STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-215	A. BUILDING: _____ B. WING _____ DHSR - Mental Health	C 07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOMES	625 N MEBANE STREET BURLINGTON, NC 27217

AUG 3 2022
Lic. & Cert. Section

(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 000	INITIAL COMMENTS A complaint survey was completed on July 1, 2022. The complaints were substantiated (intake #NC00190260 and NC00190567). 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 was identified in this report. The sister facility will be identified as sister facility A. Client will be identified using the letter and a numerical identifier. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000	Systematic Change to Prevent the Out-of-Compliance Issues: The (QP) Qualified Professional has provided the facilities with "Incident Reporting Forms" for all incidents. The QP provided the staff with a form that shall be read and signed/dated by each staff, this provided the staff with directions on how to complete the form, when the form should be completed, the levels of the incidents. All staff that refuse to sign, date and or acknowledge the incident guidelines, is in jeopardy of losing his/her position within the facility. Staff shall report all Level II/III incident immediately to the QP and director. The QP and or Director will file an IRIS Report when needed. Unsupervised forms have been implemented for each client; all clients must be able to answer the questions on the test to receive unsupervised time. Any client that will receive unsupervised time, will have the form completed/signed off by the QP and placed in their book; any client that receive unsupervised time, will have it listed in their treatment plan. A Protocol form has been created and placed in the office for all staff to adhere to, for client #3, and an incident report level II will be completed immediately. Timetable for Implementation of the Corrective Actions: The director/QP will retrain all staff immediately, forms and policy were implemented on July 20, 2022.	07/20/22
V 106	27G .0201 (A) (8-18) (B) 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: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client;	V 106		

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V 106	Continued From page 1 (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for facility areas including special client activity areas; and (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement their policy for incident reporting. The findings are: a. Review on 6/28/22 of client #2's record revealed: -Admission date of 4/1/22. -Diagnoses of Bipolar II Disorder, Post Traumatic Stress Disorder, Social Anxiety Disorder, Gastroesophageal Reflux Disease, Attention Deficit Hyperactivity Disorder, Pseudoseizures and Asthma. b. Review on 6/28/22 of client #3's record revealed: -Admission date of 2/15/22. -Diagnoses of Schizophrenia and Hypersexuality. Review of facility records on 6/29/22 of the policy for incident reporting revealed:	V 106	Systematic Change to Prevent the Out-of-Compliance Issues:	

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V 106	Continued From page 2 -"Incident form will be completed when there is an unusual occurrence, considered Level I, II or III incident, or death, as defined by the Division of MH/DD/SAS (Mental Health/Developmental Disabilities/Substance Abuse Services). A copy of the form and the Restrictive Intervention form shall be posted in the office. The documentation will include a description of the event, actions taken on resident, date/time/duration of the event, the intervention by staff and the resident's condition following the event. Interviews of the staff and the clients will be conducted within 24 hours of the incident and the information provided in the report as required. The legal guardian and Case Manager shall be notified within 24 hours of the incident. If the incident is a Level I incident, the report shall be filed internally and provided to the Quality Assurance Committee and Client Rights Committee for review." Interview on 6/29/22 with staff #1 revealed: -There was a recent incident between clients #2 and #A7. Initially clients #2 and #A7 were horse playing and then they started getting serious. Client #2 and #A7 starting arguing with each other. Client #2 was upset and punched a hole in the wall. He did see client #2 with a lighter in his hand, but he was just flicking the lighter. He never saw client #2 make any threatening movements towards client #A7 with the lighter. -He confirmed client #2 had no strategies to address his aggression. Interview on 6/28/22 with Former Staff #3 (FS #3) revealed: -Clients #2 and #3 walked away from the home without staff supervision on several occasions. They walked to a local store and/or visited neighbor's homes. She thought clients #2 and #3 walked away from the facility unsupervised on a	V 106		

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V 106	Continued From page 3 weekly basis. -She thought about 2 months ago client #3 walked to the store and brought some Benadryl. Client #3 took all of the Benadryl, she was not sure how many was in the container. Client #3 came to her and said he thought he overdosed on the Benadryl. Client #3's eyes were big, "it was like he was on speed." Client #3 said he did not want to go to the hospital, he would be ok. -About a month ago she gave client #3 a Benadryl capsule and saw him put the medication in his mouth. A few minutes later she saw client #3 in his bedroom. He was snorting the powder from the Benadryl capsule up his nose. -She wrote down all of these incidents and reported them to the Director/Licensee. She was not sure where the documentation for those incidents was located. Staff normally write all incidents in a notebook, she could not locate that notebook. She didn't do any incident reports because there was no document to fill it out. They just recently got the document to fill out the incident. The incident report the Director/Licensee gave them looks like a book and it was not easy to follow. Review of facility records on 6/29/22 revealed no documentation of incident reports for the above issues. Interview with the Director on 6/30/22 revealed: -He and his wife talked with all of the staff about incident reporting. There was an incident report form for Level 1 incidents at the facility. Some of the staff were not receptive to using this new incident report form. Staff normally documented incidents, "but refused to document the incident on the appropriate form." -He confirmed the facility failed to implement their policy for incident reporting.	V 106		

