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V 000	INITIAL COMMENTS A complaint survey was completed on March 21, 2023. One complaint was unsubstantiated (intake #NC00199235). The other complaints were substantiated (intake #NC00199333 and intake #NC00199757). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 3 current clients and 2 deceased clients. An outpatient mental health services provider agency is referred to in this report. The outpatient mental health services agency is owned by the daughter of the Licensee of Edwards Group Home #4. The Qualified Professional/Registered Nurse/Licensee of Edwards Group Home #4 is the Registered Nurse for the outpatient mental health services agency.	V 000		
V 105	27G .0201 (A) (1-7) 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: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document;	V 105		

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V 105	Continued From page 1 (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this	V 105		

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V 105	Continued From page 2 purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the performance of coronavirus disease of 2019 (COVID-19) testing including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are: Review on 3/21/23 of client #3's record revealed: - 24 year old male admitted 6/15/22. - Diagnoses was Schizophrenia, paranoid type. - No documentation of COVID-19 testing or results. On 3/21/23 the clients were asked by the Registered Nurse/Qualified Professional/Licensee (RN/QP/L) if they would participate in interviews with the surveyors client #3 stated "No." Review on 3/21/23 of Center Disease Control (CDC) COVID-19 testing guidelines revealed "If you have symptoms (of COVID-19), test	V 105		

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V 105	Continued From page 3 immediately." Interview on 3/9/23 and 3/20/23 the House Manager (HM) stated: - Client #3 had COVID-19; he tested positive "yesterday." - Her supervisor, the Registered Nurse/Qualified Professional/Licensee (RN/QP/L), informed her "yesterday" that client #3's symptoms started "yesterday." - Client #3's symptoms were "runny nose" and "sore throat." - Client #3 had not been to the doctor; then stated, she was not sure if he had been tested. - On 3/20/23 the HM very loudly stated the following: - "You need to talk to her (the RN/QP/L) about that." - "We're frustrated right now." - "You're really annoying us right now." - "I gave my statement to the police, if you need it, go get it." - "Did she (the RN/QP/L) explain that we've had a very busy day?" - The HM refused to answer further questions. Interview on 3/14/23 the local county Health Department staff stated: - Group homes were required to report positive COVID-19 test results. - The facility had not reported a positive COVID-19 test result in the past week. - She had verified with the county Health Director, if a facility was prohibiting visitation because of COVID-19, the facility should have a positive COVID-19 test result to "back it up." Interview on 3/21/23 the RN/QP/L stated: - Client #3 had COVID-19 symptoms on 3/9/23. -The HM performed a COVID-19 test for client #3	V 105		

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V 105	Continued From page 4 using a home test kit. - Client #3 had tested negative for COVID-19; the date tested was not provided. - " ... you really should not test for 4-5 days after symptom onset because you can get a false positive." -The facility did not have a CLIA waiver but they were "linked" to another lab; the identity of the other lab was not provided by the RN/QP/L. - The RN/QP/L checked with a person "high up" in the state that was responsible for COVID-19 testing after speaking with the surveyor on 3/21/23 regarding client #3's COVID-19 testing. - This unidentified person told the RN/QP/L there were "flexibilities" in place that allowed facilities to perform COVID-19 testing without a CLIA waiver. The name, place of employment or position of her resource was not provided when requested by the surveyors. - The RN/QP/L made a phone call to the local Health Department after conversation with the surveyor and was told the facility was not required to report positive test results when they used the "home test." - Following the phone call to the Health Department, the RN/QP/L stated she checked with the HM and was told client #3 performed his own COVID-19 test; therefore, she did not consider a CLIA waiver required.	V 105		
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	V 112		

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V 112	Continued From page 5 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 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 reviews and interviews the facility failed to develop and implement strategies based on assessment for 1 of 2 deceased clients (DC #6). The findings are: Review on 3/10/23 of DC #6's record revealed: - 29 year old male admitted 5/11/14. - Date of death 3/02/23. - Diagnoses included Schizoaffective Disorder and Paraphilia. - Person Centered Plan (PCP) dated 5/18/22 included: "What's important . . . [DC #6] stated	V 112		

