Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MHL084-093		R-C 11/14/2022

NAME OF PROVIDER OR SUPPLIER: COGGINS GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 235 COGGINS AVENUE, ALBEMARLE, NC 28001

(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 November 14, 2022. The complaint was unsubstantiated (intake #NC00192899). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000	V 106	12/19/22
V 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and	V 106	V106 The Program Manager, Director of Operations and Regional Vice President will work with the Quality Assurance Department to develop an RHA Policy on transporting the people supported safely. The Qualified Professional and Program Manager will re-train the Coggins Group Home staff on Van/Vehicle Safety including pulling the van over during unsafe behaviors. In addition, the staff will be trained on Transportation Policy. A certified Pro Act Instructor will retrain all the staff on Pro Act Training which includes de-escalating behaviors. The Director of Operations and/or Regional Vice President will review and monitor training completion to ensure all in-services and retraining are completed. The clinical team will complete routine observations to ensure staff are seated on the van per the policy. In the future the Program Manager will ensure staff are following the Transportation Policy. DHSR - Mental Health NOV 22 2022 Lic. & Cert. Section	

Division of Health Service [redacted]
LABORATORY DIRECTOR'S [redacted]

Katherine Bent[redacted]

TITLE: Director of Operations

(X6) DATE: 11/17/2022

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V 106	Continued From page 1 continuing education; (17) safety precautions and requirements for facility areas including special client activity areas; and (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to develop and implement a policy for transportation. The findings are: Review on 10/12/22 of facility records revealed: -There was no transportation policy. Interview on 10/12/22 with staff #4 revealed: -She had been working at the facility for about a month. -When she was hired the Qualified Professional did talk with her about the procedures for the van when transporting clients. -Prior to the incident on 10/10/22 with clients #1 and #3 she was told that one staff drove the van and the other staff sits in the back with the clients. -During the incident on 10/10/22 with clients #1 and #3 she was sitting in the passenger seat while staff #6 drove the van. Interviews on 10/12/22 and 10/13/22 with staff #6 revealed: -She had been working with the agency for about a year. -Staff #4 was sitting in the passenger seat during	V 106		

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V 106	Continued From page 2 the incident with clients #1 and #3 on 10/10/22. - Management told them at hire during transportation of clients the second staff was supposed be sitting in the back with the clients. Interviews on 10/12/22 and 10/28/22 with the Program Manager revealed: -The agency does not have a transportation policy. -There are no written procedures for transporting clients in the agency van. -It's best practice that during transportation both staff are not sitting in the front seat of the facility van. -One staff should drive the van and the other staff should be sitting in back with the clients. -The agency had been using these procedures when transporting clients on the van for years. -She confirmed the facility failed to develop and implement a policy for transportation. This deficiency is cross referenced into 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (V536) for a Type A1 rule violation and must be corrected within 23 days.	V 106	V112 The Director of Operations has in-serviced the Program Manager and Qualified Professional to ensure appropriate follow-up is completed to prevent future incidents from occurring in a timely manner. The Qualified Professional will request the Individualized Support Plan (ISP) & Behavior Support Plan (BSP) be updated to add Fire Starting as a target behavior. In addition, the Qualified Professional will pursue a Rights Limitation with appropriate due process to prevent client #1 from owning, purchasing, holding or using a lighter at all times. The staff were in-serviced not to have or bring a lighter to the Coggins Group Home. All lighters must be kept in their personal vehicles at all times to prevent clients from having access to a lighter. The Qualified Professional will ensure all clients' Behavior Support Plans are updated as needed and annually. The Program Manager and Qualified Professional will continue to notify the Director of Operations and Regional Vice President of all significant incidents and/or events. The Director of Operations and/or Regional Vice President will review all incident reports and ensure all follow-up is completed as appropriate in a timely manner. In the future the Qualified Professional will ensure strategies are implemented timely to prevent reoccurring incidents.	1/18/2023
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:	V 112		

