STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-053	A. BUILDING: _____ B. WING _____	07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VISTA GROUP HOME	38 THOMAS PARK DRIVE WAYNESVILLE, NC 28786

(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 An annual and complaint survey was completed on 7/18/22. The complaints (intake# NC00189162 and NC00189427) were substantiated. The complaint (intake # NC00189265) was unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 4 current clients.	V 000	RECEIVED By Mental Health Licensure & Cert. Section at 11:47 am, Aug 15, 2022	
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10 A	V 109	V 109 Program Coordinator and QM Residential Specialist draft training for all Residential QPs. Once the training s approved, it will be uploaded in ESUCP's online Training system and assigned at hire and annually. The online training will track completion. Program Coordinator will run a quarterly report to ensure all trainings are up to date. Attached copy of the terminated QPs training compliance. Program Coordinator's developed a new hire checklist for GH Managers to use.	8/10/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leslie Flowers, Snr. QM Director

TITLE

(X6) DATE: 8/10/22

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 109	Continued From page 1 NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 2 audited Qualified Professionals (Former QP #1) demonstrated the knowledge, skills and abilities required by the population served. The findings are: Review on 7/7/22 and 7/13/22 of the FQP #1's personnel record revealed: -hired 1/28/15 -position was House Manager/QP -terminated on 5/17/22 for "gross misconduct." Interview on 6/29/22 and 7/7/22 with Client #1 revealed: -when she went to bed Friday night (5/6/22), Former Staff #3 (FS #3) was at the facility; he was gone when she woke up the next morning -called FQP #1 and told her that FS #3 was not at the facility; FQP #1 said she could not come to the facility because she had her own AFL	V 109		

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V 109	Continued From page 2 (Alternative Family Living) clients -FQP #1 gave her the phone number for the Regional Program Director (PD); Client #1 called the Regional PD -FQP #1 "had already put in her 30 day notice but left before then." Interview on 6/29/22 with Client #2 revealed: -he was "shocked" when FQP #1 quit; she came back and then got fired -she "got fired on the account of [FS #3] walking out." Interview on 6/28/22 with Client #3 revealed: -FS #3 left while "we were all in bed;" he gave out medications the evening before and when she woke up, he was gone -they called FQP #1 but she didn't come in; "she had already quit but then they fired her" -the Regional Program Director (PD) arrived about 12:00pm. Interview on 6/29/22 with Client #4 revealed: -FQP #1 got fired because she didn't come in when they called her (on 5/7/22). Interview on 7/8/22 with FQP #1 revealed: -FS #3 left the facility sometime during the night (5/6/22) -Client #1 called her on the morning of 5/7/22 to inform her that FS #3 was not at the facility -she told Client #1 that she wasn't able to come to the group home because she couldn't leave her AFL (Alternative Family Living) clients -gave Client #1 the Regional PD's phone number and told Client #1 to call the Regional PD because she couldn't come to the facility -didn't have a phone list of other staff who she could call to go to the facility to work; the Regional PD had the list because she is over the	V 109		

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V 109	Continued From page 3 group homes -called the facility about 30 minutes later to check in; spoke with Client #1 who said the Regional PD was coming to the facility -she didn't get any texts from FS #3 the night that he left the facility -the facility was short staffed since last August (2021); both Staff #2 and FS #3 said the same thing (about being short staff) -she resigned 5/3/22 because she couldn't do the job of DSP (Direct Support Professional) and QP or stay ovenrights; she wanted to leave in good standing -was told she had to work a 4 week notice to leave in good standing becasue she was a house manager/supervisor -was fired once the IRIS (Incident Response Improvement System) reports were completed and HCPR (Health Care Personnel Registry) was notified -"nobody could get us any staff and when this happened (incident on 5/6/22), then they showed up with staff." Interviews on 7/1/22, 7/7/22 and 7/13/22 with the Regional PD revealed: -FQP #1 told Client #1 to call her (Regional PD) when they woke up and FS #3 was not at the facility on the morning of 5/7/22 -clients tried to call FQP #1 but the calls went to voicemail -she called FQP #1 several times but the calls went to voicemail -normally lived within an hour of the facility but was in a city approximately 4 hours from the facility at the time she received the call -there were no other staff available to go to the facility; she drove to the facility and arrived at approximately 1:00pm on 5/7/22	V 109		

