not able to report to the facility on 10/27/21 until approximately 4:30pm to begin the survey process as she was caring for her granddaughter. -Licensee #2 was the designated staff to allow access to the facility, but he had been unavailable because he was under quarantine. -She had attempted contact with the facility's House Manager several times, but the House Manager had not returned her calls. -The facility did not have an activity calendar and the facility's plans were normally spontaneous. -She had given the office staff the day off. -Client #1 and client #2 had attended a program in a nearby city. -Client #3 and client #5 had been with the House Manager, but she did not know where they were. -Client #4 had been one on one with staff #8 who had not returned her call. -The House Manager would be back at the facility around 4:00pm because the House Manager knew what time client #1 and client #2 would return to the facility. -She would send files to the surveyors at the facility by staff #A6, but staff #A6 would not have a key or access to the facility. -The facility staff would follow protocol if there was a client emergency and if she (Licensee #1) or Licensee #2 were not available to respond to crisis situations. -There was no other designated management authority to allow surveyors access to the facility and facility records on 10/27/21. -The QP #1 had worked at a school, had worked part-time at the facility, did not have specific hours or days to work at the facility. -She had no additional contact numbers for	V 105		

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V 105	Continued From page 5 Licensee #2 (her spouse who was under quarantine). -She agreed to request Licensee #2 and QP #1 contact surveyors for interviews. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professional and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 105		
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.	V 109	The facility will continue to report and document all incidents involving clients in accordance with the IRIS reporting guidelines. The House Manager will document all incidents on the facility incident reporting log and report all incidents to the QP. The QA Director will monitor all incidents to ensure compliance with this rule.	12/18/21

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V 109	Continued From page 6 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 1 of 1 Licensee #1 demonstrated the knowledge, skills and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105). Based on record review, observation and interviews, the facility failed to develop and implement written policies for the delegation of management authority. Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review, observation and interviews the facility failed to develop and implement strategies based on the assessment for 1 of 3 audited clients (#4). Cross Reference: 131E-256. Health Care Personnel Registry (V132). Based on record review and interview, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) and failed to submit the results	V 109		

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V 109	Continued From page 7 of all investigations within five working days of the initial notification to the Department. Cross Reference: 10A NCAC 27G .5603 Operations (V291). Based on record review, observation and interviews the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the clients treatment affecting 1 of 3 audited clients (#4). Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record review and interview, the facility failed to implement written policies governing their response to level II incidents for allegations of abuse. Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record reviews and interview, the facility failed to report incidents to the Local Management Entity/Managed Care Organization (LME/MCO) as required. Review on 10/28/21 of the Licensee #1's personnel record revealed : -Hire date of 1/1/00. -Registered Nurse, License valid through 12/31/22. -No signed job description was provided on 10/28/21 after request for personnel record. Review on 11/5/21 of an unsigned job description for the Qualified Professional (QP) revealed: - "Key Function...II Ensure all duties are performed independently and is guided by comprehensive service plans, program policies, guidelines and instructions...IV Continuous contact with member and other staff in planning	V 109		

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V 109	Continued From page 8 and providing member services. Regular contact with family members, guardians and members of other services agencies providing other services to members...VI Prepare written documentation such as: reports, service plans, business communications, member progress notes, etc..." -"Principle duties and responsibilities: Writes and implement individual service plans; counsels members; acts as role models for members, Coordinate positive member relationships within the community groups, civic leagues and neighborhood business. Serves as a liaison with daytime activities, vocational placements, family members and significant others...Coordinates the acquisitions of members entitlement with other human services professional and families..." Review on 11/5/21 of the Plan of Protection dated 11/5/21 written by Licensee #1 revealed: -"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? The allegation of abuse was unsubstantiated by both parties involved including DSS (Department of Social Services); therefore it was documented as a Level I incident. The incident was reported to the Guardian and to the Care Coordinator. In the future, all allegations will be reported in IRIS (North Carolina Incident Response Improvement System)/HCPR (Healthcare Personnel Registry). The QP will ensure that the treatment plan is followed and will contact the responsible agency to ensure all ordered services are delivered in a timely manner." -"Describe your plans to make sure the above happens. Training will be provided by the Director/QP [Licensee #2] tomorrow, November 6, 2021 on Incident Reporting Guidelines and Service Coordination." -During interview with Licensee #1 on 11/5/21	V 109		

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V 109	Continued From page 9 when asked about the Plan of Protection and each rule area not addressed, Licensee #1 stated it discussed the treatment plans, care coordination and incident reports. Client #4 is diagnosed with Schizoaffective Disorder Bipolar Type, Borderline Personality Disorder, Posttraumatic Stress Disorder, Depression and Mild Intellectual Disorder. She also has a history of frequent disrupted placements, physical assaults, verbal aggression, elopements and self-injurious behaviors with pending criminal assault with a deadly weapons charge. Client #4 was admitted to the facility on 8/13/21 after a 3 month stay at the hospital where ACTT services were recommended based on client #4's needs to include managing everyday issues/challenges associated with symptoms and reduce propensity for relapse, crisis, and hospitalizations. Licensee #1 continued to request CST services even though the assessment for client #4 indicated the continued need for ACTT services. Licensee #1 consistently failed to have client #4 available to the ACTT provider not allowing them to provide the recommended and needed service. Client #4's treatment plan also identified the need for ACTT services. Observations occurred by DHSR surveyors during the survey in which ACTT attempted to provide services for client #4 which were unsuccessful due to Licensee #1 failing to allow access to the facility and coordinate the recommended services. Licensee #1 did not allow access to the facility on 10/27/21 to surveyors or provide a delegation of authority staff to assist in the survey process. There was no schedule Licensee #1 could refer to as she attempted to locate clients and staff whereabouts while in the community for the	V 109		