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V 112	Continued From page 3 (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to develop and implement strategies to meet the needs and behaviors affecting one of three audited clients (#1). The findings are: Review on 10/12/22 of client #1's record revealed: -Admission date of 5/5/22 -Diagnoses of Mild Intellectual and Developmental Disability, Autistic Disorder, Oppositional Defiant Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Hypothyroidism, Vitamin D3 Deficiency	V 112		

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V 112	Continued From page 4 and Osteopathy. -Client #1's Individualized Support Plan (ISP) dated 5/1/22 had no strategies to address fire starting. -There was no documented history of fire starting. Observation on 10/12/22 at approximately 11:05 am of outside area of the facility revealed: -A 50-gallon plastic trash can was pushed against the facility near the porch area. -The lid to that trash can was burned. Review on 10/12/22 of the Incident Response Improvement System (IRIS) revealed: -Incident report dated 8/11/22- "On 8/11/22 at approximately 6:30pm [client #1] began displaying her target behavior of aggression / property destruction at Coggins group home. [Client #1] asked the Coggins direct care staff if she could go sit on the back porch, staff reported [client #1] went outside on the back porch and immediately came back in the house. Someone from the community knocked on the door and reported to staff the trash can by the back porch was on fire. Staff was able to put the fire out without anyone being harmed. [The Program Manager] spoke with [client #1] and [client #1] admitted she was upset and started the fire ..." Interview on 10/12/22 with client #1 revealed: -She had an incident at the facility in August 2022. -She was upset with staff #1. She asked staff #1 if she could sit outside on the front porch for a few minutes to calm down. -After a few minutes she asked staff #1 if she could sit on the side of the home because the sun was in her eyes on the front porch. -She sat on the side of the home for about 10-15 minutes.	V 112		

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V 112	Continued From page 5 -She then decided to set a trash can on fire that contained a bag of trash. -She also set the lid to the trash can on fire. -She used a lighter to set the bag of trash and trash can lid on fire. -She purchased the lighter from the store. -After setting the bag of trash and trash can lid on fire she went back into the facility. -She didn't say anything to staff #1 about setting the fire outside of the facility. -She thought the bag of trash and trash can lid had been burning about 5 minutes before staff #1 was made aware. -The neighborhood kids came over to the facility and told staff #1 about the fire. -Staff #1 put the fire out with water. Interview on 10/12/22 with staff #1 revealed: -Client #1 had an incident at the facility in August 2022. -Client #1 asked if she could sit outside on the front porch for a few minutes. A few minutes later client #1 said the sun was in her eyes and asked if she could sit on the side of the facility. -She told client #1 to leave the door open to the side of the facility. -She was in kitchen while client #1 was sitting on the side of the facility. -Client #1 was only on the side of the facility about 1-2 minutes. She didn't think client #1 ever sat down on the side of the facility. -She never saw anything in client #1's hand when she went outside. -About 2-3 minutes later a female neighbor was knocking on the door. -The female neighbor says "come, come." -When she went outside, she saw the trash can was on fire on the side of home. -The green trash can was full of trash, and it was burning. The lid of the trash can was also on fire.	V 112		

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V 112	Continued From page 6 -She moved the trash can away from the house. -She got a container from inside the facility and filled it with water and put out the fire. - "I contained the fire, I didn't call the fire department because I was able to put the fire out." -Client #1 denied setting the fire outside of the facility when she asked her about it. -The Program Manager talked to client #1 after the incident. Client #1 admitted to the Program Manager that she set the fire outside of the facility. -Client #1 told the Program Manager she was upset due to not going on an outing. Interviews on 10/12/22 and 10/31/22 with the Qualified Professional revealed: -She was aware of the incident on 8/11/22 with client #1. -She was told client #1 was sitting on the side of the facility vaping. -Client #1 lit the trash can lid on fire while sitting on the side of the facility. -She was told client #1 started the fire with a lighter. -They were not sure where client #1 got a lighter. -Client #1 had "a history of burning things." -Client #1 lived at one of the agency's other facilities. -Client #1 set a water cooler on fire when she lived at that other facility. -She couldn't remember when client #1 burned the cooler at the other facility. -She didn't put anything in client #1's treatment plan after the fire incident on 8/11/22 because she was on vacation when that incident occurred. Also, when client #1 set the fire at the previous location "it was an isolated incident." -She confirmed client #1 had no strategies to address fire starting.	V 112		

