STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 000	INITIAL COMMENTS A complaint, annual and follow up survey was completed on 5/2/22. The Complaints were substantiated (Intake # NC 00186615 and 00187988). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities This facility is licensed for six and currently has a census of six. The survey sample consisted of audits of four current clients. The survey was orginally closed on 4/6/22 but was reopened on 4/20/22 due to an additional complaint.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness;	V 110		

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V 110	Continued From page 1 (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 record review and interview the facility failed to ensure one of three (#1) audited staff demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 3/30/22 of staff #1's personnel record revealed: -Date of hire: 6/10/19 -Paraprofessional staff, worked on Sundays. Review on 4/4/22 of an Incident Report dated 4/1/22 regarding client #1 revealed: "On 3/30/22 an employee from the state came to our facility in regards to a complaint filed by a members father and to begin an annual review. The complaint was in regards to member [client #1] informing his father that he was left unattended on a weekend outing in January. On 2/18/22, Director of Operations received a call from members father stating that [client #1] had told him that staff refused to allow him to go to the store and that he left him in the car unattended.	V 110		

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V 110	Continued From page 2 After receiving the call [the Director of Operations] called staff [staff #1] in for an interview. During the interview [the Director of Operations] requested that staff tell her what happened on an outing when he had refused to take [client #1] to the store. [Staff #1] reported to [the Director of Operations] that the only incident that he remembered was when [client #1] had gotten sick on an outing in which they were going to pick up lunch. Staff provided an oral and written statement to what happened during that outing. In staff's written report, he stated that on an outing to get lunch, [client #1] had informed him that he wasn't feeling well. Staff informed [client #1] that once they picked up lunch, that he would return them to the group home. [Client #1] asked staff if he could go to the store. Staff explained to [client #1] why he thought it was best for them to return to the home. [Client #1] asked staff to allow him to get out of van. Once he was out of the vehicle, [client #1] began to vomit. When he finished staff made sure he was ok and transported him back to group home. On the way back [client #1] again requested to stop at the store and again staff explained to him why he thought it was best that they returned to group home. [The Director of Operations] also interviewed [client #1] in regards to this day. At the time of the internal investigation, [client #1] reported to [the Director of Operations] that he told his dad that because he was upset that staff didn't allow him to go to the store. No other interviews were completed due to [client #1] stating that what he told his father wasn't true. [Client #1] understood he was wrong for telling his dad this and stated that he was sorry." Review on 3/30/22 of client #1's record revealed: -Date of Admission-11/19/19 -Diagnoses of Autism, Attention	V 110		

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V 110	Continued From page 3	V 110		

Deficit/Hyperactivity Disorder (ADHD), Impulse Control and Intermittent Explosive Disorder.
-Treatment Plan dated 12/1/21-"Required supervision when out in the community for safety and he is at risk of exploitation...history of self injurious behaviors..."

Review on 3/30/22 of client #2's record revealed:
-Date of Admission- 10/15/17
-Diagnoses of Autism, Bipolar Disorder, Anxiety Disorder, Moderate Intellectual Developmental Disability (IDD), Epilepsy

Review on 3/30/22 of client #3's record revealed:
-Date of Admission- September 2017
-Diagnoses of Mild IDD, Bipolar Disorder and Epilepsy

Interview on 3/30/22 client #1 stated:
-A few weeks ago, he went to a mall in neighboring town with staff #1 and some other clients.
-Had been sick on his stomach the night before that outing.
-While on the outing, threw up in the mall parking lot.
-Staff #1 was with him when he threw up and helped him.
-Got back into the van and felt better, "but not completely healthy."
-Then staff #1 and client #2 went into the mall.
-Staff #1 did not tell them anything before he and client #2 went into the mall.
-Staff #1 and client #2 were in the mall "30-60" minutes.
-He and other clients stayed in the van alone.
-No one got out of the van during that time.
-After staff #1 and client #2 came back, they went through a drive thru for pizza.
-They returned home and he was instructed to go

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V 110	Continued From page 4	V 110		

to his room so he would not get others sick.
-This had never happened before.
-Only talked to his mom and dad about the situation.
-No one from the home ever talked to him about what happened when they went to the mall.