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V 109	Continued From page 10 survey making both staff and clients unavailable for access to the surveyors. Licensee #1 learned of an allegation of abuse on 10/7/21 from DSS made by client #4 against the house manager and failed to report allegations to required entities and document the internal investigation of allegations. The refusals of ACTT services by staff and the absences of client #4 from the facility interfered with the attempted provision of services and failed delivery of services to client #4. Client #4 attempted to elope from the facility on 10/4/21. There was no documentation of contact with the ACTT to render services during client #4's attempted elopement crisis on 10/4/21 or after the elopement attempt. The Licensee #1's failure to perform duties and responsibilities which included the delegation of management authority, ensuring the treatment plans and services met individual client needs, ensuring those services could be carried out by coordination with other agencies identified to provide those services, responding to allegations of abuse and reporting allegations of abuse as required resulted in serious neglect. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day. 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan	V 109		
V 112		V 112		

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V 112	Continued From page 11 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 record review, observation and interviews the facility failed to develop and implement strategies based on the assessment for 1 of 3 audited clients (#4). The findings are: Review on 10/28/21-11/4/21 of client #4's record revealed:	V 112	The facility will continue to encourage clients to participate in authorized services.	12/18/21

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V 112	Continued From page 12 -31 year old female. -Admitted on 8/13/21. -Diagnoses of Schizoaffective Disorder, Bipolar Type, Borderline Personality Disorder, Post Traumatic Stress Disorder, Depression, Mild Intellectual Disorder, Hypertension and Type 2 Diabetes. Review on 10/28/21 of client #4's treatment plan dated 8/24/21 revealed: -"Presenting problem: [client #4] is a transfer form [Another Assertive Community Treatment Team (ACTT)] in [local city]...[client #4] is placed at her current group home after being hospitalized since May 2021...for stabbing another group home resident at her previous placement with a fork. [client #4] has a current charge of misdemeanor assault with a deadly weapon because of the incident." -"History of present illness: [client #4] has a history of multiple hospitalizations due to suicide ideation/attempts, and homicidal ideation/attempts and physical aggression..." - The facility was identified and listed as one of the service providers who would be responsible for implementing the plan's strategies and goals. - ACTT services were authorized to be provided daily or as needed. -The plan was completed by the ACTT and the services were ordered by the physician. Interview on 11/3/21-11/4/21 the ACTT leader stated: -The ACTT provides intensive community based services. -To be eligible for ACTT services an assessment process based on the state service definition must be completed, diagnoses, hospitalizations, guardians and had a pattern of crisis situations. -The ACTT is composed of a peer specialist,	V 112		

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V 112	Continued From page 13 mental health specialist, housing specialist, employment specialist, nurse and psychiatrist to meet individual client needs. -The ACTT provider received a referral from the hospital and care coordinator for client #4. -The ACTT provided a schedule calendar to Licensee #1. -She developed the treatment plan and Licensee #1 emailed the facility's goals and strategies to be included in the treatment plan for client #4. -She had concerns the facility would not allow the ACTT to meet with client #4. -Licensee #1 informed the ACTT client #4 received Community Support Team (CST) services but she (ACTT leader) confirmed client #4 had not received CST services. -A few times client #4 was present at the facility, but the facility would not allow the ACTT to visit client #4 and refused treatment sessions/visit. Observations of visitors at the facility between 10/28/21-11/5/21 revealed: -On 10/28/21 at approximately 10:30am, Division of Health Service Regulation (DHSR) surveyor requested client #4's information not be discussed while other clients are present. Licensee #1 responded what she was saying was not anything the clients had not heard or seen then requested client to go to the back of the facility. Client #5 verbally expressed disgruntlement at request and Licensee #1 responded "I Know." An ACTT member arrived at the home during the morning hours and requested to visit client #4. Licensee #1 informed ACTT member client #4 was not present and stepped onto the porch to speak with her. The ACTT member returned later that afternoon while client #4 was present. Licensee #1 informed ACTT member client #4 did not want to speak with her. At no time did DHSR surveyors observe	V 112		

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	MHL040-055	A. BUILDING: _____ B. WING _____	11/05/2021

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V 112	Continued From page 14 Licensee #1 attempt to inform client #4 that ACTT was present. -On 11/5/21 at approximately 10:30am, DHSR surveyors arrived at the facility. Clients #3, #4 and #5, Licensee #1, House Manager and staff #7 were in the living room area "prepared for survey exit" as stated by Licensee #1. Approximately 5 minutes later, an ACTT member arrived at the facility. Licensee #1 informed ACTT member client #4 did not want to see her. The ACTT member requested client #4 be allowed to inform her of refusing ACTT services. Licensee #1 turned to client #4 with all staff, clients and DHSR surveyors present and client #4 stated she did not want to talk. Licensee #1 walked the ACTT member to the porch and continued to speak with her and client #4 remained in the facility. Client #4 also went onto the porch a short time later with Licensee #1 and ACTT member. Licensee #1 returned into the facility. DHSR surveyors requested to interview Licensee #1 without clients present. Licensee #1 requested staff and clients leave the area. Client #5 left the living area and could be heard saying "I'm tired of these b*****s" she was not redirected by Licensee #1 or House Manager. At approximately 11am client #4's guardian arrived at facility. Licensee #1 informed guardian client #4 was not present and spoke with guardian on the porch. Guardian was allowed to view client #4's bedroom and guardian and Licensee #1 returned to the porch. Interview on 10/28/21-11/5/21 Licensee #1 stated: -She "worked with the clinical home to complete client's treatment plans." -ACTT developed the treatment plan and she provided goals and strategies for the facility. -ACTT is a 24 hour service. She "does not have any control of ACTT services." -They "encourage ACTT to come and they just	V 112		