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V 109	Continued From page 4 Review on 7/8/22 of FQP #1's written statement about the incident revealed: -received a call around 9:00am from Client #1 who informed her that FS #3 left the group home and the doors were unlocked -explained to Client #1 why she couldn't come to the facility and told Client #1 to contact the Regional PD -provided Client #1 with the phone number of the Regional PD -called the facility about 30 minutes later; Client #1 informed her that she talked to the Regional PD who would be at the group home around 2:00pm -asked if everyone was "Ok" and Client #1 said they were OK -called the group home again around 2:00pm and was informed by Client #5 that the Regional PD had arrived. This deficiency is cross referenced into 10 A NCAC 27D .0304 (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
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	V 110	V 110 Program Coordinator and QM Residential Specialist draft training for all residential DSPs. Once approved, this training will be uploaded in ESUCP's online Training system and assigned at hire and annually. The online training will track completion. Program Coordinators will run a quarterly report to ensure all trainings	8/10/22

			are up to date. Attached copy of the terminated DSPs training compliance.	

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V 110	Continued From page 5 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; (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 reviews and interviews, the facility failed to ensure 1 of 2 audited paraprofessionals, (Former Staff #3) (FS#3) demonstrated the knowledge, skills and abilities required by the population served and received supervision by a Qualified Professional (QP). The findings are: Review on 7/1/22 of Former Staff (FS) #3's personnel record revealed: -hired on 5/31/16 -position was Direct Support Professional (DSP) -terminated on 5/7/22 -reason for termination: "performance" -the last supervision note in FS #3's personnel record was dated 11/3/21	V 110		

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V 110	Continued From page 6 -a supervision plan signed on 6/25/21 by FS #3 and the Former Qualified Professional (FQP) #1 included: -supervision frequency as "monthly/daily" with "the minimum standard as 6x/year" -contact frequency: "monthly/daily" -contact methods: "1:1 Group: Telephone" -supervision topics were " ...training, essential learning, communication, availability." -the last supervision note in FS #3's personnel record was 11/3/21. Interview on 7/7/22 with FS #3 revealed: -was hired for the Wednesday 4:00pm to Saturday 8:00am shift but "shifts changed a lot" -in the six years he worked there, they were did not have full staff, the "main problem was staffing" -since August 2021, he worked 3-4 nights per week -he expressed the need for help to FQP #1 and the Regional Program Director (PD); he developed sleep apnea due to stress -told them (FQP #1 and Regional PD) that he was burned out; worked overtime for 8 months straight -FQP #1 only worked 4-5 overnights the whole time he worked at the facility -on the evening of 5/6/22, he texted FQP #1 and the Regional PD and said they need to get someone to the facility, that he was leaving -called FQP #1 but she did not respond to his call -he had been telling FQP #1 and the Regional PD that he was "burned out" and they needed additional staff -he left the facility around 8:30-9:00pm on 5/6/22 -there was no other staff at the facility when he left -he called and texted the Regional PD and informed her that he was leaving the facility that	V 110		

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V 110	Continued From page 7	V 110		

evening
-called FQP #1 but she did not respond to his call
-does not remember getting supervision from FQP #1 except one time
-got an "occasional thanks for working so hard"
-there were no monthly meetings.

Interview on 6/29/22 and 7/7/22 with Client #1 revealed:
-when she went to bed Friday night (5/6/22), FS #3 was at the facility; he was gone when she woke up the next morning (5/7/22).
-FS #3 "couldn't take it no more.....didn't feel like he was getting paid enough or feel appreciated"
-"[Client #4] was the first one up Saturday morning"; the front door and medication door were unlocked
-the Regional PD came "within a half hour."

