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	MHL0411171	A. BUILDING: _____ B. WING _____	R-C 08/25/2022

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(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 and follow up survey was completed on 8/25/22. The complaints were substantiated (intakes #NC00191107 and #NC00191127). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living: Alternative Family Living in a Private Residence. The facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 1 current client and 1 former client.	V 000		
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 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	V 512		

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V 512	Continued From page 1 dismissal of the employee. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 paraprofessional (the Alternative Family Living (AFL) provider) and 2 of 2 qualified professionals (the Qualified Professional #1 (QP #1) and the Qualified Professional #2 (QP #2)) neglected 1 of 2 current clients (client #1) and 1 of 1 former client (Former Client #2 (FC #2)). The findings are: Review on 8/10/22 of client #1's record revealed: - An admission date of 10/2020 - Diagnoses of Mild Intellectual Disabilities; Cerebral Palsy; Mild Intermittent Asthma with Acute Exacerbation; Gastroesophageal Reflux Disease; Cellulitis; Hypertension; Hyperlipidemia; Esophageal Stricture; Sleep Apnea; Onychomycosis; DM (Diabetes Mellitus),Type 2 with Diabetic Dyslipidemia and Hiatal Hernia - 48 years old - An Individual Support Plan (ISP) dated 5/1/22 which was completed by client #1's care coordinator with a LME/MCO (Local Managed Entity/Managed Care Organization) and signed off on by the Qualified Professional #1 reflected the following: "...While at home, [client #1] requires physical assistance with most tasks involving a lot of physical movement. He uses a wheelchair to get around in the home and in the community and therefore relies upon others to complete most daily tasks, including using the toilet, taking care of his clothes, housekeeping and cleaning, bathing and taking care of personal hygiene and grooming, avoiding health and safety hazards ..." - "... [Client #1] can participate in these tasks in	V 512		

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V 512	Continued From page 2 many ways; he still needs the support of others to ensure that they are complete. [Client #1] also requires total assistance with getting dressed and taking medications, as he is unable to complete these tasks on his own - In addition to these factors, [client #1] cannot reposition himself independently and requires assistance from staff to protect his skin's integrity. [Client #1] cannot independently get out the bed and into his wheelchair in the event of an emergency. This causes a tremendous amount of anxiety for [client #1] - Medical support needs: [Client #1] has some medical needs that he requires support in order to maintain. [Client #1] is legally blind and would not benefit from wearing corrective lenses. He also requires support due to choking during meals and has severe acid reflux - [Client #1] must be lifted and transferred in all settings and is unable to complete this task on his own. He must be transferred to his wheelchair, to the bed, into his vehicle, into the tub or onto the toilet - [Client #1] can spend some time without support staff each day, either in the home or in the community. He is capable of using the phone and asking or calling for help. He is also capable of using his urinal without help as long as it has been stored in an accessible place when he is at home. He requires assistance when the urinal is not accessible..." - It was important he have access to his lumbar pack at all times as it held his wallet and cell phone - With proper planning, [client #1] can spend up to 2 hours alone safely in the home..." Interview on 8/10/22 with client #1 revealed: - On 7/11/22, the AFL provider left the facility to seek medical treatment	V 512		

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V 512	Continued From page 3 - While he and Former Client #2 (FC #2) remained at the facility, client #3 went with the AFL provider - He (client #1) was in bed in his bedroom as he had been recently diagnosed with Covid and was still recovering - He could not transfer himself from his bed to his wheelchair without assistance; however, he knew how to call the AFL provider if he needed to as well as 911 if there were an emergency - FC #2 was in his bedroom and most likely watching television although, he could not see him from where he was in his bedroom - He was not concerned about being alone in the facility because he had his cell phone and urinal next to him - Was more concerned about FC #2 because "[FC #2] is the type of person who will holler." - The AFL provider told him QP #1 and QP #2 were coming to the facility; however, he never saw or talked to either of them - "You know you can't see us through the window, come on." - When the AFL provider returned to the facility, he made sure he and FC #2 were ok, but he was upset that neither QP #1 nor QP #2 came inside the facility to check on him or FC #2 or to make sure they had something to eat or drink - "Nothing bad" happened while they were left alone at the facility - He didn't become hungry or thirsty while alone at the facility and he never heard FC #2 yell out - "[FC #2] seemed to be ok." - "[FC #2] was my main concern." - The AFL provider "had to go to the doctor ..." Review on 8/10/22 of Former Client #2's (FC #2's) record revealed: - An admission date of 12/21/18	V 512		