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V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 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 reviews and interviews, the facility failed to develop a treatment plan and failed to develop and implement strategies to meet the needs and behaviors affecting two of	V 112	Systematic Change to Prevent the Out of Compliance Issues: Treatment Plans for all clients will be completed within 30 days of admission. The QP will complete a Admission Assessment and Treatment Plan for all new admits, the treatment plan will be completed with the help of the client and or guardian/family member. All Treatment plans will be updated annually and reviewed based on the goals, needs and hospitalization of the client. All Staff will be trained on how to read and implement the treatment plans for all clients, all staff shall follow/work with the clients on their goals daily. Timeframe for Implementation of the Corrective Action: QP will complete the treatment plan July 20, 2022. An "Elopement Policy has been created for the facility, Training will be conducted with all staff by QP on August 05/2022. QP will train all staff on "Supervision" the risk and Consequences" of not monitoring the the clients throughout the day. This class will be completed by August 19, 2022.	

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V 112	Continued From page 5 three audited current clients (#2 and #3). The findings are: a. Review on 6/28/22 of client #2's record revealed: -Admission date of 4/1/22. -Diagnoses of Bipolar II Disorder, Post Traumatic Stress Disorder, Social Anxiety Disorder, Gastroesophageal Reflux Disease, Attention Deficit Hyperactivity Disorder, Pseudoseizures and Asthma. -There was no documentation of a treatment plan. -Client #2 had no strategies to address his aggression and walking away from the facility. b. Review on 6/28/22 of client #3's record revealed: -Admission date of 2/15/22. -Diagnoses of Schizophrenia and Hypersexuality. -Discharge summary from local hospital dated 6/8/22- On 6/8/22 he was placed in a psychiatric hold and a psychiatric evaluation was completed due to aggressive behavior. -Discharge summary from hospital dated 2/16/22-He was seen for Hypersexuality and Aggression with sexual assault of a woman. -There was no documentation of a treatment plan. -Client #3 had no strategies to address his aggression, walking away from the facility and substance abuse issues. Incident #1 Review on 6/28/22 of facility records revealed: -Incident report dated 5/15/22-"Found [Client #1] laying on sidewalk checked him looked like he was punched or hit with object in the face called EMS (Emergency Medical Services) and 911 took	V 112		

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V 112	Continued From page 6 to hospital." Client #1 had a fractured nose. Interview on 6/28/22 with client #1 revealed: -He went to the hospital a little over a month ago. His nose was broken and bleeding. He didn't know what happened to his nose. -He was reluctant to discuss any specifics about his fractured nose. Interview on 6/28/22 with client #2 revealed: -During that incident with client #1 he never touched or hit him. -He found client #1 laying on the ground in the front yard at the facility. He brought it to FS #3's attention. Interview on 6/28/22 with Former Staff #3 (FS #3) revealed: -She worked at the facility during the incident with clients #1 and #2. She thought the incident happened about a month ago. She heard client #1 "telling [client #2] what to do, like he was staff." She was looking out the window in the kitchen area and saw client #2 hit client #1 in his mouth. Client #2 hit client #1 in his face hard, he "cold cocked" client #1 in his face. Client #1 was laid out in the yard. She knew client #2 hit client #1 hard because he wore a lot of rings on his hands. She went outside and saw blood coming from client #1's nose. Client #1 was laying on the ground with his eyes closed. Client #1 was "knocked out cold." She was shaking client #1 and he came back around. Client #1's upper lip was split and his nose was still bleeding. Client #2 broke client #1's nose. She called the police department and Emergency Medical Services (EMS). She told the police what happened, because she thought client #1 was scared to tell client #2 hit him.	V 112		

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V 112	Continued From page 7 Interviews on 6/28/22 and 7/1/22 with the Manager revealed: -There was an incident with clients #1 and #2 that occurred towards the end of April 2022. He didn't have a lot of specifics because he wasn't working at the facility that day. Staff told him about the incident. He was told clients #1 and #2 got into an altercation. He thought client #1's jaw or nose was fractured. Staff called the police department. Client #1 refused to press any charges against client #2 . He thought EMS was called and client #1 was transported to the hospital. Incident #2 Review on 6/28/22 of facility records revealed: -Incident report dated 6/8/22-"[Client #3] was showing signs of aggression all day per staff. He was showing signs of agitation, no matter what was ask of staff he would say profanity towards the staff (F**k you) and he said that the staff can not tell him what to do or the owner... Around 4:30 pm today, [Client #3] and [Client #2] was having a heavy and heated talk about following rules. [Client #3] became upset and he stood up and I had [Client #2] ask him to back up out of his face. By the time the staff came out of the office, [Client #3] had choked [Client #2], and the staff said [Client #3] was moving his hand from around [Client #2's] face. Staff said that ask [Client #2] what happened, and [Client #2] said that [Client #3] had his hands around his neck. Staff check [Client #2's] neck and it was red, staff proceeded to call the police...[Client #3] was arrested and taken to local jail for assault." Interview on 6/28/22 with client #2 revealed: -He had an incident with client #3 about 3-4 weeks ago. He thought FS #4 was in the staff office area. He and client #3 were arguing, he	V 112		