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V 112	Continued From page 7 Interview on 10/12/22 with the Program Manager revealed: -She was aware of the incident with client #1 on 8/11/22. -She was informed by staff #1 that client #1 set a trash can on fire outside of the facility. -She knew client #1 had an incident with setting a cooler on fire at another facility. -She really wasn't sure why client #1 had a lighter. -Client #1 was "really not a smoker." She thought client #1 possibly got the lighter from a former client. -She made the Qualified Professional aware of the incident with client #1 setting the fire. -The Qualified Professional was responsible for addressing clients behavioral needs. -She confirmed client #1 had no strategies to address fire starting. Review on 10/31/22 of a Plan of Protection (POP) written by the Director of Operations dated 10/31/22 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? [The Qualified Professional] will request Individualized Support Plan Update to add Fire Starting as a target behavior for client by 10/31/22. In-service with [The Program Manager] and [The Qualified Professional] to ensure appropriate follow-up is completed to prevent future incidents from occurring in a timely manner on 10/31/22. [The Qualified Professional] will pursue a Rights Limitation with appropriate due process to prevent client from owning, purchasing, holding or using a lighter at all times. In-service all direct care staff not to have or bring a lighter to the Coggins Group Home. All lighters must be kept in their personal vehicles at all	V 112		

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V 112	Continued From page 8 times to prevent client from having access to a lighter by 11/2/22. Describe your plans to make sure the above happens. [The Director of Operations] and/or [The Regional Vice President] will review all incident reports and ensure all follow-up is completed as appropriate in a timely manner. [The Program Manager] and [The Qualified Professional] will continue to notify [The Director of Operation] and [The Regional Vice President] of all significant incidents and/or events." Client #1's diagnoses included Mild Intellectual and Developmental Disability, Autistic Disorder, Oppositional Defiant Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Bipolar Disorder and Attention Deficit Hyperactivity Disorder. On 8/11/22 client #1 set a bag of trash and a trash can lid on fire outside of the facility. A neighbor informed staff #1 of the fire outside of the facility. Staff #1 contained the fire by pulling the trash from the side of the facility and putting the fire out with water. Client #1 set a water cooler on fire at a previous placement. Client #1 did not have any strategies to address fire starting prior to or after the incident on 8/11/22. The Qualified Professional was responsible for addressing client #1's behavioral concerns and needs and had not developed any strategies. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 112		

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V 536	Continued From page 9	V 536	V 536	12/19/2022
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served;	V 536	Cross Reference V106	

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V 536	Continued From page 10 (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence	V 536		

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V 536	Continued From page 11 by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name.	V 536		

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V 536	Continued From page 12 (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, two of three audited staff (#4 and #6) failed to demonstrate competence in de-escalating behaviors with clients affecting two of three audited clients (#1 and #3). The findings are: Cross Reference: 10A NCAC 27G .0201 GOVERNING BODY POLICIES (Tag 106) Based on record review and interviews the facility failed to develop and implement a policy for transportation. Review on 10/12/22 of the facility's personnel records revealed the following: Staff #4: -Hire date was 9/22/22 -Hired as a Direct Support Associate -ProAct Preventive Intervention was completed	V 536		