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V 512	Continued From page 4 - Diagnoses of Psychotic Disorder (D/O), Not Otherwise Specified; Asperger's D/O; Major Depressive D/O, Recurrent and Moderate Intellectual Disability - 76 years old - A discharge date of 8/1/22 - An ISP dated 9/1/21 and completed by his care coordinator with an MCO and signed off on by the AFL provider on 7/27/21 which reflected the following: "... [FC #2] is unable to bare weight to stand or walk and uses a wheel chair. He utilizes a hoyer lift for all lifts and transfers at the AFL and at the Day program. The hoyer lift is used to transfer in/out of bed, toilet, shower chair, recliner, sofa, Gerry chair and his wheel chair - [FC #2] takes daily medication to help control his symptoms of Major Depressive Disorder. When [FC #2] is frustrated it may turn into a crying spell especially if he really wants something or is not getting the attention he is seeking - [FC #2's] Psychotic d/o (disorder) symptoms are mainly controlled with daily psychotropic medication. When upset, [FC #2] will shake, yell and talk to himself - These symptoms seem to increase when he is tired. Support staff should talk with him, offer reassurance and redirection ..." - A "Risk/Support Needs Assessment" completed on 7/13/21 by FC #2's care coordinator revealed: " ... [FC #2] ...relies on others for all lifts, carries and transfers ..." - Required support to promote skin integrity which included being repositioned and turned every two hours or more often at the client's request as he had a history of developing pressure sores - FC #2's vision was impaired, and he relied on staff to describe his surroundings as well as full physical assistance to access help in case of an	V 512		

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V 512	Continued From page 5 emergency - Could not be left alone in the home or community as he required 24-hour supervision to ensure his safety No attempt was made to interview FC #2 as he had been discharged from the facility on 8/1/22 Interview on 8/12/22 with the AFL provider revealed: - Client #1 had been diagnosed with Covid during the weekend (7/9/22-7/10/22) and had been to the hospital twice but returned to the facility the same weekend - On 7/10/22, he notified QP #1 he (AFL provider) was not feeling well and might need other staff to provide coverage of the home should he need to seek medical treatment; however, neither the QP #1 nor the Director of the agency which oversaw his facility "had come up with a plan." - On 7/11/22, he had difficulty taking deep breaths and was experiencing pain in his back - Was concerned that if he were to begin to feel worse, neither he nor his clients would be able to call 911 - Sent the QP #1 and the Director a text message which stated he needed to go to an urgent care center because of the symptoms he was experiencing - The QP #1 and the Director responded to his text messages; however, neither of them were able to offer an immediate solution for staffing coverage - He sent a second email to the QP #1 and the Director and reported he was leaving the facility and going to an urgent care center - When he left the facility at approximately 12 pm, there were no other staff present in the facility	V 512		