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V 112	Continued From page 8 could not remember the specifics of the argument. Client #3 then choked his neck. FS #4 came into their bedroom and asked them what was going on between them. He told FS #4 he was choked by client #3. FS #4 called 911 and client #3 was arrested. He had a red mark on his neck after client #3 choked him. Interview on 6/28/22 with Former Staff #4 (FS #4) revealed: -There was an incident with clients #2 and #3. She thought the incident occurred about three weeks ago. She was in the bathroom and heard a loud commotion and loud voices. Clients #2 and #3 were arguing and cussing at each other. When she came out of the bathroom she saw a shelf laying on the floor in the hallway outside of clients #2 and #3's bedroom. She then saw clients #2 and #3 standing in their bedroom. She saw client #3 bringing his hands down to his side. Client #2 said client #3 choked him and she saw a reddish mark around client #2's neck. She did not see client #3 choking client #2. She felt like something happened because client #2's neck had a reddish mark. She called 911 and reported the incident. Client #3 was arrested and taken to the hospital for a psychiatric evaluation by the police officers. Interviews on 6/28/22 and 7/1/22 with the Manager revealed: -He thought clients #2 and #3 got into an altercation about three weeks ago. Staff informed him client #3 choked client #2's neck. Client #3 was arrested and went to jail. Client #3 went to the hospital after leaving jail. He thought it was possibly for psychiatric reasons. -He thought staff mentioned that there was an incident with client #3 not taking his Benadryl as prescribed. He could not remember any specifics	V 112		

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V 112	Continued From page 9 about the incident. Incident #3 Interview on 6/28/22 with client #2 revealed: -He was recently at the sister facility next door and had an incident with client #A7. Client #A7 got upset and tried to stab him with a fork. He had a lighter on him, took it out and burned client #7A's shirt by mistake. He was trying to scare client #A7, he didn't want to burn him. He thought staff #1 was working, however he didn't know if he was around during that incident with client #A7. Interview on 6/29/22 with staff #1 revealed: -There was a recent incident between clients #2 and #A7. Initially clients #2 and #A7 were horse playing and then they started getting serious. Client #2 and #A7 starting arguing with each other. Client #2 was upset and punched a hole in the wall. He did see client #2 with a lighter in his hand, but he was just flicking the lighter. He never saw client #2 make any threatening movements towards client #A7 with the lighter. -He confirmed client #2 had no strategies to address his aggression. Incident #4 Interview on 6/28/22 with client #3 revealed: -He had a "Substance Abuse Disorder." Staff caught him snorting the powder from a Benadryl capsule up his nostril 1-2 times. He also brought Benadryl from the store on one occasion. He thought he took about 16 Benadryl capsules at one time. He felt normal after taking those 16 Benadryl capsules, he just felt "buzzed." He was taking Benadryl for his "anxiety." He thought those incidents with the Benadryl happened when	V 112		

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V 112	Continued From page 10 he was admitted in February 2022. Interview on 6/28/22 with Former Staff #3 (FS #3) revealed: -She thought about 2 months ago client #3 walked to the store and brought some Benadryl. Client #3 took all of the Benadryl, she was not sure how many was in the container. Client #3 came to her and said he thought he overdosed on the Benadryl. Client #3's eyes were big, "it was like he was on speed." Client #3 said he did not want to go to the hospital, he would be ok. -About a month ago she gave client #3 a Benadryl capsule and saw him put the medication in his mouth. A few minutes later she saw client #3 in his bedroom. He was snorting the powder from the Benadryl capsule up his nose. She told client #3's physician he was not taking the Benadryl as prescribed. The physician discontinued the Benadryl because he was not taking it as prescribed. She thought client #3 told the doctor he needed the Benadryl and the doctor prescribed it for him. Interviews on 6/28/22 and 7/1/22 with the Manager revealed: -He thought staff mentioned that there was an incident with client #3 not taking his Benadryl as prescribed. He could not remember any specifics about the incident. Incident #5 Interview on 6/28/22 with client #2 revealed: -He walked to the store about 2-3 times without staff supervision. He thought he last walked to the store unsupervised about two weeks ago. Interview on 6/28/22 with client #3 revealed: -He walked to the store a few times without staff	V 112		

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V 112	Continued From page 11 supervision since he resided at the facility. He was unable to specify how many times he walked to the store. Interview on 6/28/22 with Former Staff #3 (FS #3) revealed: -Clients #2 and #3 walked away from the home without staff supervision on several occasions. They walked to a local store and/or visited neighbor's homes. She thought clients #2 and #3 walked away from the facility unsupervised on a weekly basis. -When client #2 was first admitted to the facility, he was caught going out the window. Client #2 was seen going over to a neighbor's house right down the street. Client #2 was seen sitting on the porch and talking to the people who occupied that home. She thought client #2 went out that window twice to visit that neighbor's house. There was another home in the area that client #2 also visited. The person who occupied that home approached her and said client #2 stole some Marijuana from him. Client #2 also walked to a store in the area. -Client #3 would leave the facility whenever he felt like it. Client #3 would normally walk to a store in the area. Client #3 was crossing the highway near the group home just recently and was almost struck by a vehicle. Client #3 was running across the highway and was trying to beg a stranger for a soda. One of the neighbors just recently told her he saw client #3 at their home peeping through the window at him and his wife. She thought client #3 was walking to other neighbor's homes as well. -If a client walked away from the facility "you can't follow them because you are working by yourself and can't leave the other clients behind." Interview on 6/28/22 with Former Staff #4 (FS #4)	V 112		

