STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-288	A. BUILDING: _____ B. WING _____	R 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENT LIVING GROUP HOME AT OLD SALISE	2415 OLD SALISBURY ROAD WINSTON-SALEM, NC 27127

(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 follow up survey was completed on 11/2/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

[redacted] SIGNATURE Operator TITLE 11/23/22 (X6) DATE

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V 111	Continued From page 1	V 111		
	This Rule is not met as evidenced by: Based on records review and interview, the facility failed to ensure an assessment was completed prior to the delivery of services affecting 1 of 3 clients (#1). The findings are: Review on 10/28/22 of client #1's record revealed: - Admission date: 7/15/19 - Diagnoses: Mild Intellectual and Developmental Disabilities (IDD); Oppositional Defiant Disorder and Disruptive Mood Dysregulation Disorder - Admission assessment did not include the following information about client #1: needs, strengths, social history, family history and medical history. Interview on 11/1/22 with the Qualified Professional: - He was unable to provide a completed admission assessment for client #1.		The agency will ensure that a admission assessment is done on all residents and placed in their records. The Director will be responsible for ensuring this takes place. This will happen immediately and will be ongoing	11/21/22
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration:	V 118		

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V 118	Continued From page 2 (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have written orders of a physician and to keep the MARs current affecting 1 of 3 audited clients (#1). The findings are:	V 118	The agency will ensure that we keep an ongoing record of all prescriptions/physicians orders for any medication prescribed. The agency will also ensure that the MAR are kept current and in the client file. The Director and QP will ensure that this takes place by increasing staff monitoring. This will be ongoing.	11/21/22

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V 118	Continued From page 3 Review on 10/28/22 of client #1's October 2022 MAR revealed: - Benztropine 1 mg (milligrams): take one tablet twice daily - Divalproex 250 mg: take 3 tablets twice daily - Topiramate 100 mg: take 1 tablet twice daily - Chlorpromazine 100 mg: take 1 tablet 3 times daily - Gabapentin 300 mg: Take 1 capsule 3 times daily. - There were no staff signatures that indicated client #1 had been administered her medication from 10/1/22-10/28/22. Interview on 10/28/22 with staff #4 revealed: - She had received client #1's October 2022 MAR sheet from the pharmacy today. This was the reason there was no MAR sheet for client #1 with staff signatures for October 2022. Review on 10/28/22 of client #1's record revealed: - There were no physician orders for her medications. Interview on 10/28/22 with client #1 revealed: - She took medications every day and could visually identify her medications. - Denied staff missing any doses of her medications. Interviews on 10/28/22 and 11/2/22 with the Licensee #1 revealed: - She had requested all the physician orders for the clients on 10/28/22. - Questioned if the staff had provided client #1's MAR for October 2022.	V 118		

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V 366	Continued From page 4	V 366		
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 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	V 366		

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V 366	Continued From page 5 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 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	V 366		

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V 366	Continued From page 6 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; (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 review and interviews the facility failed to implement written policies governing their response to level I incidents. The findings are: Interview on 11/1/22 with client #3 revealed: - He had run away 3 times in the past month to various stores. Interview on 11/1/22 with staff #2 revealed: - Client #3 had run away 3 times in the past month and was found at various stores. Review on 11/2/22 of Level I incident reports revealed:	V 366	The agency will ensure that all incidents are categorized and put into IRIS based on the NCDHSR rules and regulations. The agency QP will be responsible for ensuring these reports are put into IRIS within the timeframe. This will happen immediately and will be ongoing.	11/21/22

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V 366	Continued From page 7 - There was no level I incident reports regarding client #3 running away from the group home. Interview on 11/1/22 with the Qualified Professional revealed: - He did not write any incident reports regarding client #3 running away from the group home in the past month.	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 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	V 367	See V366	11/24/22

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V 367	Continued From page 8 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 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	V 367		

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V 367	Continued From page 9 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 all Level II incidents that occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings are: Review on 10/27/22 of the Incident Response Improvement System (IRIS) revealed: - There were no incident reports regarding client #1 eloping in October 2022. Interview on 10/28/22 with client #1 revealed: - Since she had returned to the group home in September 2022 she had "walked off two times." - The police had been called both times. Interview on 11/1/22 with the Qualified Professional revealed:	V 367	See V 364	

