STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G060	A. BUILDING _____ B. WING _____	C 09/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH STREET HOME	112 SMITH STREET CLEVELAND, NC 27013

(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) COMPLETION DATE
W 000	INITIAL COMMENTS Complaint Intake #: NC00180784	W 000	DHSR - Mental Health SEP 29 2021 Lic. & Cert. Section	
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to ensure implementation of written policies and procedures that prohibit abuse, neglect or exploitation of clients (W149). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated client protections.	W 122	W122 - Cross Reference W149	10/27/21
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to implement policies and procedures to prevent neglect for 1 of 6 clients (#1). The finding is: Review of facility documents on 9/13/21 revealed an internal investigation dated 8/30/21. Review of the internal investigation revealed that on 8/30/21 facility staff checked client #1's room and discovered that the client's window was partially open, the window alarm was dismantled, and the client was not in his room. Continued review of the investigative summary revealed that client #1's whereabouts were unknown for a total of 15 minutes. Client #1 was found by staff in the street on Highway 70 receiving medical attention	W 149	W149 - The Corporate QA Specialist will conduct IDT Training with the clinical team and Regional Administrator. The training will include the IDT process: PCP Development/Implementation/ Monitoring/Revisions, Compressive Functional Assessment, Core Teams, and Mini Teams. Emphasis will be placed on monitoring trends, implementing interventions and strategies for client protection. The Regional Administrator will in-service staff on completing work orders, contacting the Regional Administrator and Maintenance Technician immediately of any device that is not working correctly and jeopardizes health Con't pg 2	10/27/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Director of Operations (X6) DATE: 9/23/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 by emergency services. Review of interviews documented in the internal investigation revealed staff A verified that on 8/30/21, client #1 went AWOL from the facility by dismantling his window alarm and going out his bedroom window. Review of interview with Staff A also revealed that client #1 was able to get out of the facility gate through the "lawncare gate entry" and went down the street to Highway 70. Further review of the interview with staff A revealed that client #1 attempted to cross the highway and was struck by a vehicle sustaining numerous injuries to his face, teeth and shoulders. Interview with staff A on 9/13/21 revealed that a teacher from the local high school on Highway 70 contacted the facility to report that client #1 was found in the street and was receiving medical attention by emergency services personnel. Further interview with staff A revealed that staff had reported to management that client #1 and other clients had been removing the carabineer latch from the gate since it was installed in April 2021. Interview with the qualified intellectual disabilities professional (QIDP) on 9/13/21 revealed that on 8/30/21, client #1 was redirected several times to move from the front door, displaying increased agitation and pacing around the facility. Review of internal reports indicated that client #1 went to his room and slammed the door. Continued interview with the QIDP revealed that once she discovered that client #1 was missing from his room on 8/30/21, she went outdoors to discover that client #1 was not in sight and the (main entry/exit) gate was still secured. The QIDP also	W 149	cont from pg 1 and safety of clients. The Regional Vice President will in-service the Regional Director and Regional Administrator on monitoring of Incident Reports for trends and to ensure appropriate interventions and strategies are implemented to prevent reoccurrence and ensure client health and safety. The clinical team will hold weekly Core Team meetings for 3 months and then on a monthly basis to ensure Person Centered Plans are being implemented and interventions and strategies are in place for client protection. The Regional Director will monitor all Incidents reports for 3 months and then on a routine basis to ensure trends are being addressed. In the future the Qualified Professional and Regional Administrator will ensure the team addresses trends and implements interventions and strategies to ensure client protection in a timely manner.	

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W 149	Continued From page 2 revealed that she walked down the street to discover that client #1 had been struck by a car on Highway 70 and EMS was providing medical attention. Further interview with the QIDP revealed that the facility nurse and management were contacted immediately to report the incident involving client #1. Client #1 was immediately transported to the local hospital for emergency medical treatment. The QIDP also verified during the interview that upon completion of the internal investigation, it was determined client #1 was able to leave the premises through the "lawncare gate" which was not secured. The QIDP also revealed that client #1 has a history of leaving his supervised area without permission, dismantling his window alarm and removing the carabineer latch attached to the side gate of the facility. Review of the records for client #1 on 9/13/21 revealed a person-centered plan (PCP) dated 6/11/21. Continued review of the record for client #1 revealed a behavior support plan (BSP) dated 3/18/21. Review of the BSP revealed target behaviors of client #1 to include activity refusal, minor physical aggression, self-injurious behaviors (SIBs), inappropriate touching, inappropriate self-stimulation, inappropriate urination, AWOL, untrue statements, seat belt removal, invading personal space and pulling staff/others. Further review of the 3/18/21 BSP for client #1 revealed that carabineer latches were added to the gates of the group home to slow the client down if he attempted to leave the lawn of the group home and to ensure the gate was secure each time it was opened and closed. Additional review of records for client #1 on 9/13/21 revealed a QIDP note dated 4/11/21 that reflected staff caught client #1 going out his	W 149		

