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LIFESPAN, INC-PAYTON PLACE HOME	**291 STEWART ROAD ANDREWS, NC 28901**

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V 000	INITIAL COMMENTS A complaint survey was completed on December 19, 2022. The complaint was substantiated (intake NC#195022). 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 4 and currently has a census of 4. The survey sample consisted of an audit of one current client.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for	V 109		

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V 109	Continued From page 1 MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interviews, 1 of 1 Qualified Professional (QP), failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Review on 12/1/22 of the QP's record revealed: -Date of hire: 4/6/10 -Position: QP -Job description dated 3/1/16 revealed: -"Under limited supervision is responsible for coordinating, overseeing and supervising activities and personnel involved in the DD (Developmental Disabilities) programs, ensuring compliance with relative rules, regulations, policies ... -Essential Duties and Responsibilities: -Serve as an advocate for the individuals we serve; -Perform and assist with parts of problem-solving duties which occur ...including investigating ... deciding most appropriate plan of action; -Communicate appropriate recommendations and/or needs to Program Director and/or	V 109		

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Executive Management
-Manage staff on a day-to-day basis ...
-Ensure Health and Safety and incident requirements are upheld."

Review on 11/30/22 and 12/1/22 of the "Summary of Investigation of Unknown Bruises" regarding Client #1, completed by a Compliance Specialist dated 11/11/22 revealed:
"The Qualified Professional [QP] failed to report the incident in a timely...She was notified of his injuries by 9:00 AM on 11/09/2022 but did not report to her supervisor or the Quality team until 3:30 PM. Though the resident did not suffer any serious physical injuries, she waited until 5:00 PM to seek medical care."

Review on 12/1/22 of discharge paperwork for Client #1 from a local hospital revealed:
Discharge Date: 11/10/22
"Chief Complaint: Facial Injuries from an unknown source;
-Diagnosis: Head Injury, Facial Contusion, and Bilateral Hand Contusions;
-CTs (Computed Tomography) of the head, facial bones, and CT cervical spine did not show any fractures ...X-rays of the hands did not show any fractures."

Review on 11/30/22 at 10:30 AM of a picture on the QP's phone revealed:
-a picture of Client #1's face from 11/10/22;
-there were red scratches and marks on the client's cheeks, nose, above his eyes, and head;
-small cuts appeared in the scratch marks;
-bruising over his right eye that appeared swollen.

Review and interview on 12/1/22 at 11:12AM of pictures from Client #1's guardian revealed:
-pictures of Client #1's head and hand that she

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had taken at the facility on 11/10/22;
-the right side of Client #1's face had a swollen knot above his eyebrow that was purple and brown;
-his nose had bruising on the left side and a scratch;
-the left side of his face had red linear scratch marks on his cheek, from the temple area to his ear, and marks above his ear to the back of his head;
-there were red marks above his left eyebrow that were bruising a dark red;
-his left hand had marks on his third and fourth finger that were in different stages of bruising of red, purple, and brown.

Interview on 11/29/22 with Client #2 revealed:
-she doesn't know what happened to Client #1;
-she knew Client #1 was outside her room the night of 11/9/22, "because he is very loud ...and was banging on my door;"
-she found Client #1 sitting outside her door at 12AM, "sitting crisscross applesauce;"
-she went to use the restroom and walked around Client #1 because he wouldn't get out of the way ..."yelled at him;"
-Former Staff #3 (FS #3) was in the living room;
-went to sleep around 1:00 AM;
-she saw Client #4 open his door because Client #1 was being loud;
-"The next day, (11/10/22) [Client #1] had a cut above his eyes on both sides and scratches on his face."
-FS #3 told Staff #1 she didn't know what happened to Client #1.