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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 536	Continued From page 13 on 9/29/22. Staff #6: -Hire date was 12/20/21 -Hired as a Direct Support Staff -ProAct Preventive Intervention was completed on 12/22/21. a. Review on 10/12/22 of client #1's record revealed: -Admission date of 5/5/22 -Diagnoses of Mild Intellectual and Developmental Disability, Autistic Disorder, Oppositional Defiant Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Hypothyroidism, Vitamin D3 Deficiency and Osteopathy. -Mental Health Services Agency Evaluation dated 4/3/20- Client #1 had a history of physical and verbal challenges when she was upset. b. Review on 10/12/22 of client #3's record revealed: -Admission date of 8/15/22. -Diagnoses of Mild Intellectual and Developmental Disability, Autism Spectrum Disorder, Bipolar 1 Disorder, Depression, Prediabetes, Obstructive Sleep Apnea and Hypothyroidism. Review on 10/12/22 of the Incident Response Improvement System (IRIS) revealed: -Incident report dated 10/10/22- "On 10/10/22 at approximately 11:45 am, [client #3] displayed his target behavior of attempting AWOL (absent without leave), physical aggression, property destruction, peer to peer aggression and verbal threats of harm. The Coggins Avenue group home direct care staff immediately attempted to	V 536		

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	MHL084-093		R-C 11/14/2022

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V 536	Continued From page 14 redirect [client #3], but he continued to escalate his behaviors. The Coggins Avenue direct care staff called 911 for police assistance. [Name of town] police arrived and immediately secure the home and separated [client #3] from the rest of the individuals and staff. [Name of town] police processed with [client #3] and then the rest of the individuals and staff. [Qualified Professional] arrived on the scene and was able to take [client #3] to Urgent Care in [Name of town] due to [client #3] having two human bite marks (one on his hand and one on his arm). [Client #3] was ordered antibiotic oral and ointment to take and his wounds were cleaned, and antibiotic ointment applied. Also, [client #3] received a tetanus shout (shot) ..." Interview on 10/12/22 with client #1 revealed: -There was an incident on 10/10/22 with client #3. -Client #3 tried to open the van door while staff was driving. -She put her leg on the door and client #3 started kicking her leg. -She was trying to "defend myself." Client #3 kept kicking her and hitting the head rest on van. -Once they arrived at the facility they started fighting. -Client #3 kicked and punched her in the face on the van. -Client #3 was trying to push her in the face and she bit his hand and arm. -Her face was bruised after the incident. -Staff #6 told her to get off the van and go to her bedroom. -She got off the van went into the facility and locked her bedroom door. -A little later client #3 was trying to get into her bedroom. -He was using a metal pipe to try to get into her bedroom.	V 536		

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V 536	Continued From page 15 -Client #3 kept banging on her bedroom door. -She didn't recall staff #4 and staff #6 trying to separate her and client #3 during that incident. -She thought staff #6 was on the phone the entire time. -She thought staff #4 got off the van and went into the facility with client #2. -Staff called the police department during that incident. Interview on 10/12/22 with client #3 revealed: -There was an incident with client #1 on 10/10/22. -They were on the van during the incident and were playing around at first. -He hit the back of client #1's seat and she got upset with him. -He tried to open the van door while staff were still driving because he was upset. -Client #1 blocked him from opening the door. -He "nudged" client #1's leg and client #1 slapped his leg. He then kicked client #1. -All a sudden client #1 pinned him down in the seat. -Client #1 "ripped off" his shoes and threw them. -Client #1 held his arm back and put her other hand around his neck. Client #1 tried to choke him. -He put his arm up and she bit his hand and arm. -He punched client #1 in the face. -Staff #4 opened the van door and tried to pull client #1 out of the van. -He was "enraged at this point." -Client #1 pushed him down in the van and ran into the facility. -Client #1 went into the facility and locked her bedroom door. -He got off the van went into the back yard and got a metal pipe -He "bashed" in the front door with the metal pipe. -He was trying to get into client #1's bedroom.	V 536		

