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	MHL032-523	A. BUILDING: _____ B. WING _____	C 06/27/2022

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FAITH HOMES & HABILITATION, LLC	2711 FAYETTEVILLE STREET DURHAM, NC 27707

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V 000	INITIAL COMMENTS A complaint survey was completed on June 27, 2022. The complaint (intake #NC00190245) was substantiated. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness The facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by	V 290		

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V 290	Continued From page 1 the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on interviews, observation and record review, the facility failed to have staff coverage to ensure safety and meet the individual needs of one of three audited clients (#1). The findings are: Review on 6/23/22 of Client #1's record revealed; -Admission date 1/26/22. -Diagnoses of cognitive impairment, schizoaffective disorder, diabetes, gastroesophageal reflux, hypertension, wernicke encephalopathy, alcohol abuse by history and blind in right eye due to a drunk driving accident. -Review on 6/23/22 of Client #1's Admission Assessment dated 1/25/22 revealed:	V 290		

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V 290	Continued From page 2	V 290		

-"[Client #1] is a frail African American lady; [Client #1] speaks loudly and seems to have muscle spasms - a lot of jerking. [Client #1] seems to have a lot of uncontrolled movements. [Client #1] is in a hospital where [Client #1] has been for 3 months. [Client #1] needs to be discharge to a facility for [Client #1's] safety. [Client #1] is blind in one-eye. This is a result of a drunk driving accident. [Client #1] was driving and crashed into a wall.
-[Client #1] was living independently prior to admission ... [Client #1] would have frequent hallucinations. These hallucinations would lead to [Client #1] wanting to fight her neighbors and be disruptive.
-[Client #1] was diagnosed with schizophrenia and bipolar. [Client #1's] brother lived with [Client #1] one year ago and [Client #1] was introduced into drugs. [Client #1] was introduced to crack-cocaine. [Client #1] was already an alcoholic. [Client #1] started drinking in [Client #1's] 20s. [Client #1] was arrested several times for fighting and assault. [Client #1] has stabbed 2 people."

Review on 6/23/22 of Client #1's Level II Incident Report dated 6/15/22 revealed:
-"On 6/15, [Client #1]j reported to the [House Manager] that [Client #1] had fallen. [House Manager] didn't witness a fall but [Client #1] was acting disorganized. The [House Manager] called the [Administrator/Qualified Professional], the [A/QP] told [House Manager] to take [Client #1] to the emergency department for evaluation. The [House Manager] got [Client #1] checked in at [Regional Hospital]. The [House Manager] called the [A/QP] and asked permission to leave [Client #1] in the emergency department. The [A/QP] told [House Manager] that it was ok to leave [Client #1] as long as the emergency department

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V 290	Continued From page 3	V 290		

staff had the [A/QP's] contact information. The [A/QP] was called at approximately 7:30 a.m. on 6/16 to say that [Client #1] was found wandering in [City]. The [A/QP] thought [Client #1] was still at the hospital."

Review on 6/23/22 of Client #1's Level II Incident Report dated 6/16/22 revealed:
-"[Client #1] was escorted to the facility this morning after being missing overnight. The [A/QP] wanted [Client #1] examined after being missing. [Client #1] was taken back to the [Regional Hospital]. The [A/QP] received a call at approximately 7:00 p.m. from [Regional Hospital Charge Nurse] stating that [Client #1] is ready for discharge. [Regional Hospital Charge Nurse] stated that the hospital could arrange [Car Service] to escort [Client #1] to the facility. At 8:45 p.m. the [A/QP] called back to the [Regional Hospital] to check on the status of [Client #1]. [Regional Hospital Charge Nurse] stated that while [Client #1] was waiting for [Client #1's] ride [Client #1] walked off. [Regional Hospital Charge Nurse] stated that she looked for [Client #1] for approximately 30 minutes. Faith Homes called the police - Officer made a missing person report. [Client #1] has been missing since for over 2.5 hours."

Review on 6/23/22 of the Police Report dated 6/16/22 revealed:
-"On 6/16/22 at 9:11 p.m. [Officer] responded by phone to a missing person call at [Street Address], [Regional Hospital]. [Officer] spoke with [House Manager], Faith Homes, who said [Client #1], the victim, was last seen and heard from at [Regional Hospital] on 6/16/22 at 8:00 p.m. [Client #1] was discharged and waiting for a ride to take [Client #1] back to Faith Homes on [Street Address]. [Client #1] did not make the

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V 290	Continued From page 4	V 290		

pickup time and the driver left. The hospital staff did not wait with [Client #1] since [Client #1] was discharged and waiting on a ride.
-[Officer] contacted [Regional Hospital] and they were not aware of [Client #1's] discharge. [Officer] sent a Be on the Lookout message for [Client #1].
-[Officer] entered [Client #1] as a missing person at 10:30 p.m.
-[Client #1] was located sleeping in a locked room in [Regional Hospital] on 6/16/22 at about 11:15 p.m. [Client #1] was removed from National Crime Information Center. Faith Homes was made aware and they made arrangements for [Client #1] to be picked up."

Interview on 6/23/22 with Client #1 revealed;
-She went to regional hospital.
-"I left the hospital because it was boring."
-"I sat there for 4 hours when I finally got to the doctor."
-"That's when my other personality came out."
-"You are not supposed to wait for 12 hours."
-"I left the hospital and made my way back here."
-"I did not see the nurse, that's when I walked out."
-"I should not have because I was intoxicated."
-"The police caught me out there in the parking lot."