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V 367	Continued From page 10 - He had entered two reports in IRIS when client #1 had run away in October 2022. Interview on 11/1/22 with the IRIS staff revealed: - There were 2 incidents: one on 10/16/22 and one on 10/22/22 in IRIS that were created regarding client #1 running away but they were never submitted.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on record review, observation, and interviews, the facility was not maintained in a safe, clean, and orderly manner. The findings are: Observations from 3:40 pm - 4:43 pm on 10/27/22 of the group home revealed: - Client #1's bedroom window had screws on both sides of the window which prevented it from opening. Client #1's bedroom had only one window. - The inside of the oven door and oven had baked/burnt food. The microwave had splattered food inside. - The refrigerator had liquid marks running down the outside of the refrigerator door. - There were various items cluttering the den	V 736	The agency will ensure that the home is kept in a safe and orderly manner. The agency will ensure that the staff and residents are keeping the house clean. The agency will ensure that any appliances are kept clean	11/21/22

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V 736	Continued From page 11 floor. On top of the den furniture were the following items: a plate, drink bottles, papers, box, and paint can. - The bathroom countertop had: a roll of toilet paper, wet wash cloth, 5 used soap bars with a toothbrush/toothbrush bristle that laid on the dirty counter near the used soap. - The bathroom sink was clogged. - The inside of the toilet had a dark ring. The caulking around the toilet had dirt and urine stains. Review on 10/28/22 of client #1's record revealed: - Admission date: 7/15/19 - Diagnoses: Mild Intellectual and Developmental Disabilities (IDD); Oppositional Defiant Disorder and Disruptive Mood Dysregulation Disorder - Review of client #1's person-centered profile dated 7/18/22 revealed: " ...needs staff to monitor her due to aggressive behavior, her sexual promiscuity, elopements (and attempts to persuade other housemates to go with her) ..." Interview on 10/28/22 with client #1 revealed: - Sometime around Christmas time 2021 someone put screws in her bedroom window "because I kept running away." - "One day I was looking at the window and I was trying to see if they were real screws. I tried to open up my window and it wouldn't (open)." Interview on 10/27/22 with staff #1 revealed: - There were screws on each side of client #1's window because "she used to elope a lot." - "Probably maintenance" put the screws on the sides of client #1's window. Interview on 10/27/22 with the Licensee #1 revealed:	V 736	and that anything in disrepair will be removed/replaced. the agency QP will increase monitoring at the group home and will be responsible for ensuring this happens. the group home owner will ensure that any repairs that are needed at the home will not cause a safety hazard to the	

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V 736	Continued From page 12 - Client #1's window had screws installed on both sides that prevented the window from opening because "I think her window was broken." The glass on the window was not broken but the window was broken. - She would have to check with her husband (Licensee #2) who did maintenance on the group homes to find out more information. Interview on 10/28/22 with the Qualified Professional (QP) revealed: - From his understanding client #1's window had screws installed on both sides that prevented the window from opening because "the window was broken." - "[Licensee #2] couldn't lock the window and he screwed it down." Interview on 11/1/22 with the Licensee #2 revealed: - He had put screws in client #1's window "about 3-4 months ago." - He put screws on both sides of client #1's window because client #1 had pushed the latches out and that is what broke the window causing it to fall out. - On 10/27/22, he got new latches for the window, and it is now repaired. Review on 10/27/22 of the Plan of Protection dated 10/27/22 written by the Licensee #1 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The agency will implement increase fire drills which include the residents demonstrating opening their window and this will be done on a monthly basis instead of quarterly. The agency will maintenance checks to include ensuring windows open properly. Describe your plans to make sure the above	V 736	people we Serve. This will take place immediately and will be ongoing.	

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INDEPENDENT LIVING GROUP HOME AT OLD SALISI	2415 OLD SALISBURY ROAD WINSTON-SALEM, NC 27127

(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 736	Continued From page 13 happens. The QP and the Director will be responsible for ensuring that the drills are documented." The facility served client #1 who had a history of running away. Client #1's only window in her bedroom had screws on both sides and the window could not be opened. Client #1 had indicated that she noticed the screws were in place around Christmas 2021 and that she could not open her window. Client #1 felt her bedroom window had screws installed to prevent her from running away. Licensee #2 had placed the screws in client #1's bedroom window. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 736		