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V 536	Continued From page 16 -He did "let up" when he realized client #1 was crying, he thought she was scared. -Police officers arrived at the facility. Staff told the police officers he started the entire incident. -He had to go to Urgent Care after the incident. -He got a tetanus shot and antibiotics due to the bites from client #1. Interview on 10/12/22 with staff #4 revealed: -There was an incident on 10/10/22 with clients #1 and #3. -She and staff #6 took clients #1, #2 and #3 to a local restaurant for lunch. -The clients got their meals to go. -When they were all on the van, she asked client #3 if he got sweetened or unsweetened tea. -Client #3 said he had sweet tea. They went back in the restaurant and client #3 got the unsweetened tea. -Client #3 got upset. -When they got back into the van client #3 started saying "stuff." Client #3 was "being disrespectful, cussing at [staff #6]." -She was sitting in the passenger seat of the van while staff #6 drove back to the facility. -Client #3 started banging on the windows of the van. Client #3 was yelling while staff #6 was driving. -They were close to the facility. Client #3 reached over client #1 and tried to open the van door while staff #6 drove. She told him not to do that. -Client #1 then put her leg on door. -Client #3 he started hitting client #1's leg with the heel of his foot. -When staff #6 pulled into the driveway of the facility client #1 got up and stood over client #3. -Client #1 was holding client #3 down in the seat. -Client #1 had torn client #3's shirt. -Client #3 punched client #1 in the face. -She thought they "scuffled" for about 2-3 minutes	V 536		

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V 536	Continued From page 17 before they got off the van. -She did not intervene during that incident when clients #1 and #3 were fighting. She didn't intervene because she felt like she needed to stay with client #2. She didn't want client #2 to get upset and start having behaviors. -She decided to take client #2 into the facility. -As she was going into the facility with client #2, she saw client #1 get off the van. -Client #1 ran into the facility. She told client #1 to go into her bedroom and lock her door. -She went into client #2's bedroom with him and they locked the door. -She was "afraid" and didn't want client #2 to get upset -A few minutes later she heard a loud commotion outside of the bedroom. -Client #3 was trying to bust down client #1's door. She didn't know he had the metal pipe until the incident was over. -She could hear client #1 "screaming out of fear" during that incident. -She thought staff #6 was outside on the phone with the police department. -She thought police officers arrived within a few minutes. -When she came out of client #2's bedroom she saw the damage to the front door and client #1's door. -She felt like client #1 was trying to defend herself during that incident. -She thought she just recently had de-escalation training. She couldn't remember which training she received. Interviews on 10/12/22 and 10/13/22 with staff #6 revealed: -There was an incident with clients #1 and #3 on 10/10/22. -She and staff #4 took clients #1, #2 and #3 to a	V 536		

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V 536	Continued From page 18 local restaurant to get lunch to go. -She stayed on the van while staff #4 took the clients in the restaurant one at a time to get their lunch. -Client #3 was the last client to go in with staff. -Client #3 returned to the van and said he got sweet tea to drink. -Client #3 was diabetic and knew he was supposed to get unsweetened tea. -Staff #4 said to client #3 "you" were supposed to get unsweetened tea. -Staff #4 and client #3 went back into the restaurant to get the unsweetened tea. -Client #3 was mad when he got back on the van -Client #3 was "ranting and raving" over the sweet tea. -They were headed back to the facility and client #3 grabbed the van door handle. -Client #1 was sitting close to the door and client #1 said don't open that. -They were not far from the facility and she kept driving. -Client #1 then placed her foot on the door. -Client #3 started kicking client #1's leg with the heel of his foot. -Client #3 also "popped" client #1 behind her head. -Staff #4 was in the passenger seat up front with her during that incident. -Staff #4 turned around and told client #3 to stop kicking client #1. -When they pulled up to the facility, she called management to report the incident once the van was parked. -Clients #1 and #3 then started fighting each other on the van. -They were hitting, tussling and punching each other. -Client #1 also bit client #3 on his arm and hand. -She tried to get in between them, however client	V 536		