Interview on 3/30/22 client #2 stated:
-On the weekends they occasionally go out to eat and to the mall.
-Liked to go in and shop in the stores.
-Was on an outing when client #1 got sick in a parking lot and he threw up.
-Staff #1 was with client #1 when he was throwing up.
-Could not remember who was all in the van that day.
-Had not been left in the van alone while on an outing.

Interview on 3/30/22 client #3 stated:
-On the weekends staff #1 would take them out to get pizza and to the store.
-On one outing client #1 got sick and threw up.
-They had gone to the mall with staff #1 and client #1 threw up in the parking lot.
-While at the mall, staff #1 went in the mall and he took client #2 with him.
-Stayed in the van with other clients.
-Could not remember how long he was in the van alone while staff #1 went into the mall.
-Staff #1 let client #2 go in with him because he said there were "too many clients" to take inside.
-Staff #1 went in to get some "Jordans (shoes)."
-Had never been left in the van alone before.

Interview on 3/31/22 client #1's mother/legal guardian stated:
-Was informed by her ex husband regarding the incident with client #1 being left on the van.

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V 110	Continued From page 5 -Client #1 told her he was left alone on the van a few weeks ago. -Client #1 told her they were at the mall when he was left alone on the van. -Client knows the difference between a mall and a store, he can be very specific about details. -He stated he had got sick when they got to the mall and he threw up -Client #1 assumed he could not go into the mall because he had been sick -Client #1 told her he was unsupervised in the van "a while." -Client #1 needed to be supervised 24 hours because he would likely get out of the van "and we would never see him again." -Client #1 could hurt other people or himself due to his self injurious behaviors and his history of assault on others. -Client #1 could make up stories when he did not get his way, but he also told the truth about situations. -Client #1 had been consistent with his story of this and felt he was truthful. -Contacted the Director of Operations who said she interviewed everyone and this incident did not happen. -Staff would be "stupid" to have left client #1 alone on the van as he would definitely tell someone. Interview on 4/6/22 client #1's father stated: -Spoke with his son every Sunday -On 1/30/22 he did not speak to client #1 as usual. -On 1/31/22 he spoke with client #1 and he was telling him about getting sick the day before on the van. -Client #1 was telling him how he threw up in a parking lot while on an outing. -Asked client #1 more about him being sick and	V 110		

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V 110	Continued From page 6 what happened when client #1 mentioned after he got sick that staff #1 went into the mall leaving him and other clients in the van. -Client #1 did not seem to think being left on the van was wrong as he continued to question him about it. -Client #1 then stated they went to get pizza and then home. -Was very upset that client #1 was left unsupervised for any amount of time. -Client #1 required 24 hour supervision for safety reasons. -This was the first time client #1 had said anything about being left alone in the van and felt he was very truthful about the incident. -Had contacted his ex wife who is client #1's legal guardian to inform her to address this with the facility. -After a few weeks client #1 stated no one had discussed this with him, so he contacted the Director of Operations to address it. -The Director of Operations stated, "Do you really think this is true?" -The Director of Operations stated she went out and spoke to everyone and found it was not true. -The Director of Operations told him client #1 was making the allegation because he wanted to go to the store that day and was not allowed to due to being sick. -Did not feel management took the incident serious and she told him she found they did not even go on an outing that day. -Client #1 did fabricate stories when he did not get his way. -When client #1 informed him of the incident the following day, he was not trying to get anyone in trouble as he did not realize it was wrong. -Client #1 continued to be consistent with his story over the last few weeks and it has not changed.	V 110		