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V 112	Continued From page 15 don't come." -"My responsibilities are to provide the service that I'm licensed for." -When Division of Health Service Regulation surveyor asked about implementation of treatment plan and ACTT services, Licensee #1 responded "How am I responsible for not implementing the treatment plan?" -"Let me just shut up, cause you've already decided what you're going to cite me with, it's just a waste of time." This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professional and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.	V 132	The facility will continue to report and document all incidents involving clients in accordance with the IRIS reporting guidelines. The House Manager will document all incidents on the facility incident reporting log and report all incidents to the QP. The QA Director will monitor all incidents to ensure compliance with this rule.	12/18/21

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V 132	Continued From page 16 c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) and failed to submit the results of all investigations within five working days of the initial notification to the Department. The findings are: Review on 10/25/21 and 11/4/21 of a North Carolina Incident Response Improvement System (IRIS) revealed: -No incident reports which pertained to the	V 132		

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V 132	Continued From page 17 allegations of abuse were submitted for facility between August 2021-October 2021. -No allegation of abuse against the house manager was submitted within 24 hours or a 5 day report to the HCPR as required. Interview on 10/28/21-11/5/21 Licensee #1 stated: -She completed a Level I incident report for client #4's attempted elopement on 10/4/21. -She became aware of the allegations of abuse that involved the house manager from the Department of Social Services worker who made a visit to facility on 10/7/21. -She spoke with client #4 and the house manager, and they both denied the allegation. -She unsubstantiated the allegation of abuse against the house manager. -She did not report the allegation of abuse to the HCPR because she unsubstantiated the allegation. No documentation was provided by Licensee #1 for the facility's internal investigation, related to the allegation of abuse by the house manager, as requested on 10/28/21 and 11/3/21. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professional and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days. 27G .5603 Supervised Living - Operations	V 132		
V 291	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	V 291		

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V 291	Continued From page 18 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, observation and interviews the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the clients treatment affecting 1 of 3 audited clients (#4). The findings are: Review on 10/28/21-11/4/21 of client #4's record revealed: -31 year old female.	V 291	The facility will continue to encourage clients to participate in authorized services and will continue to participate in coordination of services to ensure clients receive appropriate care to meet their treatment goals.	12/18/21

PRINTED: 11/24/2021
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V 291	Continued From page 19 -Admitted on 8/13/21. -Diagnoses of Schizoaffective Disorder, Bipolar Type, Borderline Personality Disorder, Post Traumatic Stress Disorder, Depression, Mild Intellectual Disorder, Hypertension and Type 2 Diabetes. Review on 10/28/21 of client #4's treatment plan dated 8/24/21 revealed: -The plan was completed by the ACTT (Assertive Community Treatment Team) provider and the services were ordered by the physician. -The facility was identified and listed as one of the service providers who would be responsible for implementing the plan's strategies and goals. - The ACTT service was to be provided by ACTT daily or as needed. -"Step-down care coordinator: When [client #4] is deemed by the team, including psychiatrist, to be ready to be safely and effectively transitioned, the team will coordinate with [client #4's] guardian in a timely manner with the appropriate service providers to smoothly transition [client #4] to a lower level of care." -"Criteria for discharge: Clinician addressed possible criteria for discharge with [client #4], and will continue to address discharge throughout treatment. Once symptoms are ameliorated and discharge is imminent, appropriate referrals will be made." Review on 10/28/21 of a Clinical Assessment provided by Licensee #1 for client #4 dated 9/15/21 revealed: -The assessment was completed by a Community Support Team (CST) provider. -The CST provider is Licensee #1 and Licensee #2's daughter. -"Clinician Recommendations: Clinician recommends that [client #4] herein referred to as	V 291		

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V 291	Continued From page 20 a member participates in Community Support Team Services and Residential Placement as the member is in danger of homelessness due to the severity of mental health issues, and Medication Management to manage mental health symptoms. Member requires education and interventions to gain insight into symptoms, how to manage symptoms, aggressive behaviors, and unhealthy behaviors, gain an understanding of how medication management can alleviate the symptoms associated with mental health and behavioral health issues...Clinician recommends...behavioral management skills to support member with managing everyday issues/challenges associated with symptoms and reduce propensity for relapse, crisis, and hospitalizations..." -"Recommended Goals:...With support from CST services, [client #4] will learn coping skills and strategies to refrain from any type of verbal or physical/assaultive behaviors...[client #4] will increase her ability to live independently by learning effective ways to maintain a clean-living environment, perform personal hygiene/grooming, learn budgeting skills and manage her diabetes...[client #4] will maintain her residential placement by complying with the rules..." -No signed service order or recommendation by medical doctor. -The CST recommended goals were similar to the goals in ACTT treatment plan. -There was no documentation of consent for the assessment or input by the legal guardian. Review on 11/3/21 of Assertive Community Treatment Team (ACTT) service notes between 8/9/21 - 10/29/21 for client #4 revealed: -8/9/21 "[Care Coordinator (Local Management Entity/Manage Care Organization)]...inquired if TL	V 291		