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V 112	Continued From page 12 revealed: -During her shift she thought client #2 walked away from the facility twice. She thought he walked to a store near the facility. -She thought client #3 walked away from the facility 4-5 times. He also walked to the store near the facility. They were gone between 15-30 minutes. Interviews on 6/28/22 and 7/1/22 with the Manager revealed: -During his shift he thought client #3 walked away from the facility a few times, he could not specify how many times. Client #3 walked to the store near the facility. Interview on 6/29/22 with the Qualified Professional (QP) revealed: -She just became the QP for that facility in June 2022. She was still getting to know the clients and staff for that facility. She was still in the process of getting the client's paperwork together for that facility. She looked through the client records to see what documentation was missing. She knew clients #2 and #3 had no treatment plan in their record books. -She knew client #3 was walking to the store without staff supervision because he mentioned it to her when he was requesting unsupervised time. She didn't know client #2 was walking away from the facility and going to the store and/or neighbor's homes without supervision. -She was aware of the choking incident with clients #2 and #3. She heard about the incident with clients #1 and #2, however there was another QP working at that time. She was not aware of the incident between clients #2 and #A7 that occurred at the other facility. She didn't know about the issues with client #3 and the Benadryl. She thought some of those issues possibly	V 112		

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V 112	Continued From page 13 occurred prior to her becoming the QP for that facility. -She confirmed the facility failed to develop a treatment plan for clients #2 and #3. -She confirmed client #2 had no strategies to address his aggression and walking away from the facility. -She confirmed client #3 had no strategies to address his aggression, walking away from the facility and substance abuse issues. Interview on 6/29/22 with the Former QP revealed: -She resigned as QP for that facility at the end of May 2022. -The Director/Licensee told her clients #2 and #3 had treatment plans. The Director/Licensee said those client's Assertive Community Treatment Teams (ACTT) completed their treatment plans. She was not sure why the treatment plans were not in the client records. -Staff never talked to her about any of the clients walking away from the facility when she was the QP. -She wasn't aware of any incidents with aggression between clients. She wasn't aware of any substance abuse issues with clients. -Now that she was no longer the QP, staff contacted her about several incidents that just recently occurred with those clients. Interview on 6/30/22 with the Director/Licensee revealed: -The Former QP was responsible for completing a Person Centered Plan (PCP) for clients #2 and #3. The Former QP was responsible for ensuring clients had strategies in their PCPs to address any issues they were having at the facility. He was not sure why she had not completed PCPs for those clients. She was no longer the QP for	V 112		

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V 112	Continued From page 14 his facility because she was not doing her job. -He was aware clients #2 and #3 were walking away from the facility unsupervised. -Client #2 had been walking away from the facility since he was admitted in April 2022. They talked to him about walking away from the facility, however he continues doing it. Client #2 was walking to the store and neighbor's houses in the area. Client #3 was also walking to the store near the facility. They normally don't go too far and are only gone about 20 minutes. The Manager did inform him that client #3 was almost hit just recently crossing to the other side of the street near the facility. -Staff informed him client #2 assaulted client #1 during an incident in May 2022. FS #3 said both clients were on the front porch. FS #3 said she was in the staff office area getting some paperwork completed. She saw client #2 come into the facility and wash his hands. She said she saw blood on client #2's hands. She went outside and saw client #1 laying on the ground and his nose was bleeding. He told her to call 911. Client #1 went to the hospital. They found out later client #1 had a fractured nose. -He was aware of the incident with clients #2 and #3. He couldn't remember which staff was working. Staff told him client #2 flipped a book shelf over onto client #3. Client #2 told staff he did that because client #3 choked him. Staff called 911 and client #3 was arrested. -He knew about the incident between clients #2 and #A7. He was told client #2 walked over to the facility next door. He was not supposed to be going to that facility to visit other clients. He was told client #A7 got agitated with client #2 and they got into an argument. Staff did not tell him client #2 had a lighter and burned client #A7's shirt. -He knew client #3 was taking Benadryl that was not prescribed. Staff informed him that client #3	V 112		

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V 112	Continued From page 15 took several Benadryl he purchased from the store. He went to the home that day and client #3 seemed to be ok. He thought he was fine because he had a history of substance abuse. Staff also made him aware of client #3 snorting the powder from a Benadryl capsule. The medication was discontinued by his physician after that incident. -He confirmed facility staff failed to develop a treatment plan for clients #2 and #3. -He confirmed client #2 had no strategies to address his aggression and walking away from the facility. -He confirmed client #3 had no strategies to address his aggression, walking away from the facility and substance abuse issues. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility.	V 289	Systematic Change to Prevent the Out-of-Compliance Issues: An Unsupervised form/questionaire has been completed for all clients, the will access all clients to determine if they are capable of having at least 3-4 hours of unsupervised time. Any client that is granted unsupervised time will have a form included within their books, and it will be notated in their treatment plan. Each client that has been granted unsupervised time will be provided with emergency contact information.	

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V 289	Continued From page 16 (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)	V 289	Timetable for Implementation of the Corrective Actions: QP will have forms/treatment plans in place by July 20, 2022.	