Interview on 11/29/22 with Client #4 and his guardian present revealed:
-he woke up to Client #1 being in front of Client #2's door.. "I woke up because the light was on

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and heard [Client #2] cursing;"
-"tried picking him up with his armpits and tried to drag him ...and got him into a chair with his hand;"
-FS #3 was in the living room when Client #1 was in the hallway (by client bedrooms);
-denied hitting Client #1 ... "don't know how those bruises got there;"
-"took [Client #1] back to his room ...and waited in the living room till [Client #1] laid down ...and saw the bruises on his face around 7:00 am;"
-"it looked like someone had scratched him;"
-FS #3 was "sick and weak that night ... and told him (Client #4) to go back to bed ...I told her I was going to stay up and watch both of them."

Interview on 11/30/22 with Staff #1 revealed:
-she came in the morning of 11/10/22 by 8AM and observed Client #1's face;
-she contacted the QP by phone at 9:00 AM because the staff on shift, FS #3 had not done so;
- FS #3 told her she "didn't know what had happened to [Client #1] ...he had got loose from her back there ... and there was a skinned place on the wall where he may have fell ...[Client #4] had come out of his room trying to get him up;"
-Client #1 falls a lot and picks stuff up out of the floor;
-FS #3 was sick;
-"[Client #1] had a pump knot bruise on the right side of his face ...had scratches in his head and places on his hands where he bit himself;"
-"[Client #1] seemed fine other than what he looked like;"
-"[QP] usually notifies guardians of issues, injuries, and has all their numbers."

Interview on 11/30/22 with Staff #2 revealed:
-he "worked the day shift on 11/9 from 8:00am to 8:00PM and [Client #1] was fine."

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-Client #1 had laid down when he left the group home;
-he came to the group home the next day around 3pm and "it looked like he had been in a prize fight with Rocky Balboa;"
-"he had a bruise on the right side of his face, little bit of a cut ...claw marks on his face ...he was bruised pretty good."
-"you could tell he was hurt."
-Staff #1 didn't know what had happened to him;
-Staff #1 and the QP took Client #1 to the emergency room later that night.

Interview on 12/1/22 with Client #1's guardian revealed:
-went to the facility on 11/10/22 and "discovered ... by his face that he (Client #1) had been assaulted;"
- she "did not get a phone call from anybody ...it had happened the previous night ...and I went by there the next day at 3pm;"
-she has "text messages from the QP at 10:30AM that morning...and nothing was said;"
-"walked in the door of the facility, asked what happened and [Staff #1] said, did [QP] not call you?"
-was very upset, left the facility, and tried to contact the QP and couldn't get in touch with her;
-she came back to the group home and took pictures;
-"told the QP that he needed to go to the emergency room (ER) ... and the QP told her she had a meeting at 4:00pm and could take him after;"
-she sent her daughter to the local ER to meet Staff #1, QP, and Client #1;
-she "wished that the incident had been treated as an emergency ...he should have been taken to the ER and yes, I should have gotten a call;"
-they had to sedate Client #1 at the hospital to

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complete a CAT scan, and x-rays of his fingers, and hands.

Interview on 11/30/22 with the QP revealed:
-she got a call from Staff #1 about Client #1 around 9:00AM and came to the group home after on 11/10/22;
-was "devastated" when she saw Client #1;
-"[Client #1] had bruising on his face, on the sides and under his eyes, looked like fingernail scratches on his face ...had bite marks on his hands that weren't fresh;"
-"at first it looked like a bite mark on his face;"
-"got bluer as the day went on;"
-regarding a mark on the wall where Client #1 may have fallen, the facility was having painting done during this time, "it's not there;"
-"nobody seemed to know what happened to [Client #1], we don't know;"
-regarding not taking Client #1 to the emergency room right away, she reported Client #1 was acting normal, eating, and walking when she came to the facility;
-"if [Client #1] had been in any distress, I would have called 911;"
-Staff #1 asked her to contact Client #1's legal guardian;
-attempted to call Client #1's guardian when she left the facility, but the call did not go through;
-during this time Client #1's guardian showed up to the group home and "went ballistic;"
-had a meeting with facility compliance that afternoon and she was going to take Client #1 to the ER after;
-she tried to contact FS #3 to get an incident report but she was unable to get in touch with her until the next day;
-FS #3 told her she was sick and that " [Client #1] was wild ...had been wild for a few days...wasn't sleeping and going backwards and forwards to