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that his family and being more independent is important to him . . . What's Working? . . . CST (Community Support Team) services have worked for [DC #6] with managing some of his negative behaviors and modifying those behaviors. What's Not Working? [DC #6] struggles with anger issues, inability to control impulsivity, coping skills to manage anxiety and depression and ability to regulate his emotions at times, improve social skills and how he relates to others. [DC #6] struggles with decision making skills, stealing, and following the negative actions of others."
- ". . . sexually assaulted his younger adopted brother . . . reports that he feels guilt, remorse, and shame for sexually assaulting of his younger brother especially now that his younger brother died in 2018. . . does not know what made him sexually assault his younger brother . . . continues to present with poor insight and judgment and inappropriate thoughts and behaviors of sexual urges towards animals and small children. Staff reports they have to redirect member (DC #6) about inappropriate behaviors in public, in order for him not to offend people in the community. Staff reports member has a continued habit of stealing from housemates and has been destroying property and urinating on the floor in the group home . . . member required 24-hour supervision at all times . . . Staff indicates member is mischievous, inappropriately playful, at times and often annoying to peers and staff in the residential setting . . . becomes angered easily and member reports that when he becomes angry . . . he destroys property . . . denies any current acts of inappropriate sexual behaviors . . . denies any current suicidal ideation or hallucination; he does report past history of hallucinations and delusions . . . reports he feels more able to control sexual urges and redirect

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urges and behaviors since receive support services . . . Member presents with displaced anger and struggles with relational and social skills. Member lacks interpersonal skills and impulse control . . . will benefit from community based services as support."
- ". . . Goal #1: With assistance from the Community Support Team, [DC #6] will maintain positive coping skills that will support him in his day to day functioning, 5 out of 7 days a week, as evidenced by him attending all scheduled appointments with primary care physician, dentist, psychiatrist and mental health provider and by learning the coping skills that assist him in managing his irrational thoughts, identifying troubling situations, and challenging negative thoughts. Who is Responsible [DC #6]-Member [Outpatient services provider agency] Edwards Group Home (Residential Provider) [the Psychiatrist] . . . "
- " . . . Goal #2: With assistance from Community support Team Staff, [DC #6] will learn coping skills that will assist him in redirecting away from negative and illogical thoughts, 5 out of 7 times weekly, as evidenced by addressing his feelings with staff and therapist, before he reacts with negative behaviors, over the next 60 days, as reported by [DC #6], CST staff and residential staff . . . Who is Responsible [DC #6]-Member [Outpatient services provider agency] Edwards Group Home (Residential Provider) [the Psychiatrist] . . ."
- ". . . Goal #3: With assistance from residential staff, [DC #6] will maintain his residential placement by complying with the rules, completing chores and complying with staff's directives of Group Home. [DC #6] will interact appropriately with peers and staff by increasing positive peer interactions and refraining from communication of threats and self-injurious

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behavior, when he does not want to follow residential rules with less than three incidents over the next 90 days as reported by [DC #6], and Group Home Staff. . . Who is Responsible [DC #6]-Member Edwards Group Home [the Psychiatrist] . . . How (Support/Intervention) Edwards Group Home Staff will: Counsel with [DC #6] when he becomes non-compliant refusing to follow staff request or follow rules. Staff will process with [DC #6] the importance of following the rules and staff request. Staff will review daily with [DC #6] the rules of the home to ensure his understanding of each rule. Staff will redirect [DC #6] when he is being non-compliant and will provide positive feedback when he is compliant. Staff will allow [DC #6] to discuss concerns about rules and will document concerns; and inform QP (Qualified Professional) of any problems. Staff will process with [DC #6] appropriate peer interactions and social skills . . . "

- No residential goals or strategies to address DC #6's contacts with his family or his identified behaviors of stealing, elopement attempts, inappropriate sexual behaviors, inappropriate sexual comments, property destruction, or anger issues.
- No documentation of review or update of goals and strategies after July 2022.

Review on 3/21/23 of DC #6's "QP (Qualified Professional) Monthly Summary" documentation from 7/1/22 - 2/28/23 signed by the Registerd Nurse/Qualified Professional/Licensee (RN/QP/L) revealed:
- Property destruction documented in July 2022, August 2022, September 2022, October 2022, December 2022, and January 2023.
- 3 elopement attempts: 1 in November 2022 and 2 in December 2022.

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-July 13, 2022 stealing from his roommate resulted in an altercation.
- February 2023 summary documented, "He was caught stealing cigarettes and smoking in the facility x 3."
-On 2/5/23 DC #6 punched and hit client #2 in his head and face.
-Inappropriate sexual behaviors were documented as follows:

-August 2022 summary, "... he (DC #6) admitted to touching someone inappropriately. Verbal report by staff indicated that the staff had to redirect him on August 22 for shouting out offensive sexual remarks toward an underaged child at [fast food restaurant]."

-December 2022 summary, "Staff had to stop him when he tried to get a stray dog to come into the group home yard on December 16, 2022. Staff had to remind him that he cannot have contact with animals after he revealed to staff why he wanted the dog to come into the yard."

-January 2023 summary, "Member (DC #6) anger outbursts decreased during this month as evidenced by having only three anger outbursts. The anger outbursts would only occur when he was redirected from having inappropriate sexual behaviors at home and in the community."

