Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-143	A. BUILDING: ______ B. WING ______	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAVERNE'S HAVEN-CENTER COURT	**147 CENTER COURT EDEN, NC 27288**

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 4/4/23. The complaint was substantiated (intake # NC00200163). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G.5600C Supervised Living for Adults with Developmental Disabilities. The facility is licensed for 5 beds and currently has a census of 5. The survey sample consisted of 3 current clients.	V 000		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children.	V 115		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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This Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to provide supervision to ensure the safety of 1 of 5 clients (client #1). The findings are:

Review on 3/30/23 of the North Carolina Incident Response Improvement System (IRIS) revealed:
- The facility's Director last submitted an incident report to IRIS on 3/27/23 regarding the unplanned absence of client #1 from the facility for more than 3 hours beginning on 3/26/23 while staff #1 was working on third shift
- The incident report revealed staff #1 "reported she conducted a scheduled supervision on all of the residents at 1am and observed [client #1] was not in bed ..."
- She checked inside and outside of the facility but was unable to locate client #1
- At 2 am, staff #1 received a telephone call from a hospital staff person who informed her client #1 was at the hospital
- Upon learning of client #1 being at the hospital, she and the other four clients(#2, #3, #4 and #5) in the facility went to the hospital to pick up client #1
- While at the hospital, she spoke with a "charge nurse" and a police officer regarding client #1's behavior
- Staff #1 telephoned the Director and reported what had happened
- The Director came to the hospital and spoke with the "charge nurse," police officers and an

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V 115	Continued From page 2 Adult Protective Services (APS) worker He assured the APS worker would be "properly supervised and safe" as he planned to remain at the facility until the first shift staff arrived - The Director assured the APS worker it would be safe to allow client #1 to leave with him, client #1 was discharged from the hospital at 4:20 am - Once he was back at the facility, the Director spoke with staff #1 about how client #1 was able to have left the facility without her knowledge - She reported to the Director she last checked on the clients at 11 pm that evening and then "lost track of time while cleaning the facility and did not do a supervision check until 1 am ..." - She believed client #1 must have left when she was cleaning the bathroom - Staff #1 was given a written warning, a two-day suspension without pay for "not properly supervising the residents ..." by the Director - Plans were to install a camera in the common area of the facility to assist staff with monitoring the clients for "safety and supervision ..." Observation of the facility on 3/30/23 at 3:30 pm revealed: - A residential street which ends in a cul-de-sac with houses to the right and left of the facility as well as across the street - The front door of the facility which required one to walk through the kitchen and living room areas of the facility to exit the facility via the front door - One of two doors in the kitchen that led outside onto the deck and then into the backyard of the facility - Clients (#1 and #2's) bedroom was located nearest the kitchen and laundry room area of the home - The client's bathroom down the hallway and	V 115		

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between the kitchen and living room areas of the facility with clients (#3, #4 and #5's bedrooms) located on the same hallway
- Chimes sounded when the doors were opened

Review on 3/31/23 of client #1's record revealed:
- An admission date of 5/31/22
- Diagnoses of Moderate Intellectual Disability; Schizophrenia, Unspecified; and Hypercholesterolemia, Unspecified
- Client #1 had eloped from placements in the past
- A document staff used to note when they checked on a client and if they were asleep or awake
- Staff #1 documented on the sleep schedule that during her bed checks she observed client #1 to be asleep until 11:30 pm on 3/26/23 and then awake from 11:30 am until 8 am of the following morning (3/27/23) as the client was not at the facility
- Staff #1 had completed a progress note dated 3/26/23 for her shift (8 pm until 8 am) which revealed "When staff arrived, [client #1] was in his room asleep. [Client #1] got up and left the facility while staff (#1) was in the restroom and ended up at the hospital. [The Director] was called and he went and picked [client #1] up and brought him back to the facility. [Client #1] ate breakfast and went to his room to lay down."

Interview on 3/30/23 with client #1 revealed:
- Client #2 had bitten one of his fingers and he wanted to seek medical attention for the bite
- He had told staff #1 about having been bitten by client #2 and she had called the "boss man" (the Director) and informed him of what had happened
- His finger was "bleeding real bad and it hurt."