Interview on 6/29/22 with Client #2 revealed:
-he spoke to FS #3 before he went to bed "around 9:30pm" and "everything was fine"
-when he woke up on the next morning, Client #1 and Client #3 were in the kitchen and told him that FS #3 was gone
-he started getting ready for his home visit
-the Regional PD had not arrived at the facility by the time his mother picked him up
-he was "maybe nervous about being there alone but more afraid of the unknown"; who was going to come in, staff that was going to be hired, who was going to give them their meds (medications).

Interview on 6/28/22 with Client #3 revealed:
-Former Staff (FS) #3 left while "we were all in bed;" he gave out medications the evening before and when she woke up, he was gone
-they called FQP #1 but she didn't come in; "she had already quit but then they fired her"
-the Regional PD arrived about 12:00pm

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V 110	Continued From page 8	V 110		

-when she learned FS #3 was not at the facility, "felt happy I guess;" she "didn't really like him very much"
-"everyone just had breakfast."

Interview on 6/29/22 with Client #4 revealed:
-she and Client #3 were up first on the morning after FS #3 left the facility
-was worried because she thought something happened to FS #3 but she was not scared about being without staff
-FS #3 was "mad ...something happened and he was mad about Easter Seals (licensee)"
-the Regional Program Director arrived at the facility around 11:00am.

Interview on 7/8/22 with the FQP #1 revealed:
-she provided supervision to FS #3
-Easter Seals (licensee) changed to another computer system around December 2021 and she wasn't trained in how to upload documents; she wasn't able to upload supervision notes
-she provided verbal supervision to FS #3 when she saw him.

Interviews on 7/1/22, 7/7/22 and 7/13/22 with the Regional PD revealed:
-at approximately 7:30pm on 5/6/22, FS #3 called her and stated he was going to quit; she replied that he needed to speak with FQP #1 (house manager) and follow protocol of giving a notice
-FS #3 also texted her that he was not going to be there but did not say that he was leaving that night
-had "problems" with him previously saying that he was going to quit; the next day, everything was OK
-knew that FS #3 was upset; in past he would get "cranky" and it "would blow over...had the same conversation with him every 3 months"

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V 110	Continued From page 9 -at approximately 8:30-9:00am on 5/7/22, Client #1 called her to say that FS #3 was not at the facility -the clients wouldn't necessarily know when FS #3 left or that he was gone if they were in their rooms or had gone to bed -FS #3 had clocked out at 8:30pm on 5/6/22 -Client #1 called Staff #2 who could not come to the facility -she did not review supervision notes for FQP #1 or other group home managers; she trusted that they did what they said they were doing. Interview on 7/6/22 with Staff #2 revealed: -she was out of town on 5/7/22 and not available to go to the facility. This deficiency is cross referenced into 10 A NCAC 27D .0304 (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 110		
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	V 112	V112 Program Coordinator will provide training to residential DSPs and QPs regarding documentation uploads in ESUCP's Electronic Health Record. Program Coordinator, QM residential Specialist, Program Director will review individual records and make corrections	8/30/22

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V 112	Continued From page 10 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 obtain the written consent for the treatment /habilitation or service plan by the client or legally responsible person and include a projected date of achievement for 2 of 4 audited clients (Client #1 and Client #3) The findings are: Review on 6/30/22 and 7/7/22 of Client #1's record revealed: -admitted on 9/3/16 -she has a guardian -diagnoses of Schizophrenia, Bipolar, Alcohol Use Disorder (d/o), Hypothyroidism, GERD (gastroesophageal reflux disease), Constipation, Fatigue, Hyperlipidemia, Hypertension, Type 2 Diabetes, Viral Hepatitis, Unspecified Intellectual Developmental Disability (IDD) -residential assessment for up to 6 hours of unsupervised time completed and signed by Former Qualified Professional (FQP) #1 and Client #1 on 7/28/21.	V 112		