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W 149	Continued From page 3 housemate's window. The QIDP note also indicated that on 4/10/21 client #1 eloped from the facility and walked to Highway 70. The local police department was called to intervene and client #1 returned to the facility. A review of internal incident reports on 9/13/21 revealed from 4/2021 through 8/2021 three incidents occurred at the group home, before the 8/30/21 incident of client #1, that involved clients #1 and #2 getting out of the facility gate after the carabineer latch system was implemented and bedroom window alarms were installed on bedroom windows for all clients. Continued review of internal incident reports revealed on 7/29/21, client #2 ran out of the group home and was going through the neighbors' mailbox. Further review of incident reports revealed on 8/10/21 client #2 ran out of the group home and threw the neighbors mail into the road and client #1 ran out of the group home and attempted to drag staff down the driveway. Review of a core team note dated 9/3/21 revealed that after significant AWOL behaviors and incident, the interdisciplinary team (IDT) determined that the carabineer latches on the gates were not effective in stopping AWOL behaviors. Therefore, for the safety of all individuals, a combination lock would be added to the gates. In the coming weeks, a keypad lock would be placed on the primary entrance and exit gates, and a combination lock would be left on the non-primary gates to ensure safety of all clients. Interview with the facility administrator on 9/13/21 revealed that based on the facility's internal investigation, client #1 eloped from the facility	W 149		

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W 149	Continued From page 4 between 5:00 PM and 5:15 PM on 8/30/21 and was struck by a vehicle on Highway 70. The administrator also revealed that the lawncare company that provided lawncare services at the facility on 8/26/21 left the gate unsecured. Further interview with the administrator verified that the lawncare gate entry should have been secured due to the history of several clients that have been able to get out of the gate and into the street. The administrator also verified that there had been no changes to the locking system on the facility gate since 4/2021 when client #1 left the facility property and walked to Highway 70. Interview with the administrator confirmed that timely and appropriate safeguards should have been implemented after clients were able to get out of the gate with the carabineer latch system. Subsequent review of the 8/30/21 internal investigation determined that allegations of neglect were unsubstantiated by facility management relative to staff actions as client #1 did not require one-to-one supervision and the facility met the identified staff to client ratio at the time of the incident. Review of the facility's abuse and neglect policy on 9/13/21 titled "abuse, neglect, and exploitation" revealed that unintentional neglect with harm is defined as an act of carelessness, omission, accident or distraction that results in a substantiated allegation of neglect whereby there was harm to the person or significant risk for harm. Additional interview with the facility administrator on 9/13/21 revealed that client #1 would be returning to the facility once the client's medical needs have been met. Interview with the facility	W 149		

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W 149	Continued From page 5 administrator confirmed that there would be additional upgrades to the locking system within the next few weeks consisting of the following: motion alarms will be installed and connected to the current security system, a keyless pad gate entry would be installed, and a formal window alarm inspection checklist would be implemented to support monitoring. The administrator also confirmed that all client BSPs and interventions had been reviewed by the staff psychologist and interdisciplinary team (IDT) to further determine additional prevention measures to ensure the safety of all clients. Based on observations, interviews, and documentation review, the facility had opportunities to update interventions for client #1 and #2 prior to the 8/30/21 incident and failed to do so in a timely manner. The findings indicate that the team failed to implement adequate strategies in order to protect client #1 from injury. The team was also neglectful in failing to revise the clients' BSPs, modify systems and safeguards, and implement adequate strategies in a timely manner to address AWOL behaviors and ensure client protections.	W 149		

RHA
HEALTH SERVICES

September 23, 2021

Clarissa Henry, MHSA, QP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

RE: MHL-080-014

Dear Ms. Henry:

Please see the enclosed Plan of Correction (POC) for the deficiencies sited at the Smith Street Group Home during your Complaint Investigation Survey visit on 9/13/2021. We have implemented the POC and invite you to return to the facility on or around 10/27/2021 to review our POC items.

Please contact me with any further issues or concerns regarding the Smith Street Group Home (MHL-080-014).

Sincerely,

Katherine Benton
Director of Operations
RHA Health Services, LLC
Kbenton2@rhanet.org