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V 512	Continued From page 6 - Client #1 and FC #2 were in their bedrooms and in bed when he left the facility - Client #1 and FC #2 used wheelchairs and FC#2 required the use of a Hoyer Lift for transfers from his bed to his wheelchair - He had chosen to take client #3 with him because client #3's foods had to be pureed and if he left client #3 alone at the home without staff supervision, he might attempt to eat something he shouldn't and choke - He later learned via his "Ring" doorbell camera that QP #1 arrived at the facility within approximately 30 minutes of him having left - QP #1 and QP #2 came to the facility on 7/11/22; however, he never received an alert on his phone via his "Ring" doorbell camera that either of the QPs entered the facility - After being seen at the urgent care center and diagnosed with Covid and pneumonia, he picked up the medications he had been prescribed from a drugstore and then picked up food from a fast-food restaurant for the clients for dinner - Returned to the facility between 4 pm and 5 pm and observed QP #2 at the facility sitting in his vehicle; however, QP #2 drove away before he could speak with him - Felt both QPs (#1 and #2) should have entered the facility to check on the clients, especially because each of the clients were diabetics and their blood sugars could have dropped - QP #1 "sat outside, you can't monitor them from outside." - Client #1 reported to him he did not know the QPs (#1 and #2) had been outside of the facility - He updated the QP #1 and the Director about his medical condition; however, they had still been unable to locate staff willing to relieve him while he recovered, including his back up staff, or	V 512		

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others employed by the agency
- When he returned to the facility and found out no one was willing to come in and work for him and neither QPs (#1 or #2) had come inside the facility, he was "heated and let them know that not coming into the house was unacceptable."
- The Director informed him that it was his responsibility to find coverage for his home; however, he believed it was also the agency's responsibility to assist him in trying to find coverage as their name was on the license
- Since the events of 7/11/22, FC #2 had been discharged from the facility and he and the Director have decided to "part ways."
- Both the QP #1 and the Director were "fully aware" of what was going on at the facility and he needed assistance
- Felt he had done all he could do, in notifying the QP #1 and the Director as well as keeping them updated on the health status of the clients and himself via text and emails, so they could not refute what he had done
- "I love doing what I do ...."
- The AFL provider reported he had saved the text messages between himself and the QP #1 and the Director on 7/11/22 which would indicate the exact time when he left the facility and what he was being told by the QP #1 and the Director

Interview on 8/22/22 with QP #1 revealed:
- On 7/9/22, the AFL provider notified her via a text message client #1 had tested positive for Covid after a hospital visit on 7/8/22
- She told the AFL provider that he and all the clients should quarantine at the facility for at least the next five days per agency protocol which was based on the Center for Disease Control's (CDC's) guidelines
- On 7/11/22 at 11:51 am, she received a text message from the AFL provider requesting

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someone to come to the facility as he needed to go to the doctor (due to back pains and difficulty taking deep breaths)
- He texted again at 12:04 pm to report he planned to leave the facility to go to an urgent care center and would be taking client #3 with him and leaving clients (#1 and #2) at the facility with no staff present
- She texted the AFL provider back at 12:05 pm and informed the AFL provider she was looking for coverage for him
- She called the AFL provider and he confirmed he had already left the facility and had only client #3 with him
- Told the AFL provider he should not have left the clients (#1 and FC #2) alone at the facility and immediately went to the Director and reported the AFL provider had left clients at the facility alone
- Client #1 could be left in the facility without staff supervision for at least two hours; however, FC #2 could not be left alone
- After she spoke with the Director, she immediately left her office and arrived at the facility within "eight minutes."
- Believed it was 12:15 pm when she arrived at the facility; however, she did not enter because she had failed to bring any "PPE" (Personal Protective Equipment) with her
- "I rushed out with no gloves, mask, nothing."
- She did not feel it was safe for her to enter the facility because she did not have "PPE" and she had a family member who had already had a difficult time recovering from Covid
- Looked through FC #2's window and observed him to be asleep; however, she could not see client #1 because the blinds on his window were closed
- Believed the Director was maintaining phone contact with client #1 as he had a cell phone and could communicate