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V 289	Continued From page 17 (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to operate within the scope of the program developed and designed to provide services for habilitation/rehabilitation, care and supervision of three of three current audited clients (#1, #2 and #3). The findings are: Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (Tag 112) Based on record reviews and interviews, the facility failed to develop a treatment plan and failed to develop and implement strategies to meet the needs and behaviors affecting two of three audited current clients (#2 and #3). The findings are: Cross Reference: 10A NCAC 27G .5602 Staff (Tag 290) Based on record reviews and interviews, the facility failed to assess client's capability of having unsupervised time in the community without staff supervision affecting two of three audited current clients (#2 and #3) and failed to provide supervision to meet the needs of clients affecting three of three audited current clients (#1, #2 and #3). Review on 7/1/22 of a Plan of Protection (POP)	V 289		

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V 289	Continued From page 18 written by the Qualified Professional dated 7/1/22 revealed "What immediate action will the facility take to ensure the safety of the consumers in your care? -[The Director/Qualified Professional] will re-train all staff immediately to assure that they are tentative to the needs of the members and supervision/monitoring of all members, within the 24-hour period -[Qualified Professional] will create a treatment plan that will indicate the following: a. Needs/Goals of the members and ensure that staff is working on the necessary goals that have been implemented as soon as possible. The goals will address (with member's input) behaviors, and what goals the member would like to work on. b. [Qualified Professional] will make an (SAIOP) (Substance Abuse Intensive Outpatient) referral for Substance Abuse issues due to one of the member's constant misuses of over-the counter medication; this member will not receive unsupervised time based on his behaviors. c. Treatment plan will provide the staff with signs of substance abuse and signs to look for d. Training on how to reduce maladaptive behaviors e. Staff must make sure that all members take all prescribed medications, and document accordingly. Since there is one member who refuse to take his medication the correct way, staff must watch him take his prescribed medications (have member to open his mouth, look under tongue, side of mouth,) to determine if the medication has been consumed. f. Staff will redirect the member, when he is showing threatening, bullying tactics and use (EBPI (Evidence Based Protective Interventions)/NCI (National Crisis Intervention) techniques)	V 289	Systematic Change to Prevent the Out-of Compliance Issues: The QP will make a referral for SAIOP/Peer Support for client #3 due to his hx of AOD. Timetable for Implementation of the Corrective Action: The referral will be made by QP by August 31, 2022.	

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V 289	Continued From page 19 g. Staff will assist the members in understanding how to use self-control techniques, reduce psychotic symptoms, alleviate sense of demoralization and despair, provide the members with various activities within the community (i.e. PSR (Psychosocial Rehabilitation), male groups etc.) by keeping the members busy throughout the day, it will help in reducing behaviors at a minimum and it will allow them to build/learn self-control. h. An Unsupervised assessment will be completed to assess all members, to determine if they are eligible to have at least at a minimum of 30 minutes per day without supervision. This will be documented and placed in their file. Describe your plans to make sure the above happens. The following will be implemented immediately: These forms will be placed in the member's file upon completion: 1-Unsupervised assessment for all members will be completed by July 5th, 2022, to determine if the member is capable of being out in the community without supervision and is not a threat to himself or the community 2-Treatment plans for 2 of 2 members will be completed by July 6th , 2022 and any needed assessments will be completed by the end of the day 3-Incident reporting and training will be completed by July 6th, 2022 4-SAIOP (Substance Abuse Intensive Outpatient) referral for one of the 2 members will be completed by July 8, 2022 with documentation 5-Supervision (monthly) will be implemented by [The Qualified Professional] by July 5th 2022 6-Training of staff in regard to supervising the members more effectively will be completed by July 6th 2022 7-Although one member will be discharged from	V 289		

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V 289	Continued From page 20 the facility, a Transition Discharge plan will be created with referral to additional services, (scheduled date is July 11, 2022) 8-. An incident form has been implemented that will address all level one incident; all staff will read and sign/date the form that will address incident reporting." The facility served clients whose diagnoses included Bipolar II Disorder, Post Traumatic Stress Disorder, Social Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Schizophrenia, Hypersexuality and Intellectual and Developmental Disabilities. On 6/8/22 client #3 choked client #2 while Former Staff #4 (FS#4) was in another area of the facility. Client #2 had a red mark around his neck. FS #4 called the police department and client #3 was arrested as a result of that incident. There was another incident on 5/15/22. Client #1 was found laid out on the ground at the facility with a bloody nose and a split lip. Former Staff #3 (FS #3) called Emergency Medical Services (EMS) and the Police Department. Client #1 was transported to the hospital via EMS and had a fractured nose as a result of that incident. Client #2 went to the facility next door in June 2022. Client #2 got into an altercation with client #A7. Client #2 burned client #A7's shirt with a lighter and punched a hole in the wall during that incident. Client #3 stated he had a history of substance abuse. Client #3 left the facility without permission, walked to a store and purchased a container of Benadryl. He said he took about 16 tablets at one time. FS #3 stated client #3 approached her and said he thought he overdosed on Benadryl. During another incident FS #3 administered client #3 a Benadryl capsule and a few minutes later she caught him snorting the powder from a Benadryl capsule up his nose. Clients #2 and #3	V 289		