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client bedrooms and heard [Client #2] scream at him;"
-FS #3 told her that, "when [Client #1] laid down there wasn't bruising on his face but when he got up for 7am meds (medications), it was there.."
-staff are expected to be awake at night;
-FS #3 reported that "[Client #4] had hit [Client #1] in the face with a spoon ...and it didn't make sense;"
-she stated the policy to notify guardians regarding injuries was immediately;
-why she didn't contact Client #1's guardian right away, "I wanted to make sure he was ok ...I needed to know the 'whats' before I called her and she was going to want to know the whats."

Interview on 12/1/22 with the Senior Director of Programs revealed:
-she is the QP's supervisor;
-the QP did not contact her regarding the incident with Client #1 that occurred on 11/9/22;
-the QP attended a meeting that reviewed timelines for incident reporting and contacting management.

Interview on 11/30/22 with a Local Department of Social Services Supervisor revealed:
-"we are unsubstantiating the report but confirming the allegations ...caretaker neglect;"
-"the staff was terminated and basically didn't hear the Client getting attacked by the other resident;"
-biggest concern was how it was handled and no one let the family know about it.

This deficiency is cross referenced in to 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.

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V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by:	V 110		

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Based on record review and interviews, 1 of 1 audited paraprofessionals, (Former Staff #3 (FS#3)), failed to demonstrate the knowledge, skills, and abilities, required by the population served. The findings are:

Review on 12/2/22 of FS #3's record revealed:
-Date of hire: 9/8/17
-Termination date: 11/14/22
-Position: Residential Enrichment Specialist & Community Enrichment Specialist
-Job description dated 7/24/17 revealed:
"Job Summary: Under general supervision, responsible for supervising and assisting group home residents ...
Essential Duties and Responsibilities:
-ensure that individuals are engaged and supervised at all times;
-handle emergency situations according to emergency procedures;
-communicate with a variety of individuals and groups (e.g. residents, day program staff, supervisor, families ...) in a professional manner;
-receive review, process, file and submit a variety of documents and reports ... in a timely manner."

Review on 11/30/22 of the incident report/statement dated 11/10/22 from FS #3 revealed:
-"When [Client #1] woke up at approx (approximately) 10pm he was running, screaming, and he hit several walls and windows with his hands;
-[Client #1] was not eligible for his PRN (as needed) med (medication) ...until 2:30AM;
-[Client#1] began to enter other resident rooms and yelling and would not leave ...despite my verbal prompting;
-This behavior continued all night and the other residents were very disturbed and could not

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sleep;
-...I heard [Client #3] scream for [Client #1] to go back to his room as I was moving the table and chair to get to [Client #1];
-At that time [Client #2] came out of his room and was leading [Client #1] down the hall and into the living room;
-...I turned around and placed the table and chairs back in the doorway and when I turned around saw [Client #2] hitting [Client #1] in the face with a spoon;
-I told [Client #2] to stop and he did ...and [Client #2] led [Client #1] back to his room and I began preparing his PRN med;
-administered his PRN med at 3am ...at that time I observed no injury or marks on [Client #1's] face or body;
-he continued to yell and scream until approximately 4am ...went to sleep ...I administered [Client #1]'s morning meds and ...noticed several marks on his face;
-...[Client#2] took pictures of the marks and sent them to [QP] of the company ...I gave report to oncoming staff and went off duty."

Interview on 11/30/22 with Staff #1 revealed:
-FS #3 reported she did not know what happened to Client #1.

Interview on 11/30/22 with Staff #2 revealed:
-protocol for emergencies, "number one thing is to call and let the owner know, apply first aid...if there needs to be more, call 911...and write up an incident report."

Attempt on 12/1/22 to interview FS #3 was unsuccessful, voicemail was full.