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V 512	Continued From page 9 - Between 3:45 pm and 4 pm, QP #2 arrived at the facility which allowed her the opportunity to leave - At 3:50 pm, she received a text message from the AFL provider which stated he was leaving the urgent care center and going to a pharmacy to pick up his prescriptions and that he was "pretty sure" he had Covid - She never entered the facility from the time she arrived (12:15 pm) until she left (between 3:45 pm and 4 pm) - Did not know if QP #2 entered the facility after she left - Had submitted a report to IRIS (Incident Response Improvement System) regarding the AFL provider having left the clients (#1 and FC #2) alone at the facility - Was no longer employed as the QP for the facility as she had resigned her position during the week of 8/15/22-8/20/22 - Did not provide an explanation of why she had resigned An attempt on 8/22/22 to interview QP #2 was unsuccessful and a request for a return phone call went unmet prior to the close of the survey on 8/25/22 Interviews on 8/23/22 and 8/25/22 with the Director revealed: - On 7/11/22, at 11:51 am, the AFL provider sent her and the QP #1 a text message (via a group text) requesting staffing assistance as he needed to seek medical care - He stated he was having difficulty breathing and experiencing some pain in his lower back - Client #1 was in the home recovering from Covid and the AFL provider was concerned he had contracted Covid from client #1 - At 12:04 pm, she received a second text	V 512		

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message from the AFL provider informing her that he was planning to leave the facility and go to an urgent care center
- The AFL provider was going to leave client #1 and FC #2 at the facility and take client #3 with him
- QP #1 responded via text message to the AFL provider at 12:05 pm informing him that she was looking for staff coverage for him
- At 12:31 pm, she received a text message from the AFL provider reporting he was at an urgent care center and there was a two hour wait
- When they learned clients (#1 and FC #2) were at the facility, alone, the QP #1 began preparations to go to the facility immediately
- She instructed the QP #1 to take "PPE" with her and petty cash to purchase food for the clients as she wasn't sure if the AFL provider had fed clients (#1 and FC #2) prior to his leaving the facility
- QP #1 stated she was in a hurry and went "flying out of the door" and shut the door in the Director's face
- QP #1 texted her at 12:35 pm and reported she had no "PPE," other than a mask and she did not feel comfortable going into the home and reported that she was outside of the facility
- Offered to bring "PPE" to the QP #1; however, the AFL provider texted that there were masks and gloves inside the facility and available for the QP #1 to use
- At 3 pm, she sent the QP #2 to the facility to allow for the QP #1 to leave as the QP #1's workday ended at 3 pm
- Prior to the QP #2 leaving for the facility, she gave him the "PPE" (shoe covers, a jacket, a bonnet for his head, gloves, disinfectant spray, and masks) necessary for him to enter the facility and he left with the items in a bag
- The AFL provider continued to text with her

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and the QP #1 throughout the afternoon and at 3:50 pm she learned that he was preparing to leave the urgent care center and pick up his medications
- Believed the QP #2 left the facility when the AFL provider returned between 4 pm and 5 pm
- On 7/13/22, the AFL provider sent her a video from his "Ring" doorbell camera and reported the video indicated that neither the QP #1 nor the QP #2 entered the facility on 7/11/22 but instead remained outside
- Didn't view the video; however, she spoke to each QP and asked them if they had entered the home on 7/11/22
- The QPs (#1 and #2) each reported they chose not to enter the facility because they did not want to risk contracting Covid
- Prior to her questioning them, neither QP reported to her they had refused to enter the facility and had instead remained outside in their car and/or on the front porch of the facility
- Client #1 was in the process of being discharged from the home per his request
- Prior to 7/11/22, the AFL provider had already submitted a 60-day notice of discharge for client #3 and the agency was in the process of finding him another placement
- The QP #1 had resigned effective 8/17/22 without any notice and the QP #2 had not returned to work since 8/19/22 and had also apparently resigned without notice
- FC #2's legal guardian requested FC #2 be moved from the facility due to the AFL provider leaving him at the facility unattended and he was discharged on 8/1/22
- On 7/20/22, she informed the AFL provider she planned to sever ties with him once clients (#1 and #3) were no longer in the facility
- She did not believe she could continue to work with him due in part to his actions on