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V 291	Continued From page 21 (Team Lead) would be able to go to the group home to complete screening. [Care Coordinator] reported the group home did not feel comfortable brining her to the office because she's a new client. The group home requested for the screening to be completed in the presence of group home staff. TL declined...Screening appointment is scheduled for Monday 8/16 at 10am." -8/10/21 "TL contacted client's guardian...about coordinating transportation. She reported that the group home did not want to transport client because of her history of aggression. TL reported she would visit client at the group home to complete screening. [Guardian] called back and reported the group manager requested for client to receive CST (Community Services Treatment) services instead. [Guardian] asked if TL could do a CCA (Comprehensive Clinical Assessment) for CST. She was informed that the group home owner also provides CST services would have to complete it." -8/10/21 "TL contacted [Care Coordinator]...She was informed that the guardian and group home decided to pursue CST services instead. [Care Coordinator] reported client is currently on an ACT team and continued services were recommended by the hospital and medical team...She reported she would contact the guardian and group home for clarity." -8/13/21 "[Care Coordinator]...contacted TL and reported that client will still receive services from ACT. The screening is stills scheduled for Monday 8/16." -8/16/21 "TL completed ACT screen. Client appears to be appropriate for services." -8/25/21 "Staff called...several times to get in contact with [Licensee #1] or group home staff. ACT RN (Registered Nurse) and Psychiatrist went out to the group home to see client, but was	V 291		

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V 291	Continued From page 22 met by a staff member outside who reported [client #4] was not there. The staff member, [House Manager (HM)], reported that the group home is under quarantine due to one resident being positive for Covid (Coronavirus Disease-19). She then stated [Client #4] was out with her one to one until the afternoon. She says [client #4] goes out wit her one to one Tues-Friday. Staff rescheduled for Monday..." -9/9/21 "Meeting with [Care Coordinator]... [Licensee #1] (group home QP), [Client #4's previous guardian] (guardian), ACT team members...Guardian is considering stepping down to CST per [Licensee #1] request. Client's new guardian will be...starting 9/14." -9/14/21 "Attempted: Staff called to see if client was going to be able to meet today left a message but got no return call. Staff stopped at the Group Home and let a card and some print outs..." -9/15/21 "Attempt. Staff spoke with [Licensee #1]...reported that client had an intake with CST today and then going out with her 1 to 1. [Licensee #1] asked that staff not come due to there "being so many of y'all" and confusion regarding services." -9/16/21 "Attempts 2x, client phone is off; no answer, client was not at group home. Staff spoke with [Licensee #1] regarding client, she reported was out for her 1 on 1 for they day and she would take ACT team staff's phone number for a call back. [Licensee #1] reported she did not want client speaking with too many of ACT team staff members. Phone call was not returned from group home staff." -9/21/21 "Attempted: Staff called to see if client would be home to meet today but no one picked up the phone." -9/23/21 "Staff attempted group home 2x, client was not at group home. Staff spoke with	V 291		

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V 291	Continued From page 23 [Licensee #1] and she reported client was out with staff for her 1on1; safety and supervision. Staff left contact information for client to call back." -9/28/21 "Attempt. Spoke with [Licensee #1] group home owner, who stated that she has already administered client's injection today and that client's guardian has opted to go with CST services. She declined for ACT RN to see client." -9/28/21 "TL was informed by ACT RN that [Licensee #1] at the group home reported that client was not receiving CST services...[Care Coordinator]...reported there was not an authorization for CST services. TL contacted [CST therapist] reported that client was not approved for CST. She reported they were waiting on signed consent forms from her guardian...contact ACT staff when client is approved so that she can be discharged." -9/30/21 "Staff attempted 2x, client not at group home, no answer, from group home staff." -10/6/21 "Attempt. Group home worker informed staff that client was out for the day with her 1 on 1. Staff called group home owner, [Licensee #1], multiple times no answer." -10/7/21 "Staff attempted group home, staff spoke with group home staff [Licensee #1]; she reported client was out doing 1on 1 and would be out all day. Group home staff reported she would tell client to callback." -10/8/21 "Attempt. Staff spoke with [Licensee #1] who stated that client was at a doctor's appointment and then will be out with her 1 on 1. [Licensee #1] asked staff's role again and informed staff that client has a psychiatrist and therapist and she cannot have ACT services on top of that. [Licensee #1] took staff's number down and stated she would call staff after speaking with client's guardian regarding 'miscommunication.' "	V 291		

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V 291	Continued From page 24 -10/12/21 "Act Staff called Group Home to see if client was going to be there for a visit. Group Home staff stated they were out on a outing and then informed Act Staff that [ACT Provider] was not her service and could not see client." -10/12/21 "TL contacted client's guardian...for an update on client's service decision (ACTT or CST). TL informed [Client #4's guardian] that ACT staff was not allowed a visit today...[client #4's guardian] reported client was not receiving CST services...also reported she informed [Licensee #1] (group home owner) that she could not refuse a visit from ACT staff...reported she would like to follow the recommendations of medical staff...recommended client for ACT services." - 10/13/21 "Attempt. Group home worker stated client was out with her 1 on 1. She also stated that client receiving CST services but would not provide the name of the company. Staff called [Licensee #1], no answer." -10/14/21 "[Licensee #1] called and reported that she talked to client's guardian and she said she would sign the consents for CST services...She also reported client has been receiving CST pro bono..." -10/14/21 "Staff attempted client at group home. Group home staff would not let ACT team staff meet with [client #4]...[Licensee #1] report she would get the paperwork forwarded to the guardian so [client #4] can be discharged from ACT services." -10/19/21 "Staff called the group home owners number and was told the client was working with her one on one worker and could not meet with Act staff." -10/20/21 "Attempt. No answer from group home worker or group home owner." -10/21/21 "Staff met with Guardian, owner of Group Home and Act Staff...it was decided that the client best interest that she should be seen by	V 291		