Interview on 11/30/22 with the QP revealed:
-she couldn't get in touch with FS #3 the day after

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V 110	Continued From page 11 the incident and spoke with her the next day to complete an incident report with a witness; -regarding FS #3 putting a table across the doorway to prevent Client #1 from getting back to the other resident rooms, "she did and put it in her incident report ...I was in total shock;" -FS #3 asked Client #2 to take pictures of Client #1's face to send to her, "that's a whole other issue ... [FS# 3] didn't have a cell phone;" -FS #3 reported that she observed "[Client #2] hitting [Client #1] in the face with a spoon ...doesn't make sense." -FS #3 didn't call her about incident, Staff #1 did; -FS #3 was put on leave after this incident and dismissed. This deficiency is cross referenced in to 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least	V 112		

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annually in consultation with the client or legally responsible person or both;
(5) basis for evaluation or assessment of outcome achievement; and
(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to develop and implement treatment strategies to address the needs of 1 of 1 audited client, (Client #1). The findings are:

Review on 11/30/22 of Client #1's daily progress notes from 9/8/22 to 11/26/22 revealed:
-9/21/22: "[Client #1] acting crazy this evening ...finally settling down;"
-9/23/22: "[Client #1] hitting self, doors, walls, biting hard ...unplugged the lamp and put in kitchen sink ...went to other residents' room X 2 ...Climbed on top of dining room table ...very wild ...gave PRN (as needed) ...didn't help any;"
-9/24/22: "still very wild ...getting into everything, same as 9/23/22..hitting, kicking, pinching me;"
-9/25/22: "still can't do much with him ...hitting wall, door, tv, self, ...unplugged light..went into another resident room while in bathroom;"
-9/26/22: "same as above ...very anxious all night;"

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LIFESPAN, INC-PAYTON PLACE HOME	291 STEWART ROAD ANDREWS, NC 28901

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V 112	Continued From page 13 -10/1/22: "up and down all night;" -10/4/22: "[Client #1] got in to [Client #2]'s room ....staff redirected;" -10/10/22: "[Client #1] went in to another resident room at 1:45 AM ...got in to a glue pad for mice..stuck to hand ...opened oven door when I went to get butter from garage refridg (refrigerator);" -10/12/22: "[Client #1] up twice but awake in early morning ...;" -no notes from 10/13/22-10/18/22; -no notes from 10/20/22-10/25/22; -10/26/22: [Client #1] hitting, biting self, screaming, and eating stuff out of the floor ...administered PRN med at 7:00PM;" -10/27/22 " [Client #1] hitting, biting self, screaming ...administered PRN med at 7:00PM;" -11/1/22: "[Client #1] hitting biting self, screaming ....administered PRN med at 6:00PM;" -no notes from 11/4/22-11/7/22; -11/8/22: "[Client #1] up all night the night before ...slept a little bit this morning;" -11/9/22: "[Client #1] had bruises on his face ...taken to [local hospital] to be checked out at ER (emergency room);" -no notes from 11/9/22-11/15/22; -11/23/22 "[Client #1] caught eating poop from the toilet ...staff had him spit it out ...was trying to get into the back to other housemate rooms;" -11/26/22 "[Client #1] got up at night a couple times ...but overall was good this time;" Review on 11/30/22 of Client #1's record revealed: -Admission Date: 4/2/15 -Diagnoses: Anxiety Disorder, Obsessive Compulsive Disorder (OCD), Autistic Disorder (D/O), Generalized Idiopathic Epilepsy and Epileptic Syndromes, not intractable, without status epilepticus, Insomnia due to medical	V 112		

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condition, Hypothyroidism, Conduct D/O, PICA, and other eating D/O
-Age: 29
-the treatment plan had not been updated since 12/1/21;
-there were no strategies or interventions developed to address Client #1's wandering at night and getting into other resident rooms;
-there were no strategies or interventions developed to address Client #1's sleep schedule or other specific behaviors identified in the daily progress notes.