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V 112	Continued From page 11 Review on 6/29/22 and 7/7/22 of Client #1's Person Centered Plan (PCP) revealed: -PCP was prepared on 9/27/21 and the "effective date was 4/20/22" Goals were: -engage in some type of physical activity (20) minutes (3) times per week -will have a minimum of 6 hours unsupervised time per day; will utilize staff and community resources to have needs met during her unsupervised time. -complete a weekly schedule that addresses daily chores such as dusting, cleaning the bathroom, vacuuming as assigned -prepare a low calorie, low sugar meal -the effective date under each goal was 2/1/21, not 4/20/22 -was not signed by Client #1's guardian. Review on 6/29/22 and 7/7/22 of Client #3's record revealed: -admitted on 1/4/16 -was her own guardian -diagnoses of Schizophrenia, Anxiety, Overactive Bladder, Mixed Incontinence, Hyperlipidemia, and Overweight -residential assessment for up to 6 hours of unsupervised time dated and signed by Client #3 and FQP #1 on 4/8/21. Review on 6/29/22 and 7/7/22 of Client #3's PCP revealed: Goals effective 11/2/21 were: -continue to work toward recovery by increasing independence in the area of completing household chores -continue to work towards losing weight and improving fitness level; will be encouraged to continue to see nutritionist -needs reminders of commitments and staying	V 112		

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V 112	Continued From page 12 focused on tasks; increase independence by learning to set aside time each morning and evening to read -wishes to increase independence during her unsupervised time by finding activities she enjoys doing; approved for up to 6 hours unsupervised time per day -there was no target date/projected date of achievement listed for each goal -there was no client signature on the PCP. Interview on 7/7/22 and 7/18/22 with the Program Coordinator/QP #2 revealed: -she was helping to cover shifts until new staff were hired; her first day at the facility was 5/25/22 -target dates on goal plans need to be updated manually in the system; Former Staff #4/Qualified Professional #1 (FS #4/QP #1) may not have known to update the goals/plans manually in the system -was working on reviewing all of the clients' goal plans.	V 112		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use;	V 120	V 120 Facility Checklist includes reviewing med closet and ensuring meds are locked – this is submitted monthly to the RN and completed by the GH Manager or their designee. The RN has random unannounced visits to the homes based on known needs and concerns. While there, the RN reviews the medication closet and ensure it is locked. The RN provides a report of her visit to the GH Manager and Program Director.	8/10/22

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V 120	Continued From page 13 (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on interviews, record reviews, and observations, the facility failed to ensure medications were stored securely affecting 6 of 6 clients (Client #1, #2, #3, #4, #5, and #6). The findings are: Observation at 10:18am on 7/7/22 of the medication closet revealed: -the medication closet was located in the staff bedroom/office and required a key to unlock the closet -there was one black lock box for controlled medications that required a key to unlock it -medications were stored in individually numbered bins for each of the clients -medications included, but not limited to, Topiramate (bipolar), Olanzapine (anti-psychotic), Pantoprazole (GERD), Atorvastatin (hyperlipidemia), Clozapine (schizophrenia), Lisinopril (hypetension), Lamotrigine (mood stabilizer), Myrbetrig (overactive bladder) Tri-Sprintec (birth control), Sertraline (depression), Amlodipine (heart disease), Aripiprazole (schizophrenia), Digoxin (atrial fibrillation), Eliquis (blood thinner), and Gabapentin (mood).	V 120		

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V 120	Continued From page 14 Review on 7/15/22 of Client #4's physician orders revealed: -Lisinopril (hypertension), Sertraline (depression), Amlodipine (heart disease), Aripiprazole (schizophrenia), Digoxin (atrial fibrillation), Docusate (constipation), Eliquis (blood thinner), and Gabapentin (mood). Interview on 6/29/22 with Client #1 revealed: -she woke up on a Saturday, the day before Mother's Day (5/7/22) and there was no staff at the facility -the door to the medication closet was unlocked -did not take her morning medications; she didn't want to get in trouble -"didn't think" anyone else took their morning medications. Interview on 6/29/22 with Client #2 revealed: -when he woke on the morning of 5/7/22, Client #1 and Client #3 told him that Former Staff (FS) #3 was gone -asked Client #1 and Client #3 about taking their medications; they said they didn't know about taking morning medications but the medication closet was unlocked -about 10:00 to 11:00am, his mother arrived at the facility to take him for a home visit -showed his mother which medication box was his and she took it from the closet for the home visit; his box was #3 -the Regional Program Director (PD) had not arrived before his mother came to pick him up Interview on 6/29/22 with Client #3 revealed: -when she woke up, FS #3 was not at the facility in the morning, she wasn't sure if the medicine closet was unlocked -she did not take her morning medication -the Regional PD arrived about 12:00pm and she	V 120		

