STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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, complaint and follow-up survey was completed on September 28, 2022. The first complaint was substantiated (NC#192475) and the second complaint was unsubstantiated (NC#193110). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. The facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 2 current clients and one former client.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 108	Continued From page 1 techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure training in Cardiopulmonary Resuscitation (CPR) and First Aid for 3 of 3 audited staff (Staff #1, Staff #2, and Qualified Professional). The findings are: Review on 9/23/22 of Staff #1's personnel record revealed: -Date of hire: 5/8/11 -CPR/First Aid Certificate dated 7/30/21; -the training certificate was noted to be online only. Review on 9/22/22 of Staff #2's personnel record revealed: -Date of hire: 2/25/21 -CPR/First Aid certificate dated 3/15/21; -the training certificate was noted to be online only. Review on 9/23/22 of the Qualified Professional's personnel record revealed: -Date of hire: 5/28/19 -CPR/First Aid certificate dated 6/10/21; -the training certificate was noted to be online	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 108	Continued From page 2 only. Interview on 9/26/22 with Staff #2 revealed: -CPR training was online only, she "had to click the mouse to the beat of the compressions." Interview on 9/28/22 with the Qualified Professional revealed: -they had done online training due to COVID-19 pandemic; -the facility had mannikin dummies to use with an instructor for CPR and they needed to schedule the instructor to come back; -she knew there needed to be hands on component for CPR/First Aid training.	V 108		
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 means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information;	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 367	Continued From page 3 (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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 367	Continued From page 4 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 report level 2 incidents to the LME/MCO (Local Management Entity/Managed Care Organization) within 72 hours of becoming aware of the incident. The findings are: Review on 9/22/22 and 9/23/22 of Former Client (FC #3's) record revealed: -Admission Date: 1/20/20; -Discharge Date: 8/27/22 -Diagnoses: Severe Intellectual Developmental Disability (IDD), Autism Spectrum Disorder,	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 367	Continued From page 5 Cerebral Palsy, Nocturnal Enuresis, Spastic Paraplegia, Hypothyroidism, Depression, and Allergies; -Internal documentation of incidents with FC #3 for pulling out his foley catheter, daily falls, destruction to group home property, breaking his walker, verbal aggression, hitting his head against a wall when upset, daily incontinence, crawling into other peer's rooms at night, and stealing; -a behavioral plan dated 12/21/20 to address FC #3's self-injurious behaviors, compliance with staff, rules, and incontinence issues. Review on 9/22/22 of North Carolina Incident Response Improvement System (IRIS) revealed: -no incidents reported for FC #3 or the facility. Review on 9/23/22 of internal incident reports from 7/1/22 to 9/23/22 for FC #3 revealed: -8/20/22, "cause: self-injurious behavior ...7:15PM, [FC #3] was in his room and was asked to put clothes away ...[FC#3] wanted to go home ...; -[FC #3] hit his forehead on the wall a few times ...then took the tubing from his catheter and separated the two ends that were connected, dripping urine into the floor; -[FC #3] needed to use the restroom ...staff stepped out for a few minutes, [FC #3] hollered for staff and [FC #3] had pulled his catheter out and stated he pulled it out ...there was blood inside the toilet, floor, and on the toilet, ...[FC #3] was holding the catheter in his hand and ...and staff called 911 and QP (Qualified Professional); -8/21/22, cause: outside/crawling through a window, 8:30AM, Staff found [FC #3] in his bed this morning ...staff were unaware that [FC #3] had come back to the group home from being taken to the hospital ...[FC #3] legs/knees had	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 367	Continued From page 6	V 367		

cuts and scrapes on them;
-[FC #3] reported that he was crawling around outside last night (8/21/22) and did it when he was coming in through a peers window to get inside the house."

Review on 9/27/22 of medical records from 2/1/22 to 9/22/22 for FC #3 from a local hospital revealed:
-FC #3 had 4 visits to the emergency room via Emergency Medical Services (EMS) from the group home for pulling out his catheter on 3/21/22, 4/6/22, 5/24/22, and 8/20/22.

Interview on 9/26/22 with Staff #1 revealed:
-"[FC #3] had behaviors that day (8/20/22) ...I stepped away and came back and he said here's my catheter; I had to call 911;
-the only way I knew [FC #3] was back at the facility on 8/21/22 was because 'I saw a urine spot in the living room that morning' ... and found [FC #3] in his bedroom;
-[FC #3] told her that the sheriff brought him home and left him (at the facility) ...he crawled outside, around a bush to another client's window that was open ...he then crawled out of her room and back into the living room;"
-FC #3 was observed by Staff #1 to have his clothes on backwards and there was no catheter and he had scrapes on his knees;
-Staff #1 followed back up with the hospital who advised that FC #3 was discharged with a catheter and brought home by law enforcement.
-she completed General Event Reports (GERS) regarding these incidents and others, she did not put incidents into IRIS system.