Interview on 11/30/22 with Client #2 revealed:
-Client #1 wanders at night all the time and tries to get into their rooms;
-this is the main reason why they lock their doors.

Interview on 11/30/22 with Staff #1 revealed:
-"[Client #1] does wander at night and in the day ...try to get clients to lock their doors ...he looks to see what you're doing and can get gone in no time;"
-regarding getting Client #1 out of client rooms, "use verbal re-direction, and getting whatever he's after ...pick it up and he'll follow;"
-"it's very seldom that he'll sleep all night;"
-Client #1 loves paper, pen, and his IPAD;
-Client #1 needs supervision all the time.

Interview on 11/30/22 with Staff #2 revealed:
-"[Client #1] likes to get up in the middle of the night, get in peoples rooms ....that's the reason usually my nights are sleepless;"
-the other clients get upset when this happens and may complain;
-strategies to get Client #1 back to his room, are re-direction, "if he's restless, PRN med ...sometimes it works, sometimes it doesn't;"
-he knows the difference between the alarm on

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V 112	Continued From page 15 Client #1's door and Client #4's door. Interview on 12/1/11 with Client #1's guardian revealed: -she participated in his treatment planning and goals; -was not uncommon for him to not sleep for days ..."this is not new;" -"If daytime staff let him sleep then he will be up at night;" -"night-time staff were hired for [Client #1]." -regarding self-injurious behaviors, "[Client #1] may hit his hand the flat part his hand." Interview on 11/29/22 and 11/30/22 with the Qualified Professional revealed: -she does the treatment plans; -they have been short staffed from COVID and "were doing ok until this;" -[Client #1] has never slept well and have tried lots of things ...meds don't work ...he beats on the walls, windows, and is really loud." -Client #1 will try to get into other client rooms at night; -Client #1's behaviors impacted the other residents in the home; -it's not uncommon for him to go days without sleeping and then he will nap. This deficiency is cross referenced in to 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY	V 132		

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(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:
a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
c. Misappropriation of the property of a healthcare facility.
d. Diversion of drugs belonging to a health care facility or to a patient or client.
e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).
Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

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This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to report an allegation of abuse to the North Carolina Health Care Personnel Registry (HCPR). The findings are:

Review on 11/30/22 and 12/1/22 of the "Summary of Investigation of Unknown Bruises" regarding Client #1 dated 11/11/22 revealed:
-"11/9/22 this investigator received a call from the Qualified Professional at 3:30pm ....stating it was reported to her that [Client #1] was found with bruises on his face;
-he "was released to his sisters' care ...a call to Adult Protective Services was made ...and suspected cause of injuries were made by another person and not a fall;"
-Former Staff #3 (FS #3) "said she placed a table in the doorway of the kitchen to prevent him from getting to the back ...saw [Client #4] hit [Client #1] with an object twice ...not aware of what happened prior to moving the table;"
-the Conclusion noted that ... "bruises to [Client #1] were caused by another resident in the home."
- ..."it is unclear if [FS #3] was not forth coming about the cause of injury to [Client #1] ...she created an unsafe environment ..."

Review on 11/29/22 and 12/1/22 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-Level II incident, date of incident: 11/9/22, 3AM
-date provider learned of incident: 11/9/22;
-"does this allegation include an allegation against

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the facility: 'Yes' ;"
-verbal abuse/physical abuse was checked;
-"Abrasion/Scrape, Bruise, and Scratches ...due to Assault, Behavioral Outburst, and Self-Injurious Behavior were checked;"
-"incident comments: [Client #1] was up all night making noise and screaming ...[FS #3] placed a table in the hallway so [Client #1] could not get back to the the other room so easy ...Staff put him back in his room and put the table in doorway to kitchen ...[Client #1] went over;
[Client #4] was hitting him with a wooden spoon."
-the HCPR section of the IRIS report was not filled out regarding FS #3.