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V 120	Continued From page 15 took her medication at that time. Interview on 6/29/22 with Client #4 revealed: -she and Client #3 were the first ones up on the morning after FS #3 left the facility -the door to the staff bedroom was open and the medication closet was unlocked -her medication was in box #4 -"Oh, I know which meds (medication) to take," the medications say "am" or "pm" and are divided by rubber bands (the bubble packs) -she took her morning medications; the other clients waited to take medication until the Regional PD arrived. Interview on 6/29/22 with Client #6 revealed: -woke up later in the morning after FS #3 left the facility -was told "by everyone in the house" that there was no staff at the facility -does not remember if the Regional PD had already arrived by the time she woke up -her glucometer was in the medication closet that FS #3 left unlocked -used her glucometer to check her blood sugar but did not take her morning medication. Interview on 7/7/22 with FS #3revealed: -"to the best of my memory", he did not leave the medication closet unlocked -"maybe" he left the keys in the door to the medication closet -there was a lock box for facility keys but it required a code to open it. Interview on 7/1/22 and 7/13/22 with the Regional PD revealed: -arrived at the facility at approximately 1:00pm on 5/7/22 -when she arrived, the door to the medication	V 120		

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V 120	Continued From page 16 closet was opened -the lockbox for controlled medications was unlocked but the lid was not open -contacted the pharmacist and administered morning medications to Client #1 and Client #3 as directed by the pharmacist -Client #4 had taken her medications; she reviewed the medications and Client #4 took her morning medications correctly -called Client #2's mother and Client #2 had taken his medications as prescribed. Interview on 7/8/22 with Client #2's mother revealed: -she arrived at the facility sometime between 10:00-11:00am on 5/7/22 -there was no staff on site at the facility -Client #2 showed her his medication box and she took the box for his home visit -Client #2 was "very familiar" with his medications even before he went to live at the facility. This deficiency is cross referenced into 10 A NCAC 27D .0304 (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 120		
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	V 366	V360 Senior QM Director provide incident Report Training to Regional Director. Assign Incident Report Training through RELIAS to all Residential staff and require it annually.	8/10/22

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V 366	Continued From page 17	V 366		

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 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

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V 366	Continued From page 18 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 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;	V 366		

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V 366	Continued From page 19 (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 reviews and interview, the facility failed to respond to level III incidents, determine the facts and causes of the incident and make recommendations for minimizing the occurance of future incidents and submit written preliminary findings of fact to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days of the incident affecting 6 of 6 clients (Clients #1, #2, #3, #4, #5, and #6). The findings are: Review on 6/29/22 and 7/8/22 of the Incident Response Improvement System (IRIS) revealed: -a Level III incident occurred on 5/6/22 and was discovered by the Regional Program Director (PD) on 5/7/22 -the incident was an allegation of neglect by Former Staff (FS) #3 for the leaving the facility and abandoning the clients, leaving the medication closet unlocked and the controlled medication box unlocked -incident reports were submitted on 5/11/22 for Client #1 and Client #4: -an incident comment by a local agency on 5/13/22 noted to conduct an internal investigation and upload results into IRIS for -there were no updates to the IRIS report after 5/11/22	V 366		