Interview on 6/23/22 with the House Manager revealed:
-Started working in the house June 2022 as the live-in house manager.
-She was off the weekends.
-She took client #1 to the hospital on 6/15/22 between 11:30 a.m. and 12 noon after a fall.
-Client #1 needed assistance to walk or she would fall.
-Client #1 refused to use her cane and walker.

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V 290	Continued From page 5 -The A/QP told her to take client #1 to the hospital for an evaluation. -When she arrived at the hospital, she took client #1 to the bathroom and checked her in. -She waited with client #1 for about 20 minutes. -She left after 20 minutes when she knew "[client #1 was good with the nurse.]" -She had to leave because the other clients were returning home and would be locked out. -There was no other staff available to let the other clients in the house. -The supervisor was working at another house. -She did not leave the hospital until the triage nurse took client #1 to the back. -Prior to leaving she contacted the A/QP to provide status on client #1. -She told the A/QP that client #1 was with the triage nurse. -The A/QP gave her approval to leave the hospital. -She and the A/QP were constantly calling the hospital to check on client #1. -Client #1 was not dropped off and left alone. -Client #1 was checked in; the nurse communicated with her. -She did not leave until she knew someone was with client #1. -They learned client #1 left the hospital and that she was never in triage. -She called the A/QP to let her know client #1 did not return home. -Police brought client #1 to the house about 7:00 a.m. on 6/16/22. -The police said client #1 was on someone's porch. -Client #1 returned to the house drunk. -She called for emergency and the ambulance took client #1 back to the hospital between 8:00-8:30 a.m. -She did not meet client #1 at the hospital.	V 290		

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V 290	Continued From page 6 -She said the hospital put client #1 in a room and gave her "intravenous for vitamins." -Client #1 left the hospital when the nurse went to get the discharge paperwork. -She called the police and made a report. -Client #1 was found near the hospital. -She and the A/QP stayed in contact with the police until client #1 was located. -The hospital called transportation back and client #1 arrived home at 2:30 a.m. Interview on 6/23/22 with the A/QP revealed: -On 6/15/22 Client #1 fell in the bathroom. -She told the house manager to take client #1 to the hospital for an evaluation. -The house manager got client #1 to the check-in process. -Client #1 was passed off to the nurse in the hospital. -The house manager told her the nurse took client #1 from the waiting room to the back. -She did not know if client #1 was seen by the doctor. -The house manager told her she passed client #1 off to hospital personnel. -She did not feel the house manager had to stay until client #1 was admitted. -She was on the phone with the house manager when she informed the hospital staff that client #1 would be a poor source of information. -She was in constant contact with the charge nurse while client #1 was in the hospital. -During the 1st incident the police called her about client #1. -She told the police that client #1 was at the hospital. -She paused when the police told her client #1 was in his custody. -The charge nurse did not tell her client #1 was missing.	V 290		

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V 290	Continued From page 7 -She called the hospital and spoke to the charge nurse and the administrator to find out what happened with client #1. -They told her client #1 left the hospital. -She asked about the hospital police responsibility and was told they were too busy to monitor clients. -The hospital said to monitor clients the procedure was different if transported by emergency medical services. -She said the hospital administrator told her they should have put client #1 in the ambulance. -The 2nd time they called EMS and client #1 still went missing. -No staff escorted client #1 to the hospital during EMS transport. -She never knew client #1 was a wanderer. -This was client #1's first incident. -They would never pass clients off to the hospital personnel again. -Staff would stay with clients until admitted. Review on 6/27/22 of the Plan of Protection written by the A/QP dated 6/27/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care.? The [A/QP] will ensure that staff or the guardian will accompany all residents to the hospital until they are admitted into the hospital. Effective immediately, the [A/QP] will train all staff on the new procedure of transporting clients to the hospital to ensure their safety. Describe your plans to make sure the above happens? Effective immediately, the [A/QP] will train all staff on the new procedures of transporting clients to the hospital to ensure their safety." Client #1 had a diagnoses of cognitive impairment, schizoaffective disorder, diabetes,	V 290		

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V 290	Continued From page 8 gastroesophageal reflux, hypertension, wernicke encephalopathy, alcohol abuse by history and blind in right eye due to a drunk driving accident. On 6/15/22, client #1 was transported to the hospital by the house manager for an evaluation due to a reported fall. The house manager left her unsupervised after she reported the nurse took client #1 to the triage room. After the house manager left, at some point client #1 left the hospital and wandered off into the community. The police were called and client #1 was located sitting on a porch of a local residents. Client #1 was transported back to the facility by the police the next day on 6/16/22 at 7:30 a.m. Upon arrival on 6/16/22 the house manager reported client #1 presented drunk and called EMS to transport client #1 back to the hospital without staff supervision. Client #1 was reportedly seen by the hospital staff and given an IV. When the hospital staff was preparing client #1 for discharge, client #1 left the area without informing hospital staff. Police was called and client #1 was located sleeping in a locked room in the hospital about 11:15 p.m. Client #1 was transported back to the facility by a transportation service without staff supervision. There was no staff with client #1 during the EMS transport or during treatment. Therefore, the facility failed to provide staff supervision and monitoring to ensure client #1's safety during hospital visits. 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.	V 290		