Interview on 12/2/22 with Chief Compliance Specialist revealed:
-the HCPR section was not notified due to the facility being named in the allegations and not a staff.

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V 289	27G .5601 Supervised Living - Scope	V 289		

10A NCAC 27G .5601 SCOPE
(a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.
(b) A supervised living facility shall be licensed if the facility serves either:
(1) one or more minor clients; or
(2) two or more adult clients.
Minor and adult clients shall not reside in the same facility.
(c) Each supervised living facility shall be

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V 289	Continued From page 19 licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304	V 289		

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V 289	Continued From page 20 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record review, interviews, and observation, the facility failed to operate within its scope to provide residential services to individuals diagnosed with developmental disabilities affecting 1 of 1 audited client, (Client #1). The findings are: Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) Based on record review and interviews, 1 of 1 Qualified Professional (QP), failed to demonstrate the knowledge, skills, abilities required by the population served. Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) Based on record review and interviews, 1 of 1 audited paraprofessionals, (Former Staff #3 (FS #3)), failed to demonstrate the knowledge, skills, and abilities, required by the population served. Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review and interviews, the facility failed to develop and implement treatment strategies to address the needs of 1 of 1 audited client, (Client #1).	V 289		

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Cross Reference: 10A NCAC 27G .5602 Staff (V290)
Based on record review and interviews, the facility failed to ensure staffing to meet the individualized needs of 1 of 1 audited client, (Client #1).

Review on 12/2/22 of the Plan of Protection written and signed by the Quality Assurance (QA) Specialist on 12/2/22 revealed:

" What immediate action will the facility take to ensure the safety of the consumers in your care?

10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109)
[Senior Director], Senior Director of Facility Programs, will ensure that all competencies of the Qualified Professional in the home are documented and assessed to ensure that [QP] follows all the duties and regulatory items in her job positions.

Qualified Professional
The QP received a written warning for untimely reporting upon the findings from the internal investigation completed by the QA Specialist. The QP will go through extensive trainings with the Senior Director of Facility Programs and/or Training Department and the Compliance Department, which will include, but not limited to, Incident Reporting, Service Definitions, NC (North Carolina) Regulatory Statutes, Medicaid Policies and Procedures and specific items and requirements for residential living. Date of completion for this task is no later than 12/19/2022.

10A NCAC 27G .0204 Competencies and

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V 289	Continued From page 22 Supervision of Paraprofessionals (V110) As it pertains to the above tag, the staff member [Former Staff #3], who failed to report the incident and blocked the hallway with a table, was immediately placed on administrative leave pending an investigation. After the findings were found to be substantiated, she was terminated on 11/14/2022. Paraprofessionals All staff located in Andrews/Murphy area group homes/day programs will be retrained on [Licensee's] INCIDENT REPORTING POLICY AND PROCEDURES and Positive Intervention training by 12/15/2022 by [Senior Director], Senior Director of Facility programs or a member of the training department. 10A NCAC 27G .0205 Assessment and Treatment/Habilitation Or Service Plan (V112) The treatment plan for [Client #1] will be reviewed with the assigned [Local Management Entity/Managed Care Organization]Coordinator and [Senior Director], Senior Director of Facility Programs, along with [QP name], to ensure the plan addresses the individuals current needs and behaviors (wandering throughout the night and entering the private bedrooms of others in the middle of the night). The Senior Director of Facility Programs or [QP] (QP) will reach out to the Care Coordinator no later than 12/05/2022 to schedule a meeting to review the plan. The plan will be updated, uploaded into Therap (Electronic Health Care Record System) and implemented no later than 12/20/2022. All staff working with the individual will be trained on the updated plan by the Senior Director of	V 289		