-February 2023 summary, "He continued to make inappropriate sexual language towards others at home and in the community."

Review on 3/13/23 of PCP effective 5/18/22 and updated 7/6/22 provided by the outpatient mental health services provider Licensed Clinical Social Worker - Associate/Therapist (LCSW-A/T) revealed:
- ". . . Goal #1: . . . Date Goal was Reviewed . . . 7/6/22 Status Code D (discontinued) Progress toward goal and justification for continuation or discontinuation of goal. . . . [DC #6] has

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demonstrated and maintained progress sufficiently to discontinue goal. Goal has been completed CST services as of 7/6/22."
- " . . . Goal #2: . . . Date Goal was Reviewed . . . 7/6/22 Status Code O (Ongoing) Progress toward goal and justification for continuation or discontinuation of goal. . . . [DC #6] has completed CST services as of 7/6/22 and has demonstrated identifying illogical thought content 4 out of 7 days a week."

During interviews on 3/10/23 and 3/13/23 the LCSW-A/T stated:
- She was the Licensed Professional on the Community Support Team that provided services to DC #6.
- The CST developed the PCP with input from the group home staff and the residential provider RN/QP/L; DC #6's guardian did not participate in the development of his PCP; she emailed information to DC #6's guardian but received no response.
- The RN/QP/L reached out to DC #6's guardian on behalf of the team; she was told the guardian's response was that "she was fine with the plan and she signed off on it."
- DC #6 received CST January 2022 - July 6, 2022; she updated the PCP on 7/06/22 when CST was discontinued.
- DC #6 was "having some negative behaviors in the group home."
- DC #6 "was proud" to tell her that he had not engaged in property destruction or stealing during CST sessions.
- She was concerned about the farm animals across the road from the facility and addressed it with DC #6; he "openly and honestly" discussed his inappropriate sexual urges with her.
- She recommended DC #6 receive either Psychosocial Rehabilitation (PSR) services or

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V 112	Continued From page 11 outpatient therapy when he completed CST in July 2022; PSR and outpatient therapy were a "step-down" from CST and were "maintenance" services. - Her recommendation was documented in the Comprehensive Clinical Assessment (CCA); she provided a copy of the CCA to the group home. - She believed everyone "would benefit from maintenance therapy." - DC #6 "was not fond of PSR;" he likened the service to "school." - DC #6 did not receive outpatient therapy after his completion of CST. - She saw DC #6 once on 10/14/22 just to "check in;" she went to the facility at the request of the RN/QP/L; DC #6 "talked about the holidays, he wanted to see if he could go home for Christmas." - In July 2022 the RN/QP/L notified her that DC #6 was involved in an altercation with a peer and was hospitalized for injuries he sustained during the fight; she "reached out" to DC #6. - CST and outpatient therapy services were provided by the same mental health provider agency that provided DC #6's medication management service. - The RN/QP/L was the Registered Nurse at the mental health provider agency that provided outpatient services, including medication management to DC #6. - The residential provider was responsible for requesting service authorizations from the Local Management Entity/Managed Care Organization (LME/MCO); services were authorized based on the client's assessed service needs. - She thought transportation was a barrier to DC #6 receiving outpatient therapy. During interview on 3/09/23 and 3/20/23 the House Manager stated:	V 112		

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- There were no paper client records at the facility; the RN/QP/L had them.
- The RN/QP/L told staff "the plan everyday" for each client.
- On 3/20/23 the HM very loudly stated the following:
    - "You need to talk to her (the RN/QP/L) about that."
    - "We're frustrated right now."
    - "You're really annoying us right now."
    - "I gave my statement to the police, if you need it, go get it."
    - "Did she (the RN/QP/L) explain that we've had a very busy day?"
- The HM refused to answer further questions.

During interviews on 3/10/23 and 3/21/23 the RN/QP/L stated:
- DC #6's PCP was developed by the mental health service agency responsible for his CST services; "they are the clinical home."
- "Of course they (the mental health provider) would consult with me because they would have to include the group home, that's why you see group home goals on the plan."
- " . . . with any plan you have, they will call and talk to mom (DC #6's mother/Guardian) because mom has to review the plan and sign the plan to say she's in agreement with the goals . . . "
- DC #6 no longer received services from the mental health service agency, so she "would do the plan."
- "As long as he was receiving services they (the outpatient mental health services provider) would do his plan, they were doing his plan."
- She did not know the exact date the mental health service agency discontinued DC #6's services.
- "I had updated the plan and was waiting for the guardian to send the signature page . . . they did