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V 110	Continued From page 7 Interview on 4/4/22 staff #2 stated: -Worked on the weekends with staff #1. -Staff #1 would take some clients out in the community to the stores and out to eat while she would stay home with the other clients. -Not all clients would go out, "depends on who wants to go." -Client, #1, #2, and #3 usually went with staff #1. -Not sure which store they went to, because she did not go. -Had not heard of any of the clients being left unsupervised in the van. -Worked daily with client #1 during the week as his one on one worker. -Client #1 did have a history of fabricating stories, but he will eventually change it and tell you he was lying. -Client #1 won't stick with a story long if its untrue. -The clients should never be left unsupervised in the van. Interview on 4/5/22 staff #1 stated: -Been working at the facility for four to five years. -Worked on Sundays. -On 1/23/22 was working and took client #1, #2, and #3 out to get some lunch. -While driving to the fast food place, client #1 stated he was not feeling well. -Was going to a drive thru and client #1 stated he needed to "vomit." -Pulled into the parking lot and got out with client #1 for him to "vomit." -Afterwards client #1 stated he was good and got back in the van. -They continued in line to get their food and return to the facility. -Client #1 kept asking to go to the store and he told him they could not because he was sick. -Did not take the clients to the store when he	V 110		

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V 110	Continued From page 8 worked with them. -If he went to the store, would only take one client with him as it would be "too much hastle or confusion." -Would only take client #2 to store with him one on one. -Had never taken the clients to the mall, not sure why anyone would say that. -If client #1 and client #3 did not get their way they "would lie." -Been working with these clients for years and they have never said anything like this. -Client #1 and #3 were roommates and may have got together to make the story up about being left in the van alone. -Would never leave the clients in the van unsupervised. Interview on 3/30/22 the Director of Operations stated: -Was informed a few weeks ago by client #1's father of an incident where client #1 stated he was left unsupervised on the van. -She immediately called the Director and began her investigation by speaking to staff #1 and client #1. -Staff #1 denied he had taken clients to the mall or left them unsupervised at any time. -Client #1 had a history of "playing people against each other." -Client #1 would tell his dad stuff and his dad would always believe him. -Client #1's mother would "shut it down" because she knew he lied. -Her investigation revealed that staff #1 had taken the clients on an outing to get lunch and client #1 had expressed he was sick, but he wanted to go to the store. -Once client #1 got sick, staff #1 took him back home and he became upset.	V 110		

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-Client #1 told her he lied on staff #1 because he was upset.
-Did not interview anyone else regarding the incident.

Interview on 3/30/22 the Director stated:
-Did not believe that staff #1 would take the clients to the mall and leave them unsupervised.
-The Director of Operations did an internal investigation and found the allegation to be untrue.
-Spoke with staff #1 and he stated he had only taken the clients to a shopping center in town.
-Client #1 threw up so they had to return to the facility.
-Client #1 was upset because he was not allowed to go to the store.
-She had known that staff #1 only took clients to the shopping center in town, not the mall.
-Client #1 had a history of telling his dad stories when he did not get his way.

Review on 4/6/22 of Plan of the Protection completed by the Director on 4/6/22 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? Advantage Care will train all staff on Neglect, Abuse, Safety and Supervision. We will report all allegations to DSS (Department of Social Services) and complete IRIS (Incident Response Improvement System) and Health Care Registry report in time fashion (48-72 hrs).
-Describe your plans to make sure the above happens.
We will have documentation to show that each staff was trained on the above neglect, abuse, safety and supervision of clients We also will establish a consumer/client outing form requiring all outings to be approved by group home managers. The form will have consumers on

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V 110	Continued From page 10 outing, time leave and return and summary of outing." Clients diagnosed with Autism, Impulse Control, Intermittent Explosive Disorder, Mild IDD, Bipolar Disorder and Epilepsy were on an outing with staff #1 when they were left unsupervised in the van at the mall for a period of time. Client #1 required supervision when out in the community for safety and he is at risk of exploitation. Client #1 had been sick on the ride to the mall and threw up in the parking lot. Staff #1 then took client #2 into the mall while leaving client #1 and #3 in the van unsupervised. Client #1's story was consistent and never changed. Client #3 also confirmed being left in the van unsupervised. The Director of Operations and the Director both stated that staff #1 did take clients to a local store on the weekends. Staff #1 leaving client #1 and client #2 unsupervised constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 110		
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	V 132		

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V 132	Continued From page 11 facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview the facility failed to make every effort to protect clients from	V 132		

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neglect while the investigation of abuse was in progress for one of three audited staff (#1). The findings are:

Review on 3/30/22 of staff #1's personnel record revealed:
-Date of hire: 6/10/19
-Paraprofessional staff, worked on Sundays.