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V 291	Continued From page 25 the Act Team Setting up schedule for the staff and group home so that we can meet with client." -10/26/21 "Attempted;...Act Team nurse and CPSS (Community Peer Support Specialist) went out to see client at the group home...It was reported to the CPSS that client did not want to see her. Staff delivered 2 month calendars for the visits that the Act Team will be making." -10/27/21 "Attempted. [Licensee #1] stated that client was out with her 1 on 1 until after 5pm today." -10/28/21 "Staff attempted client at group home. Staff spoke with [Licensee #1] about visiting [client #4]...[Licensee #1] reported [client #4] no longer wants to meet with any ACT team staff. Staff was not able to physically see [client #4] or get a direct answer from [client #4]." Observations of visitors at the facility between 10/28/21-11/5/21 revealed: -On 10/28/21 at approximately 10:30am, Division of Health Service Regulation (DHSR) surveyor requested client #4's information not be discussed while other clients are present. Licensee #1 responded what she was saying was not anything the clients had not heard or seen then requested client to go to the back of the facility. Client #5 verbally expressed disgruntlement at request and Licensee #1 responded "I Know." An ACTT member arrived at the home during the morning hours and requested to visit client #4. Licensee #1 informed ACTT member client #4 was not present and stepped onto the porch to speak with her. The ACTT member returned later that afternoon while client #4 was present. Licensee #1 informed ACTT member client #4 did not want to speak with her. At no time did DHSR surveyors observe Licensee #1 attempt to inform client #4 that ACTT was present.	V 291		

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	MHL040-055	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS GROUP HOME #6	710 WEST HARPER STREET SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 26 -On 11/5/21 at approximately 10:30am, DHSR surveyors arrived at the facility. Clients #3, #4 and #5, Licensee #1, House Manager and staff #7 were in the living room area "prepared for survey exit" as stated by Licensee #1. Approximately 5 minutes later, an ACTT member arrived at the facility. Licensee #1 informed ACTT member client #4 did not want to see her. The ACTT member requested client #4 be allowed to inform her of refusing ACTT services. Licensee #1 turned to client #4 with all staff, clients and DHSR surveyors present and client #4 stated she did not want to talk. Licensee #1 walked the ACTT member to the porch and continued to speak with her and client #4 remained in the facility. Client #4 also went onto the porch a short time later with Licensee #1 and ACTT member. Licensee #1 returned into the facility. DHSR surveyors requested to interview Licensee #1 without clients present. Licensee #1 requested staff and clients leave the area. Client #5 left the living area and could be heard saying "I'm tired of these b*****s" she was not redirected by Licensee #1 or House Manager. At approximately 11am client #4's guardian arrived at facility. Licensee #1 informed guardian client #4 was not present and spoke with guardian on the porch. Guardian was allowed to view client #4's bedroom and guardian and Licensee #1 returned to the porch. Interview on 10/28/21 client #4 stated: -She wanted her guardian and Licensee #1 to be present for interview. -She resided at the facility for 2 almost 3 months. -She had one to one services with staff #7 and staff #8. -She received ACTT services and CST services. -She told ACTT she did not "want to be with them." -She wanted to work with CST therapist.	V 291		

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V 291	Continued From page 27 -The CST therapist was her therapist and she liked her. -She had received ACTT services from another ACTT provider in the past and liked it. -She had not expressed concerns to her guardian about the ACTT or informed guardian she did not want ACTT services. Attempted interview on 11/3/21-11/5/21 staff #7 stated: -No returned phone call to DHSR surveyors on 11/3/21. -She declined to be interviewed on 11/5/21. -She just started working on 10/11/21 with client #4. Interview on 10/27/21-11/3/21 client #4's guardian stated: -Her agency had been client #4's guardian since 10/7/20. -She was assigned as the guardian representative on 9/13/21. -Client #4 was placed at the facility after hospitalization. -Client #4 was authorized to receive ACTT services. -The ACTT provider notified her about unsuccessful attempts to provide services to client #4. -Licensee #1 requested CST services and requested she (guardian) sign consent for CST services. -Licensee #1 was informed by her as the guardian the facility could not prevent the ACTT provider from providing services. -She held a meeting on 10/21/21 with the ACTT provider and Licensee #1 to discuss and decide which service, ACTT or CST, was appropriate for client #4. -Prior to the meeting, she requested	V 291		

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V 291	Continued From page 28 documentation of current or recommended services from the ACTT provider and Licensee #1 for client #4. -The ACTT provider provided documentation prior to the meeting. -Licensee #1 did not provide any documentation but alleged a CCA was completed. -She requested but was not provided a copy of the CCA from Licensee #1. -Licensee #1 informed her she would not provide her anything until she signed the consents for CST services. -The CST provider was Licensee #1's daughter. -The ACTT provider provided the ACTT authorization for services and an order for ACTT services from a clinician. -After the meeting, it was decided ACTT services would continue for at least 6 months and they would revisit CST services at that time. -The ACTT provider agreed to provide a calendar with scheduled dates for services to Licensee #1 and guardian. -The care coordinator discharged client #4 from care coordination services on 10/20/21 due to client #4 deemed stable. Interview on 11/2/21 the Care Coordinator stated: -She was unsure about what she could discuss with DHSR Surveyor. -She would speak with the Care Coordinator Supervisor to see what she could discuss. -She would return call no later than close of business. Interview on 11/3/21 the Care Coordinator Supervisor stated: -The Care Coordinator informed him of contact with DHSR Surveyor. -He reached out to his direct supervisor as he was not familiar with DHSR.	V 291		