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V 289	Continued From page 21 were walking to the store and neighbor's homes in the community. Client #2 sneaked out the window twice and was found sitting on a neighbor's porch talking with the occupants of the home. According to FS #3 a neighbor reported client #2 visited his home and stole Marijuana from him. According to FS #3 another neighbor approached her about client #3, the neighbor said client #3 was looking at him and his wife through the window. FS #3 witnessed client #3 crossing the highway near the group home just recently and was almost struck by a vehicle. Clients #2 and #3 had no Person Centered Plans developed. Clients #2 and #3 had no strategies to address aggression, walking away from the facility and/or substance abuse issues. Clients #2 and #3 continued to walk throughout the neighborhood, however they had no unsupervised time in the community. Clients #1, #2 and #3 had incidents due to a lack of staff supervision. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $2000.00 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 289		
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	V 290		

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V 290	Continued From page 22 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 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.	V 290		

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V 290	Continued From page 23 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assess client's capability of having unsupervised time in the community without staff supervision affecting two of three audited current clients (#2 and #3) and failed to provide supervision to meet the needs of clients affecting three of three audited current clients (#1, #2 and #3). The findings are: The following is evidence the facility failed to assess client's capability of having unsupervised time in the community without staff supervision. a. Review on 6/28/22 of client #2's record revealed: -Admission date of 4/1/22. -Diagnoses of Bipolar II Disorder, Post Traumatic Stress Disorder, Social Anxiety Disorder, Gastroesophageal Reflux Disease, Attention Deficit Hyperactivity Disorder, Pseudoseizures and Asthma. -There was no documentation that client #2 had been assessed for capability of having unsupervised time in the community without staff supervision. b. Review on 6/28/22 of client #3's record revealed: -Admission date of 2/15/22. -Diagnoses of Schizophrenia and Hypersexuality. -Discharge summary from local hospital dated 6/8/22- On 6/8/22 he was placed in a psychiatric hold and a psychiatric evaluation was completed due to aggressive behavior. -Discharge summary from hospital dated 2/16/22-He was seen for Hypersexuality and Aggression with sexual assault of a woman.	V 290	Systematic Change to Prevent the Out-of-Compliance Issue: Unsupervised forms have been completed, and placed in the books of the clients. The treatment plans has been updated as needed to reflect unsupervised time. Timetable for implementation of the Corrective Actions: All forms/treatment plans will be completed by July 20, 2022. QP will discuss with the director about possibly additional staff during the day, to help with supervision of the client, this will help in cutting down elopement, increase supervision and allow more time to work with all clients on their goals. QP will speak to the director to have all staff retrained on EBPI Part A & B to help them understand decrease any maladaptive behaviors without an Level II Incident.	

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V 290	Continued From page 24 -There was no documentation that client #3 had been assessed for capability of having unsupervised time in the community without staff supervision. Interview on 6/28/22 with client #2 revealed: -He walked to the store about 2-3 times without staff supervision. He thought he last walked to the store unsupervised about two weeks ago. -Clients in that facility were not allowed unsupervised time in the community. Interview on 6/28/22 with client #3 revealed: -He walked to the store a few times without staff supervision since he resided at the facility. He was unable to specify how many times he walked to the store. They are not allowed unsupervised time in community. -He just recently talked to the Qualified Professional about having unsupervised in the community. The Qualified Professional told him she had to determine if he was appropriate for the unsupervised time in the community. Interview on 6/28/22 with Former Staff #3 (FS #3) revealed: -Clients #2 and #3 don't have any unsupervised time in the community. Clients #2 and #3 left the home without staff supervision on several occasions to walk to a local store and/or visit neighbor's homes. She thought clients #2 and #3 walked away from the facility unsupervised on a weekly basis. -She confirmed the facility failed to assess clients #2 and #3's capability of having unsupervised time in the community. Interview on 6/28/22 with Former Staff #4 (FS #4) revealed: -None of the clients at that facility had	V 290		

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	MHL001-215	A. BUILDING: _____ B. WING _____	C 07/01/2022

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V 290	Continued From page 25 unsupervised time in the community. -During her shift she thought client #2 walked away from the facility twice. She thought he walked to a store near the facility. -She thought client #3 walked away from the facility 4-5 times. He also walked to the store near the facility. They were gone between 15-30 minutes. -She confirmed the facility failed to assess clients #2 and #3's capability of having unsupervised time in the community. Interview on 6/28/22 with the Manager revealed: -None of the clients had unsupervised time in the community. -During his shift he thought client #3 walked away from the facility a few times, he could not specify how many times. Client #3 walked to the store near the facility. -He was not aware of client #2 walking away from the facility. -He confirmed the facility failed to assess clients #2 and #3's capability of having unsupervised time in the community. Interview on 6/29/22 with the Qualified Professional revealed: -No one in that facility had unsupervised time in the community. -Client #3 just recently approached her about having unsupervised time in the community. He wanted the unsupervised time in order to walk to the store without staff supervision. She told client #3 she had to do an unsupervised time assessment before he could walk to the store without staff supervision. -She knew client #3 was walking to the store without staff supervision because he mentioned it to her when he was requesting unsupervised time. She didn't know client #2 was walking to the	V 290		