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V 115	Continued From page 4 - He decided to walk to a neighbor's house and asked the couple who lived there to transport him to the hospital - He was taken to the hospital by the neighbors; however, they did not go inside the hospital with him - He could not tell the time he left the facility and went to the neighbor's home - When he arrived at the hospital, his finger was bleeding slightly - He was treated for the bite and prescribed medication - The neighbors and the staff at the hospital were "nice" to him - He was concerned he and staff #1 were in trouble because of his actions - The Director picked him up from the hospital and returned him to the facility - Reports that he and client #2 were friends and client #2 had not bitten him again since 3/26/23 Observation on 3/30/23 at 3:59 pm of client #1's left index finger revealed: - A small abrasion located on the tip of his finger with what appeared to be circular indentation midway down the top portion of his finger - No blood was evident Review on 3/31/23 of staff #1's record revealed: - A hire date of 2/28/22 as a paraprofessional Interview on 3/31/23 of staff #1 revealed: - When she came into work on third shift (8 pm - 8 am) on 3/26/23 all the clients were in bed asleep - She typically checked on the clients between every fifteen minutes and an hour while on shift - Each time she checked on client #1, he	V 115		

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V 115	Continued From page 5 appeared to be asleep in bed - She last checked on client #1 at 1 am and he was in his bed "snoring." - She received a telephone call from hospital staff at 2:15 am who informed her client #1 was at the hospital - When she received the phone call, she was under the impression, client #1 was still in bed asleep; however, when she went in to check on him, she realized he was not in his bedroom - Earlier during the evening, she cleaned the client's bathroom, which included sweeping and mopping the floor, putting towels in the wash, etc. - She believed this may have been when client #1 left the facility without her knowledge; or it could have been with she was using the bathroom as she had developed an upset stomach earlier that evening - She was not sure if client #1 had a plan and had been watching her and decided to leave when he was able to do so without her knowledge - Initially she told the hospital staff that she couldn't come to the hospital to pick up client #1 because she was responsible for the other clients (#2, #3, #4 and #5) who were in bed asleep - She then decided to wake the other clients and go to the hospital to pick up client #1; however, he refused to leave with her - She then contacted the Director, and he came to the hospital and spoke with client #1, hospital personnel, the police and an APS worker - Client #1 eventually agreed to the facility with the Director during the early morning hours of 3/27/23 - She had been suspended from work without pay for two days and would be working with another staff present in the facility while she was on shift - She would also be undergoing some additional training because of her failure to	V 115		

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V 115	Continued From page 6 properly supervise the clients on 3/26/23 - She remained "dumbfounded" as to how client #1 was able to leave the facility without her knowledge; however, she stated, "I take responsibility for it." Interview on 3/31 and 4/4/23 with the Director revealed: - On 3/27/23, he received a telephone call from staff #1 at 2:30 am who reported client #1 was at the hospital and refused to leave with her - When he arrived at the hospital, he observed client #1 crying and stating he did not want to return to the facility - While at the hospital, he spoke with client #1, nursing staff, police officers and an APS worker - He informed the APS worker that he would ensure client #1 would be safe once he returned to the facility because he would send staff #1 home and he would remain at the facility until the first shift staff came in to work later that morning - Once he and client #1 returned to the facility, he spoke with staff #1 about how client #1 could have left the facility without her knowledge - She reported to him that she believed client #1 had left the facility when she was cleaning the clients' bathroom - He wasn't sure if this was true because staff #1 should have been able to hear the chimes on the door when client #1 opened it to exit the facility - Based on the events of 3/26/23-3/27/23, he had written up staff #1, suspended her for two days and an additional staff would be present when she was on shift - He had spoken with her about the protocols staff were to follow when performing bed checks and the importance of contacting him when a client had left the facility without permission - Staff #1 would also be receiving additional	V 115		

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training with the facility's Qualified Professional who planned to reiterate what he had already discussed with her as well as provide additional training

Review on 4/4/23 of the "Corrective Action Notice" completed by the Director for staff #1 revealed:
- The Director spoke with staff #1 on 3/27/23 about her failure to " ...properly conduct nighttime supervision checks which led to a resident (client #1) running away ..."
- Staff #1 was suspended without pay for two days beginning on 3/28/23
- The "expected improvement" by staff #1 reflected "[Staff #1] will be expected to complete nighttime supervision; visual confirmation, every 30min on all of the resident for safety and supervision. [Staff #1] will document, appropriate on the resident's sleep record every 30min. If [staff #1] fails to adhere to these protocols, further disciplinary actions will occur, but not limited to termination ..."