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V 291	Continued From page 29 -He would contact DHSR surveyor after he received clarification from his direct supervision on who could speak with DHSR. Interview on 11/3/21-11/4/21 the ACTT provider team leader stated: -The ACTT provides intensive community based services. -To be eligible for ACTT services an assessment process based on the state service definition must be completed, diagnoses, hospitalizations, guardians and had a pattern of crisis situations. -The ACTT is composed of a peer specialist, mental health specialist, housing specialist, employment specialist, nurse and psychiatrist to meet individual client needs. -The ACTT provider received a referral from the hospital and care coordinator for client #4. -She developed the treatment plan and the group home emailed goals to include in the treatment plan for client #4. -She had concerns the facility would not allow ACTT to meet with client #4. -Licensee #1 told ACTT client #4 received CST services but she confirmed client #4 had not been authorized for CST. -A few times the client #4 was present at the facility and Licensee #1 would not allow the ACTT to visit client #4 and refused the ACTT service. -At other times ACTT was told client #4 was out with her one to one paraprofessional. -The ACTT visits began with 3 visits a week and current visits were twice a week. -The ACTT had not been told by client #4 she did not want ACTT services. Interview on 10/28/21-11/5/21 Licensee #1 stated: -She spoke with the clients and staff prior to DHSR surveyors arrival. -She informed clients and staff what DHSR	V 291		

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V 291	Continued From page 30 surveyors job was and they would be interviewed. -All staff and clients declined to be interviewed by DHSR surveyors. -Client #4 received one to one safety and supervision services. -Safety and supervision services were provided by a paraprofessional employed by Licensee #1. -The safety and supervision paraprofessional was not a facility/residential staff. -Staff #7 and staff #8 provided one to one safety and supervision services for client #4. -Safety and supervision was provided to client #4 for 8 hours a day for 7 days a week. -She "negotiated" with the treatment team at hospital and the guardian to wait to try ACTT services once released from hospital, if ACTT not appropriate client #4 be stepped down to CST. -She had talked to the prior guardian representative about the benefit of CST services. -The prior guardian representative requested she do a referral for CST services. -The ACTT therapist only spoke with client #4 once for about "10 minutes." -The ACTT staff would not schedule visits to see client #4, would "just show up", or call the day of to schedule visit. -The ACTT peer support specialist said "they don't take clients out since the pandemic" and they had "heavy caseloads" so would only talk to client about "10 minutes." -The psychiatrist visited on 8/30/21 and did not want to talk to client #4 and client #4 was upset. -She had a meeting with client #4's guardian and ACTT provider that "didn't go well" and they agreed to ACTT services and ACTT services would be provided for 1 year. -The ACTT services did not work for client #4 and client #4 had only seen the doctor and therapist once and only for 10 minutes. -Her evidence for ACTT services not working for	V 291		

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V 291	Continued From page 31 client #4 were 10 minute visits or unannounced visits observed by her and her house manager. -The peer support specialist "told a lie" on client #4. -She had never said client #4 was approved for CST services. When asked if she had documentation of her coordination with the ACTT services, Licensee #1 had not provided any documentation of coordination at exit on 11/5/21. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professional and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 291		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;	V 366	The facility will continue to report and document all incidents involving clients in accordance with the IRIS reporting guidelines. The House Manager will document all incidents on the facility incident reporting log and report all incidents to the QP. The QA Director will monitor all incidents to ensure compliance with this rule.	12/18/21

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V 366	Continued From page 32 (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;	V 366		

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V 366	Continued From page 33 (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 34 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing their response to level II incidents for allegations of abuse. The findings are: Review between 10/28/21-11/4/21 of client #4's record revealed: -31 year old female. -Admitted on 8/13/21. -Diagnoses of Schizoaffective Disorder, Bipolar Type, Borderline Personality Disorder, Post Traumatic Stress Disorder, Depression, Mild Intellectual Disorder, Hypertension and Type 2 Diabetes. Review on 10/28/21 of the facility's incident reports from August 2021 to October 28, 2021 revealed: -A Level I incident report dated 10/4/21 for client #4 " [Client #4] opened her bedroom window and tried to go out the window. Staff rushed into her room and stopped her. She sat on the floor and staff stayed with her until she was calm." Interview on 10/28/21 client #4 stated: -She did try to elope but she is "unsure why" she just "think crazy sometimes." -She tried to go outside through her bedroom window. -"It was daytime and was coming back because she has no where to go." Interview on 10/28/21-11/5/21 the House Manager stated: -The Department of Social Services (DSS) informed her of the the allegation of abuse	V 366		