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V 290	Continued From page 26 store and neighbor's homes without staff supervision. -She confirmed the facility failed to assess clients #2 and #3's capability of having unsupervised time in the community. Interview on 6/30/22 with the Director/Licensee revealed: -The clients in that facility had no unsupervised time in the community. -He was aware clients #2 and #3 were walking away from the facility without staff supervision. -Client #2 was walking to the store and neighbor's houses in the area. Client #3 was also walking to the store near the facility. They normally don't go too far and are only gone about 20 minutes. -He confirmed the facility failed to assess clients #2 and #3's capability of having unsupervised time in the community. The following is evidence the facility failed to provide supervision to meet the needs of clients. Review on 6/28/22 of client #1's record revealed: -Admission date of 6/13/13. -Diagnoses of Schizophrenia, Intellectual and Developmental Disability-not specified, Type II Diabetes, Hemoptysis, Hyperlipidemia, Hypertension and Obesity. -Admission Assessment dated 6/13/13-"[Client #1] could not return to previous group home due to aggressive behaviors [Client #1] does not interact appropriately. [Client #1] gets loud at times and ask for money and cigarettes. [Client #1] giggles at inappropriate times. [Client #1] has a history of hallucinations." -Discharge Summary from local hospital dated 5/15/22-Client #1 was seen at the Emergency Room on 5/15/22 for assault. He had a closed fracture of the nasal bone and a head injury. He	V 290		

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V 290	Continued From page 27 had a laceration repair done. Review on 6/28/22 of facility records revealed: -(1). Incident report dated 6/8/22-"[Client #3] was showing signs of aggression all day per staff. He was showing signs of agitation, no matter what was ask of staff he would say profanity towards the staff (F**k you) and he said that the staff can not tell him what to do or the owner... Around 4:30 pm today, [Client #3] and [Client #2] was having a heavy and heated talk about following rules. [Client #3] became upset and he stood up and I had (heard) [Client #2] ask him to back up out of his face. By the time the staff came out of the office, [Client #3] had choked [Client #2], and the staff said she (he) was moving his hand from around [Client #2's] face. Staff said that ask [Client #2] what happened, and [Client #2] said that [Client #3] had his hands around his neck. Staff check [Client #2's] neck and it was red, staff proceeded to call the police...[Client #3] was arrested and taken to local jail for assault." -(2). Incident report dated 5/15/22-"Found [Client #1] laying on sidewalk checked him looked like he was punched or hit with object in the face called EMS (Emergency Medical Services) and 911 took to hospital." Client #1 had a fractured nose. Interview on 6/28/22 with client #1 revealed: -He went to the hospital a little over a month ago. His nose was broken and bleeding. He didn't know what happened to his nose. -He was reluctant to discuss any specifics about his fractured nose. Interview on 6/28/22 with client #2 revealed: -During that incident with client #1 he never touched or hit him. -He found client #1 laying on the ground in the	V 290		

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V 290	Continued From page 28 front yard at the facility. He brought it to FS #3's attention. FS #3 called 911 for client #1. -He had an incident with client #3 about 3-4 weeks ago. He thought FS #4 was in the staff office area. He and client #3 were arguing, he could not remember the specifics of the argument. Client #3 then choked his neck. FS #4 came into their bedroom and asked them what was going on between them. He told FS #4 he was choked by client #3. FS #4 called 911 and client #3 was arrested. He had a red mark on his neck after client #3 choked him. -He was recently at the sister facility next door and had an incident with client #A7. Client #A7 got upset and tried to stab him with a fork. He had a lighter on him, took it out and burned client #7A's shirt by mistake. He was trying to scare client #A7, he didn't want to burn him. He thought staff #1 was working, however he didn't know if he was around during that incident with client #A7. Interview on 6/28/22 with client #3 revealed: -There was an incident with client #2 about 2-3 weeks ago. Client #2 said he choked him, he never choked client #2. Client #2 can be "manipulative, he does that to get what he wants." He got into an argument with client #2 during that incident. They were both upset and exchanged some words. Client #2 flipped over the book shelf in the hallway. He thought FS #4 was in the staff office initially, she then came into the hallway near their bedroom. Client #2 started saying he hit me, he choked me. FS #4 called the police department and he was arrested. He went to the hospital for an evaluation. -He had a "Substance Abuse Disorder." Staff caught him snorting the powder from a Benadryl capsule up his nostril 1-2 times. He also brought Benadryl from the store on one occasion. He	V 290		

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V 290	Continued From page 29 thought he took about 16 Benadryl capsules at one time. He felt normal after taking those 16 Benadryl capsules, he just felt "buzzed." He was taking Benadryl for his "anxiety." He thought those incidents with the Benadryl happened when he was admitted in February 2022. Interview on 6/29/22 with staff #1 revealed: -There was a recent incident between clients #2 and #A7. Initially clients #2 and #A7 were horse playing and then they started getting serious. Client #2 and #A7 starting arguing with each other. Client #2 was upset and punched a hole in the wall. He did see client #2 with a lighter in his hand, but he was just flicking the lighter. He never saw client #2 make any threatening movements towards client #A7 with the lighter. Interview on 6/28/22 with Former Staff #3 revealed: -She worked at the facility during the incident with clients #1 and #2. She thought the incident happened about a month ago. She heard client #1 "telling [client #2] what to do, like he was staff." She was looking out the window in the kitchen area and saw client #2 hit client #1 in his mouth. Client #2 hit client #1 in his face hard, he "cold cocked" client #1 in his face. Client #1 was laid out in the yard. She knew client #2 hit client #1 hard because he wore a lot of rings on his hands. She went outside and saw blood coming from client #1's nose. Client #1 was laying on the ground with his eyes closed. Client #1 was "knocked out cold." She was shaking client #1 and he came back around. Client #1's upper lip was split and his nose was still bleeding. Client #2 broke client #1's nose. She called the police department and Emergency Medical Services (EMS). She told the police what happened, because she thought client #1 was scared to tell	V 290		