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V 289	Continued From page 23 Facility Programs before they are able to work in the home. 10A NCAC 27G .5602 Staff (V290) LIFESPAN (Licensee) acknowledges that we need a second staff in the home. Management will work on a schedule throughout the weekend and implement a second staff on shift overnight starting the week of 12/05/2022. Describe your plans to make sure the above happens. LIFESPAN Services Compliance Department will oversee the completion of the above tasks and ensure that they are completed by the due dates stated. A sign-off sheet will be completed for a record of training attendance." This facility serves clients whose diagnoses include Intellectual and Developmental Disabilities, Autism, Attention Deficit Hyperactivity Disorder, Obsessive Compulsive Disorder, PICA, and Conduct D/O. Client #1 has Autism, is non-verbal, does not have a regular nighttime sleep schedule, and often wanders at night getting into other resident rooms. Verbal re-direction by staff is not always successful. During the overnight shift on 11/9/22, Client #1 sustained marks, bruises, scratches on his face, a visible bump and places on his hands that FS #3 did not report. FS #3 put a table across the hallway door in attempt to block Client #1 from accessing the other resident bedrooms. FS #3 requested another client take pictures of Client #1's injuries and did not fill out an incident report for the oncoming shift. The QP was notified of Client#1's injuries by 9:00AM on 11/10/22 and went to the facility and observed Client #1. The QP failed to notify her direct supervisor regarding this incident. Client #1's legal guardian showed up to the group home around 1pm, saw Client #1,	V 289		

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V 289	Continued From page 24 and no one from the facility had called her to let her know what happened. Client #1 was taken to the emergency room that evening and Client #1 was discharged to family due to concern that the injuries were caused by a person. Client #1 requires constant supervision in the facility. His lack of sleep in the evening and wandering behaviors are well known amongst staff, yet strategies to address this are not in his treatment plan. Staffing in the facility failed to meet the individualized needs of clients. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $__$1000.00__ 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 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one	V 290		

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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 290	Continued From page 25 child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staffing to meet the individualized needs of 1 of 1 audited client, (Client #1). The findings are: Review on 11/30/22 of Client #1's record revealed: -Admission Date: 4/2/15 -Diagnoses: Anxiety Disorder, Obsessive	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL020-068	A. BUILDING: ______ B. WING ______	C 12/19/2022

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V 290	Continued From page 26 Compulsive Disorder (OCD), Autistic Disorder (D/O), Generalized Idiopathic Epilepsy and Epileptic Syndromes, not intractable, without status epilepticus, Insomnia due to medical condition, Hypothyroidism, Conduct D/O, PICA, and other eating D/O. Refer to V112 for failure to develop and implement treatment strategies: -Client #1's history of wandering at night into other rooms, disturbing other clients, and an inability to maintain a regular nighttime sleep schedule was not included in his treatment plan. Interview on 11/30/22 with Staff #1 revealed: -Client #1 "will wander at night and in the day...try to get clients to lock their doors ...he can see what you're doing and can get gone in no time;" -"he has to have supervision all the time ...he will try to get into the oven while you are cooking ...be out the door;" -regarding giving Client #1's PRN (as needed) medication to help him calm down, "It's like giving him a tic tac." Interview on 11/30/22 with the Qualified Professional revealed: -"have been short staffed for a while ...don't have reserve staff;" -Client #1 will put "whatever in his mouth ...if he sees something in the floor ...if you don't beat him to it ...it's in his mouth" -"he will bite himself ... leaves bruises on his hands, fingers ...space between thumb and forefinger;" -"may go 5 days at a time without sleeping;" -Client #1's guardian doesn't want to give him a sleeping pill ..."says they don't work;" -"If he doesn't get his way, [Client #1] is pushing, shoving, screaming, beating on the wall, windows	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 290	Continued From page 27 ...he will pop his ears;" -"[Client #1] is 100% assistance." Interview on 12/1/22 with Client #1's guardian revealed: -FS #3 should not have been working the night shift, "she is a little old lady and was sick." Interview on 12/2/22 with the Senior Director of Programs revealed: -Client #1 needs additional staff and they are working on getting this in place. This deficiency is cross referenced in to 10A NCAC 27G .5601 Scope (V289) for Type A1 rule violation and must be corrected with in 23 days.	V 290		