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V 366	Continued From page 20 -incident reports were submitted on 5/12/22 for Client #5 and Client #6: -there was no internal investigation uploaded into IRIS and no updates to the IRIS report after 5/12/22 -there were no IRIS reports submitted for Client #2 and Client #3. Interview on 7/7/22 with the Regional Program Director (PD) revealed: -her internal investigation consisted of gathering statements from residents at the facility and from the Former Qualified Professional (FQP) #1 -other than reporting the incident in the Incident Response Improvement System, there were no additional investigation findings to review. This deficiency is cross referenced into 10 A NCAC 27D .0304 (V512) for a Type A1 rule violation and must be corrected within 23 days.	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 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	V 367	V367 Restructure in QM to offer additional support for Incident submissions and investigations. Add QM Residential Specialist position and Senior QM Director. QM Specialist will upload all internal investigations. Incident Report Training will review timeframe for submission and timeframe for MCO Incident question follow-up. This training will be assigned to residential DSPs and Group Home Managers	8/10/22 8/10/22

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V 367	Continued From page 21 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 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	V 367		

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V 367	Continued From page 22 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 reviews and interviews the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services were provided within 72 hours of becoming aware of the incident affecting 4 of 4 audited clients (Clients #1, #2, #3, and #4). The	V 367		

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V 367	Continued From page 23 findings are: Review on 6/29/22 of the Incident Response Improvement System (IRIS) revealed: -a Level III incident alleging neglect by Former Staff #3 was reported on 5/11/22 for Clients #1 and #4 and on 5/12/22 for Clients #5 and #6 for an incident which occurred on 5/6/22 -Former Staff #3 left the facility on the evening of 5/6/22 leaving the residents unsupervised and left the office door open, the medication closet unlocked and the control medications box unlocked. Review on 6/29/22 and 7/8/22 of the Incident Response Improvement System (IRIS) revealed: -a Level III incident occurred on 5/6/22 and was discovered by the Regional Program Director (PD) on 5/7/22 -IRIS reports were submitted on 5/11/22 for Client #1 and Client #4 -there were no IRIS report submitted for Client #2 or Client #3. Interview on 7/1/22 with the Program Coordinator/Qualified Professional #2 revealed: -only Level I incident reports were documented in their internal system; Level II and Level III incidents were entered into IRIS -was unsure why incident reports were missing for Client #2 and Client #3; she said to talk to the Regional PD about the missing incident reports. Interview on 7/1/22 and 7/7/22 with the Regional PD revealed: -she completed IRIS reports for all 6 clients residing at the facility -she was not sure why the reports for Client #2 and Client #3 were not showing in IRIS; maybe she did something "wrong"	V 367		

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V 367	Continued From page 24 -found copies of the IRIS reports for Client #2 and Client #3 but did not have the report number in order to submit the reports -will contact IRIS and ask for directions on how to submit. Interview on 7/7/22 with IRIS customer service revealed: -a report for a Level III incident which occurred on 5/6/22 was created for Client #2 and Client #3 but not submitted -she could not determine on what date the incident report was created. This deficiency is cross referenced into 10 A NCAC 27D .0304 (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of	V 512	V 512 Program Director is completing a Leadership Development and Performance Improvement Plan by the program VP. Senior QM Director provided a training to the Regional Program Director on Incidents that included Abuse, neglect exploitation definition and what to do when made aware of this.	8/10/22 8/9/22

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V 512	Continued From page 25 intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews, 3 of 6 audited staff (Former Staff #3 (FS #3), Former Qualified Professional #1 (FQP #1), and the Regional Program Director (RPD)) neglected 6 of 6 clients (Clients #1, #2, #3, #4, #5, and #6). The findings are: Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record reviews and interviews, the facility failed to ensure 1 of 2 audited Qualified Professionals (Former Qualified Professional #1) demonstrated the knowledge, skills and abilities required by the population served. Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on record reviews and interviews, the facility failed to ensure 1 of 2 audited paraprofessionals (Former Staff #3) demonstrated the knowledge, skills and abilities required by the population served and did not receive supervision by a Qualified Professional. Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V120). Based on interview, record reviews, and observations, the facility failed to ensure medications were stored securely affecting 6 of 6 clients (Clients #1, #2,	V 512		