Interview on 9/26/22 with Staff #2 revealed:
-FC #3's self-injurious behaviors were "slamming his hand in the wall, punching the wall, head

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 367	Continued From page 7	V 367		

hitting the wall, not using his walker ...it was a lot of picking at his skin ...he would pick it till he bled;"
-"Even the day he left ...he broke some of the alarms on the door;"
-she filled out GERS for FC #3 when there was an incident;

Interview on 9/27/22 with FC #3's guardian revealed:
-the facility did contact her when there was an incident with her son (FC #3);
-her son had always been incontinent ... "he was better with me than with them about that and gave them a hard time;"
-"there wasn't much they could do about the falls ...I couldn't fault them;"
-her son got a catheter 4-5 months ago, he pulled it out several times and it was replaced;
-the last time he pulled it out (the 8/20/22 incident) ....I said, "don't put it back in ....he had pulled it out 5-6 times at least."
-she reported being unaware that her son crawled through another peer's window to get back in the group home after being dropped off by law enforcement in the middle of the night on 8/21/22.

Interview on 9/27/22 with the Care Coordinator for FC #3 revealed:
-she became involved as a Care Coordinator for FC #3 after the guardian received notice of discharge on 7/28/22;
-when looking at placement for FC #3, they (LME/MCO) had never received any incident reports from the facility regarding FC #3.

Interview on 9/28/22 with the Qualified Professional revealed:
-she was responsible for reviewing the incident reports for the facility;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 367	Continued From page 8 -she also completed General Event Reports (GER)'s for FC #3; -she did not input any of FC #3's incidents in IRIS; -the facility had been short staffed and had not been able to do this.	V 367		
V 368	G.S. 122C-63 Assurance for continuity of care § 122C-63 ASSURANCE FOR CONTINUITY OF CARE FOR INDIVIDUALS WITH MENTAL RETARDATION (a) Any individual with mental retardation admitted for residential care or treatment for other than respite or emergency care to any residential facility operated under the authority of this Chapter and supported all or in part by state-appropriated funds has the right to residential placement in an alternative facility if the client is in need of placement and if the original facility can no longer provide the necessary care or treatment. (b) The operator of a residential facility providing residential care or treatment, for other than respite or emergency care, for individuals with mental retardation shall notify the area authority serving the client's county of residence of his intent to close a facility or to discharge a client who may be in need of continuing care at least 60 days prior to the closing or discharge. The operator's notification to the area authority of intent to close a facility or to discharge a client who may be in need of continuing care constitutes the operator's acknowledgement of the obligation to continue to serve the client until: (1) The area authority determines that the client is not in need of continuing care; (2) The client is moved to an alternative residential placement; or	V 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 368	Continued From page 9 (3) Sixty days have elapsed; whichever occurs first. In cases in which the safety of the client who may be in need of continuing care, of other clients, of the staff of the residential facility, or of the general public, is concerned, this 60- day notification period may be waived by securing an emergency placement in a more secure and safe facility. The operator of the residential facility shall notify the area authority that an emergency placement has been arranged within 24 hours of the placement. The area authority and the Secretary shall retain their respective responsibilities upon receipt of this notice. (c) An individual who may be in need of continuing care may be discharged from a residential facility without further claim for continuing care against the area authority or the State if: (1) After the parent or guardian, if the client is a minor or an adjudicated incompetent adult, or the client, if an adult not adjudicated incompetent, has entered into a contract with the operator upon the client's admission to the original residential facility the parent, guardian, or client who entered into the contract refuses to carry out the contract, or (2) After an alternative placement for a client in need of continuing care is located, the parent or guardian who admitted the client to the residential facility, if the client is a minor or an adjudicated incompetent adult, or the client if an adult not adjudicated incompetent, refuses the alternative placement. (d) Decisions made by the area authority regarding the need for continued placement or regarding the availability of an alternative placement of a client may be appealed pursuant to the appeals process of the area authority and	V 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 368	Continued From page 10	V 368		

subsequently to the Secretary or the Commission under their rules. If the appeal process extends beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange a temporary placement in a State facility for the mentally retarded pending the outcome of the appeal.