Refer to V110 for information regarding incident of 1/30/22 with client #1 and staff #1.

Review on 3/30/22 of Internal Investigation dated 2/18/22 completed by the Director of Operations revealed:
-"Complaint/Issue/Concern: He (client #1's dad) called stating that [client #1] was upset because [staff #1] would not stop at the store. He [client #1] stated to his father that [staff #1] left him on the van."
-Finding From Investigations: On February 18th 2022, I received a phone call from [client #1's] father. Stating he had a conversation with [client #1] and he was upset about not being able to stop at the store on an outing. H stated that staff [staff #1] wouldn't let him go to the store. After speaking with [staff #1] and the staff. My finds were that clients were out to get lunch. [Client #1] stated to staff that he was feeling sick. After which staff had to stop the van to let [client #1] out, he vomited outside of the van. At that time staff headed back to the group home. [Client #1] then became upset with the staff because he wouldn't stop at the store. Staff [staff #1] stated to [client #1] the reason why they were headed back to the gh (group home) because he wasn't feeling well there were going to head back to the group home. [Client #1] stated that he told his dad that he was left on the van and not allowed to go in the store. Because he was upset with staff

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	MHL039-039	A. BUILDING: _____ B. WING _____	R 05/02/2022

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V 132	Continued From page 13 for not stopping at the store. He understood what he did wasn't right and was sorry for that. -Resolution: After reviewing the full history of the day and speaking with all parties on the outing it was determined that because the individual didn't get what he wanted to go into the store because he was sick they all returned to home, [client #1] complaint was unsubstantiated." During interview on 3/30/22 the Director of Operations stated: -She had received a complaint from client #1's dad regarding the outing where client #1 alleged he was left in the van unsupervised. -Immediately went to the facility to complete an investigation. -Only interviewed staff #1 and client #1. -Staff #1 was still allowed to work with the clients during this time. -Did not interview any other staff or clients involved. -Client #1 had a history of fabricating stories and felt this was one because he was upset about not going to the store. -Did not complete an Incident Response Improvement System (IRIS) report or Health Care Personnel Registry (HCPR) referral because she did not find the allegations to be true. -Was not aware she needed to complete and IRIS report and HCPR referral if she unsubstantiated the complaint. Further interview on 4/6/22 the Director of Operations stated: -Had completed an IRIS report and HCPR referral on 3/30/22. -Staff #1 had been suspended and will completing her new investigation.	V 132		

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V 366	Continued From page 14	V 366		
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; (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	V 366		

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V 366	Continued From page 15 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; (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	V 366		

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V 366	Continued From page 16 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement written policies governing their response to incidents as required. The findings are: Review on 3/30/22 of staff #1's personnel record revealed: -Date of hire: 6/10/19 -Paraprofessional staff, worked on Sundays. Review on 3/30/22 of client #1's record revealed: -Date of Admission-11/19/19 -Diagnoses of Autism, Attention Deficit/Hyperactivity Disorder (ADHD), Impulse Control and Intermittent Explosive Disorder.	V 366		

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V 366	Continued From page 17 -Treatment Plan dated 12/1/21-"Required supervision when out in the community for safety and he is at risk of exploitation...history of self injurious behaviors..." Review on 3/30/22 of client #3's record revealed: -Date of Admission- September 2017 -Diagnoses of Mild Intellectual Developmental Disability (IDD), Bipolar Disorder and Epilepsy Refer to V110 for information incident report dated 4/1/22 with client #1 and staff #1. Interview on 4/6/22 client #1's Father stated: -On 1/31/22 client #1 told him about the incident from the day before where he was left unsupervised on the van while on an outing. -Had contacted his ex wife who is client #1's legal guardian to inform her to address this with the facility. -After a few weeks client #1 stated no one had discussed this with him, so he contacted the Director of Operations to address it. -The Director of Operations stated, "Do you really think this is true?" -The Director of Operations stated she went out and spoke to everyone and found it was not true. -Client #1 was making the allegation because he wanted to go to the store that day and was not allowed to due to being sick. During interview on 3/30/22 the Director of Operations stated: -She had received a complaint from client #1's dad regarding the outing where client #1 alleged he was left in the van unsupervised. -Immediately went to the facility to complete an investigation. -No actions were put in place to remove staff #1 as he was allowed to continue working.	V 366		