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V 536	Continued From page 19 #3 was kicking and she stood back because she did not want to get kicked. -Staff #4 got off the van and went into the facility with client #2. -Staff #4 did not intervene because she had client #2 with her. Staff #4 didn't want client #2 to get upset. -She told client #1 to get off the van. Client #1 got away from client #3 and ran into the facility. -Client #3 also got off the van and walked around the facility and got a metal pipe. -She told client #3 to put down the pipe, he did not listen and walked into the facility with it. -She thought client #3 was going to hit her with the pipe -Client #3 broke the front door with the metal pipe. -Client #3 picked up wood from the door and started hitting client #1's door with that piece of wood. -Client #3 was "very" angry. -She had already called 911 to report the incident and was on the phone with the 911 operator. -She was standing near the front door and saw everything with client #3. -The police officers arrived and talked with client #3. -She had de-escalation training last year when she started with the agency. Interview on 10/31/22 with the Human Resources Staff revealed: -She was the ProAct Preventive Intervention instructor for the agency. -She was aware of the incident with client #1 and #3 on 10/10/22. -The incident was not handled properly with staff #4 and staff #6. -Both staff were trained in ProAct Preventive Intervention shortly after starting with the agency.	V 536		

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V 536	Continued From page 20 - "In my opinion [staff #4 and staff #6] did not implement the de-escalation procedures appropriately for that incident." -Staff #6 should have pulled the van over instead of waiting. -One of the staff should have asked one of the clients to get off the van and that staff could have de-escalated the situation by talking with that client and trying to keep that person calm. -It was her understanding that staff #4 was sitting in the passenger seat beside staff #6 while she was driving. -Staff #4 was supposed to be sitting in the back of the van with the clients. - "If [staff #4] would have been sitting in the back she could have de-escalated that incident before it got out of hand." -She confirmed staff failed to demonstrate competence in de-escalating behaviors with clients. Interview on 10/12/22 with the Qualified Professional revealed: -On 10/10/22 the Program Manager asked her to go to the facility due to an incident. -A staff informed the Program Manager that clients #1 and #3 got into a physical altercation. -When she arrived at the facility a police officer was at the facility talking to client #1. -Client #1 bit client #3 and he had bite marks on his hand and arm after the incident. -She was told by staff that client #3 punched client #1 in her right jaw during that incident. -She took client #3 to the Urgent Care for the bites. Client #3 got a tetanus shot and antibiotics. -Client #1 said she didn't want any medical attention. Client #1 just got an ice pack from staff for her face. Interviews on 10/12/22 and 10/28/22 with the	V 536		

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V 536	Continued From page 21 Program Manager revealed: -She was aware of the incident with clients #1 and #3 on 10/10/22. -Once the incident came to her attention, she sent the Qualified Professional to the facility. -The agency used ProAct Preventive Intervention and the Human Resources staff was the trainer. -All staff are required to get ProAct Preventive Intervention prior to working with clients. -She wasn't sure why staff #4 and staff #6 didn't use their de-escalation training during the incident with clients #1 and #3. -She confirmed staff failed to demonstrate competence in de-escalating behaviors with clients. Review on 10/31/22 of a Plan of Protection (POP) written by the Director of Operations dated 10/31/22 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? [The Qualified Professional], [The Program Manager] [The Director of Operations] and [The Regional Vice President] will work with the Quality Assurance Department to develop an RHA "Licensee" Policy on transporting the people supported safely. All the Coggins Group Home staff will retrain in ProAct by 11/2/22. All the RHA [Name of town] Group Home staff will retrain in ProAct by 11/18/22. [The Qualified Professional] and [The Program Manager] will re-train the Coggins Group Home staff on Van/Vehicle Safety including pulling the van over during unsafe behaviors by 10/31/22 and the whole Unit will be re-trained by 11/4/22. Describe your plans to make sure the above happens. [The Director of Operations] and/or [The Regional Vice President] will review and monitor training completion to ensure all in-services and retraining is completed by specified dates."	V 536		