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V 512	Continued From page 26 #3, #4, #5 and #6). Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record reviews and interview, the facility failed to respond to level III incidents, determine the facts and causes of the incident and make recommendations for minimizing the occurance of future incidents and submit written preliminary findings of fact to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days of the incident affecting 6 of 6 clients (Clients #1, #2, #3, #4, #5, and #6). Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record reviews and interviews the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services were provided within 72 hours of becoming aware of the incident. Review on 6/30/22 and 7/7/22 of Client #1's record revealed: -admitted on 9/3/16 -she had a guardian -diagnoses of Schizophrenia, Bipolar, Alcohol Use Disorder (d/o), Hypothyroidism, GERD (gastroesophageal reflux disease), Constipation, Fatigue, Hyperlipidemia, Hypertension, Type 2 Diabetes, Viral Hepatitis, Unspecified Intellectual Developmental Disability (IDD) -residential assessment for up to 6 hours of unsupervised time completed and signed by Former Qualified Professional (#1) and Client #1 on 7/28/21.	V 512		

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V 512	Continued From page 27 Review on 6/29/22 of Client #2's record revealed: -admitted on 6/23/21 -diagnoses of Autism, Obsessive Compulsive d/o, GERD, Schizophrenia and Mild IDD -residential assessment for up to 6 hours of unsupervised time completed and signed by FQP#1 on 10/2/21. Review on 6/29/22 and 7/7/22 of Client #3's record revealed: -admitted on 1/4/16 -diagnoses of Schizophrenia, Anxiety, Overactive Bladder, Mixed Incontinence, PCOS, Hyperlipidemia, and Overweight -residential assessment for up to 6 hours of unsupervised time dated and signed by Client #3 and FQP #1 on 4/8/21. Review on 7/14/22 and 7/15/22 of Client #4's record revealed: -admitted on 6/20/01 -diagnoses of Paranoid Schizophrenia, Edema, Hyperlipidemia, Depression, Tobacco Use -residential assessment for up to 6 hours of unsupervised time completed on 4/15/21. Review on 7/13/22 of the Regional PD's personnel record revealed: -hired 1/1/20 -position was Adult Group Home Regional Program Director. Review on 7/8/22 of text messages sent between FS #3 and the Regional PD on 5/6/22 revealed: - text sent by FS #3 to the Regional PD at 8:53pm, " ...all done for tonight at the house with notes and meds. Yall need someone there at medtime tomorrow. Taking my other job offer for 15 doing the same. Not working a notice" -text sent by the Regional PD to FS #3 at 9:44pm,	V 512		

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V 512	Continued From page 28 "Call you house manager. I'm at another home" -text sent by FS #3 to Regional PD at 9:54pm, "texted her (FS #4/QP #1). All done and good job for helping. Thanks for entertaining my troublemaking calls and texts after 6 years" -there were no other text messages provided by FS #3 for review. Review on 7/8/22 of text messages sent by FS #3 to FQP #1 on 5/6/22 revealed: -"Was not threatening. Stating needs. All done for tonight at the house with notes and meds. Yall will need someone there at medtime tomorrow. Taking my other job offer for 15 doing the same" at 8:57pm -"about the email I sent. I'm gone sorry. I told you today" sent at 8:58pm. Review on 7/8/22 of text message sent on 5/8/22 from FQP #1 to FS #3 on 5/8/22 revealed: -"you need to tell [Regional PD]. They won't give you your vacation pay if you walk ..." sent at 5:03pm - there were no other text messages provided by FS #3 for review. Review on 7/8/22 of the Plan of Protection written and signed by the Program Coordinator/QP#2 on 7/8/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? All staff are instructed in job responsibilities that include 24-hour availability through the course of their shift. Availability during typical service hours may include direct service on-site and , in the community, but explicitly includes on duty staff remaining onsite overnight "sleep time" hours-either paid or unpaid-unless leaving to provide offsite support (i.e. hospital, transport, etc.).	V 512		