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V 366	Continued From page 18 -Only interviewed staff #1 and client #1. -Did not interview any other staff or clients involved. -Client #1 had a history of fabricating stories and "felt" this was one because he was upset about not going to the store. -Did not complete a Incident Response Improvement System (IRIS) report or HCPR referral because she did not find the allegations to be true. -Was not aware she needed to complete and IRIS and HCPR if she unsubstantiated the complaint. -Did not contact the Managed Care Organization (MCO) or the county Department of Social Services (DSS) to report the incident. -Staff #1 continued to work during this time. Further interview on 4/6/22 the Director of Operations stated: -Had completed an IRIS report and HCPR referral on 3/30/22. -Staff #1 had been suspended and was completing her new investigation.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of	V 367		

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V 367	Continued From page 19	V 367		

becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III

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V 367	Continued From page 20 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to report Level III incidents within 72 hours of becoming aware of the incident affecting two of	V 367		

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V 367	Continued From page 21 six clients (#1, #3). The findings are: Review on 3/30/22 of staff #1's personnel record revealed: -Date of hire: 6/10/19 -Paraprofessional staff, worked on Sundays. Review on 3/30/22 of client #1's record revealed: -Date of Admission-11/19/19 -Diagnoses of Autism, Attention Deficit/Hyperactivity Disorder (ADHD), Impulse Control and Intermittent Explosive Disorder. -Treatment Plan dated 12/1/21-"Required supervision when out in the community for safety and he is at risk of exploitation...history of self injurious behaviors..." Review on 3/30/22 of client #3's record revealed: -Date of Admission- September 2017 -Diagnoses of Mild Intellectual Developmental Disability (IDD), Bipolar Disorder and Epilepsy Refer to V110 for information regarding incident report dated 4/1/22 with client #1 and staff #1. During interview on 3/30/22 the Director of Operations stated: -She had received a complaint from client #1's dad regarding the outing where client #1 alleged he was left in the van unsupervised. -Immediately went to the facility to complete an investigation. -Only interviewed staff #1 and client #1. -Did not interview any other staff or clients involved. -Client #1 had a history of fabricating stories and felt this was one because he was upset about not going to the store. -Did not complete an Incident Response Improvement System (IRIS) report or Health Care	V 367		

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V 367	Continued From page 22 Personnel Registry (HCPR) referral because she did not find the allegations to be true. -Was not aware she needed to complete and IRIS report and HCPR referral if she unsubstantiated the complaint. Further interview on 4/6/22 the Director of Operations stated: -Had completed an IRIS report and HCPR referral on 3/30/22. -Staff #1 had been suspended and was completing her new investigation. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy	V 500		

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V 500	Continued From page 23 that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.	V 500		

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V 500	Continued From page 24 This Rule is not met as evidenced by: Based on record review and interview the facility failed to report allegations of abuse and neglect to the Department of Social Services (DSS) for 2 of 3 audited clients (#1, #3). The findings are: Refer to V110 for information incident report dated 1/30/22 with client #1 and staff #1. During interview on 3/30/22 the Director of Operations stated: -She had received a complaint from client #1's dad regarding the outing where client #1 alleged he was left in the van unsupervised. -Immediately went to the facility to complete an investigation. -Only interviewed staff #1 and client #1. -Did not interview any other staff or clients involved. -Client #1 had a history of fabricating stories and felt this was one because he was upset about not going to the store. -Did not complete an Incident Reporting Improvement System (IRIS) report or Health Care Personnel Registry (HCPR) referral because she did not find the allegations to be true. -Was not aware she needed to complete and IRIS report and HCPR referral if she unsubstantiated the complaint -Had not reported the allegations to DSS.	V 500		