(e) The area authority that serves the county of residence of the client is responsible for assessing the need for continuity of care and for the coordination of the placement among available public and private facilities whenever the authority is notified that a client may be in need of continuing care. If an alternative placement is not available beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange for a temporary placement in a State facility for the mentally retarded. The area authority shall retain responsibility for coordination of placement during a temporary placement in a State facility.

(f) The Secretary is responsible for coordinative and financial assistance to the area authority in the performing of its duties to coordinate placement so as to assure continuity of care and for assuring a continuity of care placement beyond the operator's 60-day obligation period.

(g) The area authority's financial responsibility, through local and allocated State resources, is limited to:

(1) Costs relating to the identification and coordination of alternative placements;

(2) If the original facility is an area facility, maintenance of the client in the original facility for up to 60 days; and

(3) Release of allocated categorical State funds used to support the care or treatment of the specific client at the time of alternative placement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 368	Continued From page 11 if the Secretary requires the release. (h) In accordance with G.S. 143B-147(a)(1) the Commission shall develop programmatic rules to implement this section, and, in accordance with G.S. 122C-112(a)(6), the Secretary shall adopt budgetary rules to implement this section. (1981, c. 1012; 1985, c. 589, s. 2.) This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to notify the area authority Local Management Entity/Managed Care Organization (LME/MCO) serving the client of the intent to discharge a client with an intellectual developmental disability at least 60 days in advance prior to discharge affecting 1 of 1 Former Client (FC #3). The findings are: Review on 9/23/22 of the facility's discharge summary for FC #3 revealed: -the date of the summary was noted as 6/1/22; -the discharge meeting described in the summary was held on 7/28/22; -the reason for FC #3's discharge was due to increased medical needs and supervision; -Intermediate Care Facility (ICF) placement or alternative placement at a specialty hospital was recommended, with 24-hour supervision. -attached to the summary was FC #3's updated behavioral evaluation, signed on 7/19/22, that included the following recommendation: "1. [FC #3] would benefit from higher levels of	V 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 368	Continued From page 12	V 368		

continuous supervision then are available at his current placement level;"
-discharge date was noted to be 8/27/22.

Review on 9/23/22 of the facility's policy for discharge revealed:
- "The ARC of Haywood will act in accordance with North Carolina Statute 122C-63 which provides standards when discharging individuals with IDD and Mental Health (MH) disabilities from a residential setting;
-3. If the Admissions/Discharge committee decides an individual should be discharged ...when health or safety issues are involved, discharge will be immediate;
-In other discharge situations, at least sixty days' notice will be given."

Interview on 9/26/22 with Staff #1 revealed:
-prior to discharge, FC #3's self-injurious behaviors had "gotten bad ....he would pick sores on his feet, said he couldn't feel it ...and would take his head and bang it repeatedly against the wall ...I would put a pillow in between it;"
-FC #3 would rip his catheter out between Urology visits and end up back at the hospital;
-his behavior plan worked at first and then "[FC #3] just didn't care;"
-"[FC #3's] needs increased over time to more than what we could do."

Interview on 9/26/22 with Staff #2 revealed:
-she did not think the facility was an appropriate placement for FC #3 due to his needs;

Interview on 9/27/22 with FC #3's guardian revealed:
-she was notified of the decision to discharge FC #3 after the meeting on 7/28/22;
-she was not aware if the facility tried to look for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-036	A. BUILDING: _____ B. WING _____	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #4	185 FARLEY STREET 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 368	Continued From page 13 placement for FC #3 after recommending discharge; -FC #3 was currently at an emergency respite facility while they were trying to find placement; -she denied having discussions about discharging her son prior to July 2022; -she did not think 30 days was enough notice. Interview on 9/27/22 with the Care Coordinator for FC#3 revealed: -she got involved with FC #3's care after the discharge notice was given by the facility; -a 30-day notice was given by the facility on 7/28/22 and the statute is 60 days; -she felt like the facility used FC #3's last incident on 8/20/22 when he went to the hospital as justification not to extend his discharge date. -the facility did not work on finding him placement. Interview on 9/28/22 with the Qualified Professional revealed: -FC #3's behaviors and urinary issues were not disclosed at admission; -in June 2022, the facility was trying to have conversations with FC #3's guardian but she stopped communicating; -the facility then sent a certified letter and email to FC #3's guardian about the discharge meeting; -the discharge meeting was held on 7/28/22 and this was when 30 day notice was given; -it had gotten to a point where the safety and well-being of the other residents in the facility were at risk; -"[FC #3] needed someone 24/7;" -they tried to get FC #3 into a rehabilitation center at this time, but the guardian did not cooperate; -she understood that the statute requirement was 60 days.	V 368		