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V 512	Continued From page 29 -Any emergency that limits availability of on-duty staff or manager who needs to provide off-site service for any duration during sleep hours, or in excess of client's unsupervised time limits will immediately notify another site manager, QP, or Program Director to confirm backup staffing arrangements. -This has already been addressed with QP supervision of current staff since the incident , as documented within staff files, supervision notes: [Staff #2] 5/25/22, 6/8/22, 6/25/22, 6/31/22 [Staff #1] 5/20/22, 5/21/22 -Ongoing supervision will be continued at Park Vista Group Home on a minimum monthly basis by [Program Coordinator/QP#2]. -Future incident response will be supervised by [Program Coordinator/QP#2] or [Program Director], with reports filed as per protocol, including 72 hour IRIS report submission, and preliminary findings documented within the agency within 5 days. -Staff will ensure all medications and records remain secured as per protocol before leaving premises. -When off-site, a phone number for on shift staff will be posted, with back up emergency contact and numbers(s) clearly posted for clients, visitors, and emergency response personnel. -This has already been addressed as evident 7/8/22 Listed emergency contacts include: [Program Director]; [Program Coordinator/QP#2]; [Group Home Manager], (city approximately 2 hours away); [Direct Support Professional]. Also included on emergency contact list are 3 staff residing within less than 30 minutes, who are willing to accept calls and assist in securing response: [Staff #2], [Staff #1], [Direct Support Professional]. -Due to resident staffing ratio of 6:1, all residents	V 512		

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V 512	Continued From page 30 will have unsupervised time safety assessments updated at a minimum yearly, or more frequently as individual needs change. -All existing client unsupervised time assessments will be reviewed and/or updated as necessary updates within the next 7 days (to be completed 7/15/22), signed by clients/guardians, and reviewed with staff & QP signatures(s) at start of their next shift, -Staff may be off-site to provide direct and indirect client support while others remain, as per the limits of the individual's assessed unsupervised time limits. All staff have already been instructed on these guidelines and client individual specific competency trainings since the incident, as documented in staff files, group home orientation records, and individual specific competencies. These expectations will be reviewed and consented to by all staff and supervisory personnel at hire, and yearly. Describe your plans to make sure the above happens. -[Program Coordinator/QP#2], BSQP (Bachelor of Science/Qualified Professional), for site will ensure above actions are in place and communicated to [Program Director] for responsibility of oversight before end of current shift, 7/8/22. -Above actions noted as pending will be reviewed for compliance by 7/15/22. By [Program Director], [QM (Quality Management) Director], and any other agency representations as deemed appropriate by Easter Seals UCP of NC (licensee). -Training of above job responsibilities and precautions will be reviewed by appropriate agency representatives for QM, risk management, and HR (Human Resources) approval.	V 512		

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V 512	Continued From page 31 -All new and current staff training will include responsibilities and protocol to mitigate future risk of this nature." This facility serves adults whose diagnoses included Schizophrenia, Bipolar, Anxiety, Alcohol Use Disorder (d/o), Obsessive Compulsive d/o, Hypothyroidism, GERD (gastroesophageal reflux disease), Constipation, Hyperlipidemia, Hypertension, Type 2 Diabetes, Viral Hepatitis, Mild and Unspecified Intellectual Developmental Disability (IDD), Autism, Mixed Incontinence, and Overweight. During the evening of 5/6/22, FS #3 was the only staff on shift and clocked out of the group home at 8:30pm leaving 6 residents unsupervised after notifying the FQP #1 and the Regional PD that he was taking another job and not working a notice. Clients woke up the next morning to discover there was no staff present in the facility. Client #1 called FS #4/QP#1 at approximately 8:30am to inform her that FS #3 was not at the facility and FS#4/QP#1 told Client #1 to call the Regional PD. The Regional PD arrived at approximately 1:00pm. There was no staff present in the facility from approximately 8:30pm on 5/6/22 to approximately 1:00pm on 5/7/22. The medication closet was left open/unlocked and the controlled medication box was unlocked leaving access to medications which treat psychosis, bipolar disorder, depression, high blood pressure, high cholesterol and heart disease. Client #4 took her morning medications as prescribed and Client #2's mother took his medication box with her when she picked him up for a home visit on 5/7/22. There were no internal investigation completed within 5 business days of the incident and IRIS reports were submitted late for Client #1 and Client #4. There were no incident reports submitted in IRIS for Client #2 or Client #3. This deficiency	V 512		

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V 512	Continued From page 32 constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1,000 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 512		