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V 366	Continued From page 35 against her during a visit on 10/7/21. -She contacted Licensee #1 who participated by phone during the DSS visit on 10/7/21. Interview on 10/28/21-11/5/21 Licensee #1 stated: -The facility had 1 incident report between August 2021 - October 28, 2021. -The incident report was a level I report. -There were no internal investigations for the facility between August 2021 - October 28, 2021. -She learned of the allegation of abuse by house manager from DSS on 10/7/21. -She did not complete an IRIS (North Carolina Incident Response Improvement System) report because she unsubstantiated the allegation of abuse when she did her investigation. -Client #4 denied trying to elope and stated she (client #4) "wanted attention." -Her internal investigation was not at the facility for the allegation of abuse by the House Manager for client #4. -No internal investigation was provided as requested on 10/28/21 or prior to the survey exit on 11/5/21. No additional information or documentation was provided in relation to incident reporting at exit on 11/5/21. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professional and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.. 27G .0604 Incident Reporting Requirements	V 366		
V 367	10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367		

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V 367	Continued From page 36 CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:	V 367	The facility will continue to report and document all incidents involving clients in accordance with the IRIS reporting guidelines. The House Manager will document all incidents on the facility incident reporting log and report all incidents to the QP. The QA Director will monitor all incidents to ensure compliance with this rule.	12/18/21

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V 367	Continued From page 37 (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 38 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report incidents to the Local Management Entity as required. The findings are: Review on 10/25/21 and 11/4/21 of a North Carolina Incident Response Improvement System (IRIS) revealed: -No incident reports were submitted for facility between August 2021-October 2021. Interview between 10/28/21-11/5/21 Licensee #1 stated: -She learned of the allegation of abuse against the House Manager from Department of Social Services on 10/7/21. -She did not complete an IRIS report because the allegation was unsubstantiated when she did her investigation. No additional information or documentation was provided in relation to incident reporting at exit on 11/5/21. This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professional and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days. 27F .0102 Client Rights - Living Environment	V 367		
V 539		V 539		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040-055	A. BUILDING: _____ B. WING _____	11/05/2021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 539	Continued From page 39 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by: Based on record review, observation and interviews, the facility failed to provide accessible areas for personal privacy, affecting one of three audited clients (#4). The findings are: Review on 10/28/21 of client #4's record revealed: -31 year old female. -Admission date 8/13/21. -Diagnoses included Schizoaffective Disorder Bipolar Type, Borderline Personality Disorder, Post Traumatic Stress Disorder, Depression, Mild Intellectual Developmental Disability, Hypertension and Type 2 Diabetes. Interview and observation on 10/28/21 during an onsite visit revealed: -During a tour of the facility between 10:30am	V 539	The facility will continue to ensure that clients have personal privacy. The House Manager will monitor daily to ensure compliance with this rule.	12/18/21

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDS GROUP HOME #6	710 WEST HARPER STREET SNOW HILL, NC 28580

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V 539	Continued From page 40 -11:15am revealed a surveillance camera on the ceiling, in the open hallway area with the camera pointed towards client #4's bedroom. DHSR surveyor had shown Licensee #1 the view of the camera was in the direction of client #4's bedroom however Licensee #1 did not verbally acknowledge the view of the camera when shown by DHSR surveyor. -Between 4:00pm - 6:00pm Licensee #1 stated the cameras were "back online" and partially showed her phone to DHSR surveyor. DHSR surveyor only viewed the camera of the living area where DHSR surveyors were working on Licensee #1's cell phone. DHSR surveyor had not seen the camera view of the camera that pointed towards client #4's bedroom and the clients bathroom. Licensee #1 denied the camera had shown any bedroom or bathroom. Interview on 10/28/21-11/5/21 the House Manager stated: -The security company was at the facility the prior day on 11/4/21. -The camera had shown the top of client #4's bedroom door. Interview on 10/28/21 - 11/5/21 Licensee #1 stated: -The cameras had been installed in May 2021. -The camera pointing towards client #4's bedroom had not worked since May 2021 when it was installed. -The camera did not show any client bedroom or client bathroom. -The live views of facility cameras were not available for surveyor to view because the cameras were "off-line." -She was the only person with access to the security camera surveillance. -Licensee #2 would only have access to the	V 539		

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V 539	Continued From page 41 security camera surveillance, if requested.	V 539		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations of the facility on 10/28/21 between 10:30am and 11:15am revealed: -3 light ceiling fan in living room had 2 lights that were not working. -2 white plastered areas on the wall under the light fixture. -Client #2 and #3's bedroom wall had a 2 feet by 2 feet unpainted area near bedroom door entrance. -Client #2 and #3 had an older model TV sitting on the floor below the window between the client beds. -Client #2's 5 drawer dresser had a missing knob on the 2nd drawer, the 3rd and 4th drawers had missing bottoms and the 5th drawer was off track. -The floor under client #2's footboard of her bed had missing tiles and visible soft, rotten and decaying wood. -Client #3's dresser had 3 missing knobs and the	V 736	The House Manager will ensure that the facility is maintained in a safe, clean, attractive and orderly manner. Anything in need of repair will be documented on the repair log and reported to the facility Maintenance Technician. The Maintenance Technician will complete the repairs in a timely manner. The AP will check the facility weekly to ensure compliance with this rule.	12/18/21