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V 536	Continued From page 22 The facility served clients whose diagnoses included: Mild Intellectual and Developmental Disability, Autistic Disorder, Oppositional Defiant Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Bipolar 1 Disorder and Prediabetes. On 10/10/22 there was an incident with clients #1 and #3. Client #3 got upset during an outing to a local restaurant because he was told by staff to follow his diet by getting unsweetened tea. Staff #6 drove the van while staff #4 sat in the passenger seat. Client #3 was upset and cussing at staff as they headed back to the facility. Client #3 reached over client #1 and tried to open the van door while staff drove back to the facility. Client #3 got upset with client #1 and started kicking her leg because she put her foot on the door. When they arrived at the facility clients #1 and #3 started physically fighting each other while still on the van. Staff #4 and staff #6 never tried to physically separate clients #1 and #3. Staff #4 got off the van and took client #2 into the facility. Staff #6 was on the phone with management and/or 911 operator during most of the incident. Local police officers responded to the facility as a result of this incident. Client #3 was bitten by client #1 and had to get a tetanus shot and antibiotics. Staff #4 and staff #6 both had ProAct Preventive Intervention training and did not implement any of those de-escalation skills. Staff #6 did not pull over and stop to address the altercation between the clients. Staff #4 did not follow the procedure for transporting clients on the agency van by sitting in the passenger seat during that incident. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is	V 536		

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V 536	Continued From page 23 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 536	V 736 The Maintenance Technician and Program Director will inspect the Coggins Group Home and complete work orders for all needed maintenance issues. The Program Manager will monitor to ensure all repairs and cleaning needs are completed. The Qualified Professional and/or Residential Team Leader will complete monthly Environmental Assessments to ensure maintenance and cleanliness of the home. In the future the Qualified Professional will ensure the home is well maintained, clean, safe and attractive.	12/14/2022
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 observation and interviews, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 10/12/22 at approximately 9:50 am revealed: -Kitchen area -Walls were stained. -Bathroom/Laundry Room-The door to the closet was off the hinges. -Client #2's bedroom-There was a hole in the wall about the size of a melon. There was a putty like substance on the wall. -Client #1's bedroom-Paint on wall outside of door was peeling. Door had a crack approximately 8 inches long. There was a faded purplish area on ceiling. Water marks on the ceiling. Approximately 14 puttylike areas on the walls. There were approximately 50 nail holes in the walls.	V 736		

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V 736	Continued From page 24 -Client #4's bedroom-There was a crack in her door approximately 3 inches long. A set of broken blinds. Approximately 7 nail holes in the walls. Paint was faded on the walls. -Bathroom #2-Sink was dirty. Back of toilet and toilet seat was dirty. Ceiling vent was dusty. Interview on 10/12/22 with the Qualified Professional revealed: - Some of the property damage to the facility was caused by client #3 during the incident on 10/10/22. -They were aware of the maintenance issues with the facility.	V 736		

RHA
HEALTH SERVICES

November 17, 2022

[redacted]
Facility Compliance Consultant I
Mental Health Licensure & Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

RE: MHL-084-093 Coggins Group Home

Dear [redacted]:

Please see the enclosed Plan of Correction (POC) for the Type A1, Type B & re-cited deficiencies sited at the Coggins Group Home during your complaint & follow-up survey visit on 11/14/2022. We have implemented the POC and invite you to return to the facility on or around 12/14/2022 to review our POC items.

Please contact me with any further issues or concerns regarding the Coggins Group Home (MHL-084-093).

Sincerely,

[redacted]
Director of Operations
RHA Health Services, LLC
Kbenton2@rhanet.org