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V 512	Continued From page 12 7/11/22 - Understood the AFL provider's frustration; however, she and QP #1 had attempted to find staffing coverage for him; however, no one was willing to go into a home with a client with an active case of Covid and a provider who might have Covid Developed a new policy regarding Covid in AFL settings as this situation had revealed how difficult it was to find coverage for clients, especially three clients who resided in an AFL setting and having those facilities simply following CDC guidelines were not sufficient - Also understood the QPs' concerns regarding Covid; however, the clients should not have been left unsupervised by the AFL provider or the QP #1 or the QP #2 - Since the events of 7/11/22, the AFL provider learned that he did not have Covid based on his test results from 7/11/22 Review on 8/23/22 at 12:40 pm of the text message sent to Director and the QP #1 via a group text revealed: - "I'm getting ready to pack up and go to [urgent care center]. [Client #1 and FC #2] can "I'll be left here unattended. Unfortunately, I have to be well too to take care of the clients and I don't want to get it destress and can't call 911 and [FC #2 and #3] can't call 911 and y'all be at the office. Hopefully, I can be back as soon as possible." Review on 8/25/22 of a Plan of Protection completed and signed by the Director on 8/25/22 revealed: - "What immediate will the facility take to ensure the safety of the consumers in your care? The agency has sent notification to staff requesting staff to sign up to provide back-up	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411171	A. BUILDING: _____ B. WING _____	R-C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 512	Continued From page 13 coverage to AFL providers in the event the AFL provider becomes sick in situations of COVID or other communicable disease circumstances, explaining that in these types of scenarios, the back-up staff will be paid time and a half per hour of their hourly rate when they cover hours for the AFL provider. Or when the staff provides overnight coverage, the staff will receive the AFL provider's full daily rate. Staff will also receive a free COVID test from the agency at the end of their coverage period. At this point, four staff have signed up including [names of staff] - Describe your plans to make sure the above happens. Back-up staff serving in situations of COVID and other communicable disease situations must document their hours in electronic billing through Therap and complete a paper time sheet. Staff persons who provide coverage during the day or by the hour will document their time and a note of consumers supported in T-Log of Therap. The time sheet must be signed by the AFL provider or other person providing oversight in the absence of the AFL provider. The signed time sheet is an added layer of protection in order to ensure proper payment of hours. The assigned QP will oversee and ensure submission of documentation. All payments will be completed through the agency payroll process. The Director will oversee and ensure the payment process." This facility is in a private residence and is licensed to serve three clients. The clients' mental health diagnoses included Mild and Moderate Intellectual Disabilities; Asperger's D/O; Major Depressive D/O and Psychotic D/O. Significant health concerns for one of the three clients included but were not limited to the following: Cerebral Palsy, Asthma, Gastroesophageal Reflux Disease; Cellulitis; Hypertension;	V 512		

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V 512	Continued From page 14 Hyperlipidemia; Esophageal stricture and Type 2 diabetes. The provider left two of his three clients in the facility without staff supervision and took the third with him when he sought medical treatment on his behalf. The two clients the provider left in the facility alone were in their beds in their individual bedrooms with one client still recovering from Covid with no staff present prior to his leaving. Neither client could ambulate on their own and relied on the use of a wheelchair. Neither client could transfer from their bed to their wheelchair without assistance from others, including the use of a Hoyer Lift. After learning the provider had left the clients alone in the facility, the Director of the agency which provided Qualified Professional (QP) oversight on behalf of the provider, sent two QPs to the facility at different times during the day to ensure the clients were cared for until the provider returned. Because one of the clients had Covid, neither QP went inside the facility but instead remained outside and sat in their car or on the front porch of the facility. Although, one of the clients could be in the home without staff supervision for two hours; he was sick in bed with Covid and with staff making no special accommodations to address his possible needs. The other client required 24-hour supervision based on his level of need and should not be left without staff supervision at any time. The provider left the facility at 12 pm and returned between the hours of 4 pm and 5 pm. Two QPs were sent to the home to care for the clients; however, the clients remained unsupervised from 12:30 pm to no later than 5 pm as neither QP entered the facility to ensure the clients' needs were attended to. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23	V 512		

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V 512	Continued From page 15 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		