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V 736	Continued From page 42 3rd drawer had 1 missing knob. -The hall bathroom had a rusty light fixture and paint was peeling around the door knob. -Client #5's bedroom had an approximate 12 inch white plastered area on the blue painted wall, the vent in the floor had an approximate 2 inch hole at the end of it and multiple floor tiles separated. -Client #5's bedroom entrance had a 2 inch by 1 foot missing laminate flooring. -Client #5's had a 12 by 12 inch unpainted repair patch near light switch at the entrance. -Client #4 had a 5 drawer chest with the 4th drawer off track and the 5th drawer had a missing handle, the 2 drawer night stand had 2 missing knobs. -An approximate 6 inch white plastered area on yellow painted wall at the entrance of the kitchen, floor tiles separating in multiple areas. -The yellow painted walls in the hallway had several white plastered area. -The microwave had food splatter in the top of the microwave, the linoleum buckling in several areas and was uneven. -The wall behind the trash can had various food stains and brown residue build up. -Client #1's 4 drawer chest had a missing knob. -Bathroom at back of facility had heavy dust on the ceiling vent, the tank cover on the back of the toilet was smeared with a black residue and the bathtub was dirty stains. -Floors had small miscellaneous dirt and debris of throughout the facility. -The baseboards had heavy dust and various color spots throughout the facility. Interview on 10/28/21 the facility repairman stated: -The wood under client #2's bed was "rotten and needed to be replaced."	V 736		

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V 736	Continued From page 43 Interview on 10/28/21 Licensee #1 stated: -She had not known what was wrong with the wood under client #2's bed. -The House Manager had been responsible for notifying the facility repairman of repairs needed at the facility. -The facility repairman would complete the repairs once notified. -The plastered area on the wall of client #2 and #3's bedroom had been caused by client #2 during a behavior. -The facility would be getting new flooring installed.	V 736		
V9999	Final Observations Based upon observation and interviews the facility failed to comply with General Statue (G.S.) 122C-25, by not allowing access to the licensed facility by Division of Health Services Regulation (DHSR) surveyors upon arrival at the facility for an annual and complaint survey. The findings are: G.S. 122C-25(a) "The Secretary shall make or cause to be made inspections that the Secretary considers necessary. Facilities licensed under this article shall be subject to inspection at all times by the Secretary." Interview and observation on 10/27/21 between 9:40am-1:30pm DHSR surveyors were unable to gain access during onsite survey attempts were as follows: -9:40am: DHSR surveyors did not receive a response when attempting to gain entry into the facility. Observation by DHSR surveyors revealed no vehicles at the facility.	V9999	The facility will allow surveyors access to the facility at all times.	12/18/21

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V9999	Continued From page 44 -9:43am: Telephone call to Licensee #1 resulted in a message left with an office staff to inform of onsite survey. -9:45am: A return call from Licensee #1 stated she was not available for an onsite visit until after 4:30pm because she was caring for her granddaughter. Licensee #1 stated she had called her backup who could not be available until 4:30pm and she was unable to contact facility staff. Licensee #2 was in quarantine however he was the usual backup. The office staff was given the day off. She could send client files for DHSR surveyors review. DHSR surveyors informed her of a possible deficiency related to delegation of management authority if no one was available to allow entrance into the facility to begin the survey process. -10:38am: Telephone call to Licensee #1 stated she was not able to contact any facility staff by phone. DHSR surveyors informed her it was urgent that she return the DHSR surveyors call. -10:54am: A return call received from Licensee #1 and she stated only the facility's house manager had a key to the facility but the house manager had not responded to the attempts to reach her by phone. DHSR surveyors informed her of a possible Civil Penalty potentially imposed if no one was available to allow DHSR surveyors entry into the facility for the survey process. Licensee #1 stated she called someone who will be able to bring client records but will not be available to stay at the facility. DHSR surveyors asked which files were being sent as no clients or staff had been identified and no client/staff census had been completed. DHSR surveyors informed her access to the facility was needed no later than 12pm. -11:15am: DHSR surveyors emailed client and staff census form to Licensee #1. -11:45am: Licensee #1 returned client and staff	V9999		

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V9999	Continued From page 45 census form by secure email. -11:55am: A telephone call to Licensee #1 to provide identified clients. Licensee #1 responded she already knew DHSR surveyors would request client #4's record so she had it ready. Licensee #1 stated she would send information via staff #A6. DHSR surveyors informed her of the continued need to gain access to the facility. - 12:45pm: Staff #A6 arrived at the facility in a van. A male exited the van and walked to the side of the facility and returned with a TV and placed in the van. Staff #A6 provided an envelope to DHSR surveyors while on the phone. Staff #A6 stated she was unsure of what was in the envelope. Staff #A6 stated she worked at another facility and Licensee #1 could provide the information to DHSR surveyors. Staff #A6 stated she did not have access to the facility or any additional information to provide to DHSR surveyors. Staff #A6 left the facility. DHSR surveyors reviewed the information in the envelope. The information appeared to be copies, dark and difficult to read. The copies were incomplete for three client records, a total of 49 pages, prior year (2020) treatment plan for client #4 and incomplete treatment plans for client #2 (5 pages) and client #3 (4 pages). -1:05pm - A telephone call to Licensee #1 who stated no staff responded to her calls. She planned to come to the facility as soon as a relief babysitter was available. She did not have a time a relief babysitter would be available. She also really needed to take the child to the pediatrician because she was having seizures. Licensee #1 stated the clients who attended the day treatment program would return at 4pm. When asked if anyone would be available, Licensee #1 responded the house manager was responsible and would be available. When asked for a solution to begin survey, Licensee #1 stated	V9999		

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V9999	Continued From page 46 DHSR surveyors could review information provided by staff #A6 and she could have everyone available when DHSR surveyors returned. Licensee #1 stated no one would be be available until at least 4pm or 4:30pm. -No staff or QP was available to allow entry and access to the facility for the survey on 10/27/21.	V9999		