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V 290	Continued From page 30 client #2 hit him. -Client #3 was crossing the highway near the group home just recently and was almost struck by a vehicle. Client #3 was running across the highway and was trying to beg a stranger for a soda. -She thought about 2 months ago client #3 walked to the store and brought some Benadryl. Client #3 took all of the Benadryl, she was not sure how many was in the container. Client #3 came to her and said he thought he overdosed on the Benadryl. Client #3's eyes were big, "it was like he was on speed." Client #3 said he did not want to go to the hospital, he would be ok. -About a month ago she gave client #3 a Benadryl capsule and saw him put the medication in his mouth. A few minutes later she saw client #3 in his bedroom. He was snorting the powder from the Benadryl capsule up his nose. She told client #3's physician he was not taking the Benadryl as prescribed. The physician discontinued the Benadryl because he was not taking it as prescribed. She thought client #3 told the doctor he needed the Benadryl and the doctor prescribed it for him. "They normally work alone, there is not two staff per shift. It's difficult working alone and trying to supervise six clients." Interview on 6/28/22 with Former Staff #4 revealed: -There was an incident with clients #2 and #3. She thought the incident occurred about three weeks ago. She was in the bathroom and heard a loud commotion and loud voices. Clients #2 and #3 were arguing and cussing at each other. When she came out of the bathroom she saw a shelf laying on the floor in the hallway outside of clients #2 and #3's bedroom. She then saw clients #2 and #3 standing in their bedroom. She	V 290		

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V 290	Continued From page 31 saw client #3 bringing his hands down to his side. Client #2 said client #3 choked him and she did see a reddish mark around client #2's neck. She did not see client #3 choking client #2. She felt like something happened because client #2's neck had a reddish mark. She called 911 and reported the incident. Client #3 was arrested and taken to the hospital by the police officers. -"They worked alone at the facility, it was not easy working with six clients. If one client is having issues or behaviors they were still responsible for supervising five other clients." Interview on 6/28/22 with the Manager revealed: -There was an incident with clients #1 and #2 that occurred towards the end of April 2022. He didn't have a lot of specifics because he wasn't working at the facility that day. Staff told him about the incident. He was told clients #1 and #2 got into an altercation. He thought client #1's jaw or nose was fractured. Staff called the police department. Client #1 refused to press any charges against client #2 . He thought EMS was called and client #1 was transported to the hospital. -He thought clients #2 and #3 got into an altercation about three weeks ago. Staff informed him client #3 choked client #2's neck. Client #3 was arrested and went to jail. Client #3 went to the hospital after leaving jail. He thought it was possibly for psychiatric reasons. -"They work alone and they are responsible for six clients. When you are working alone it can be difficult trying to supervise 6 clients." Interview on 6/30/22 with the Director/Licensee revealed: -Staff informed him client #2 assaulted client #1 during an incident in May 2022. FS #3 said both clients were on the front porch. FS #3 said she was in the staff office area getting some	V 290		

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V 290	Continued From page 32 paperwork completed. She saw client #2 come into the facility and wash his hands. She said she saw blood on client #2's hands. She went outside and saw client #1 laying on the ground and his nose was bleeding. He told her to call 911. Client #1 went to the hospital. They found out later client #1 had a fractured nose. -He was aware of the incident with clients #2 and #3. He couldn't remember which staff was working. Staff told him client #2 flipped a book shelf over onto client #3. Client #2 told staff he did that because client #3 choked him. Staff called 911 and client #3 was arrested. -He knew about the incident between clients #2 and #A7. He was told client #2 walked over to the facility next door. He was not supposed to be going to that facility to visit other clients. He was told client #A7 got agitated with client #2 and they got into an argument. Staff did not tell him client #2 had a lighter and burned client #A7's shirt. -He knew client #3 was taking Benadryl that was not prescribed. Staff informed him that client #3 took several Benadryl he purchased from the store. He went to the home that day and client #3 seemed to be ok. He thought he was fine because he had a history of substance abuse. Staff also made him aware of client #3 snorting the powder from a Benadryl capsule. The medication was discontinued by his physician after that incident. This deficiency was cited as a Standard Recite during the survey completed 5/24/22, but evidence in this survey has increased the severity of this deficiency. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 290		

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Alamance Homes I

625 N. Mebane Street
Burlington, NC 27217

DHSR - Mental Health

AUG 3 2022

Lic. & Cert. Section

North Carolina Department of Health and Human Services
Re: Annual Construction Survey

Greetings:

Thank you for allowing Alamance Homes I the opportunity to submit a plan of correction for the areas cited within our facility, on July 1 , 2022. Unfortunately, the QP (Cassandra Harvey, was stricken with Covid-19, which has caused a delay on the dates of implementing the information on the Plan of Protection for the home. As July 27, 2022, implementation of policies has been implemented.

Thank you,

Tim Rogers

Enclosed: Annual Survey Plan of Corrections