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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 112	Continued From page 13 not send it back . . . I thought it (DC #6's behaviors) was in that plan. I know it was in the plan I sent to them that they didn't send back." - "The plan that was done after the service ended was not sent back to me. She (the LCSW-A/T) included Edwards Group Home in all the goals." - "The group home goals will never end because we provide 24-7 services; she (the LCSW-A/T) included the group home in all the goals." - "I cannot make someone send things back." - "I had to have a signed plan, she didn't send it back, so we are going to continue to work on all the goals regardless of whether we have a plan or not." - "I review the plans with staff when we have a new admission; they know what the goals are." - "I keep the files (the client records) because things have a tendency to disappear. I send it (the plan) to them in an email; they send me a text message on each client, what is going on, if there are any changes, like a shift note; that's how I do my monthly QP summary." This deficiency is cross-referenced into 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (Tag V512) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.	V 291		

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V 291	Continued From page 14 (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure service coordination with the qualified professionals who were responsible for treatment/habilitation for 1 of 2 deceased clients (DC #6). The findings are: Review on 3/10/23 of DC #6's record revealed: - 29 year old male admitted 5/11/14. - Date of death 3/02/23. - Diagnoses included Schizoaffective Disorder and Paraphilia. - Person Centered Plan (PCP) dated 5/18/22 included: ". . . How best to support...[DC #6]	V 291		

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stated he feels supported when he has someone he can talk to about his feelings openly . . . "
- No documentation of a request for authorization of outpatient therapy, no service authorizations.
- No documentation of efforts to coordinate care to meet DC #6's identified mental health and behavioral needs.

Review on 3/13/23 of a Comprehensive Clinical Assessment (CCA) dated 11/17/21 provided by the Licensed Clinical Social Worker-Associate/Therapist (LCSW-A/T) revealed: ". . . Clinician Summary/Recommendations: . . . Upon successful completion of CST, member (DC #6) will transition and step down into a less restrictive service such as PSR (Psychosocial Rehabilitation) or OPT (Outpatient Therapy)."

Refer to V112 regarding "QP (Qualified Professional) Monthly Summary" documentation listing behaviors documented between the end of CST services on 7/6/22 and 2/28/23.

Review on 3/08/23 of a "Patient Care Record" dated 3/02/23 provided by the local Emergency Medical Services revealed:
- ". . . Primary Impression: Obvious Death . . . Signs & Symptoms: Obvious Death-Dependent Lividity . . . Injury: Suffocation/Asphyxiation-Hanging as cause of asphyxiation . . . HEENT (Head Ears Eyes Nose Throat): ligature marks . . . Patient has obvious dark bruising to neck, cyanotic lips and is cold centrally, with discolored face and fixed pupils. Closet had shoestring attached to bar, shoestring has been cut . . . "

During interviews on 3/10/23 and 3/13/23 the LCSW-A/T stated:

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- DC #6 received CST January 2022 - July 6, 2022.
- She was "shocked" when she learned of DC #6's death by suicide because "he never insinuated, gestured or talked about it; he never gave any indication" that he was suicidal.
- The mental health provider agency that provided DC #6's CST also provided his medication management service; the RN/QP/L was the Nurse at the mental health provider agency that served DC #6.

During interview on 3/09/23 the Medical Examiner stated:
- He did not believe DC #6's suicide was an "impulsive act" because of the method used.
- From his experience, when a person committed suicide by "leaning forward" to asphyxiate themselves, it was planned.
- DC #6 "could have stood to rescue himself" at any point before he lost consciousness.

Interview on 3/15/23 DC #6's Local Management Entity/Managed Care Organization (LME/MCO) Utilization Management (UM) Deputy Manager stated:
- DC #6 had a service authorization for group living "high" because his "needs are high."
- The facility would go "outside" if it was unable to meet these needs or if the client needed a "specialty service."
- This LME/MCO started providing DC #6's authorizations starting in 12/1/21.
- DC #6 received CST services from Jan 5, 2022 through July 2022.
- DC #6 did not have a care manager.
- The facility did not request additional services.
- Without a care manager, the UM department would approve services requested based on information supplied by the provider, the client's

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V 291	Continued From page 17 plan, and crisis plan. During interviews on 3/10/23 and 3/21/23 the RN/QP/L stated: - The outpatient mental health service agency responsible for DC #6's CST services was "the clinical home." - DC #6 no longer received services from the outpatient mental health service agency. - She did not know the exact date DC #6's CST services were discontinued. - She did not get a copy of the CCA. - "It's up to the MCO because they do the authorizations and the therapist . . . they (the LME/MCO) are going to go along with what the therapist says, so she must have decided he no longer needed the service, or either she could have thought he needed additional service and they wouldn't re-authorize. I don't know, I don't want to mis-speak, you will have to speak with her." - "I do not do outpatient services." - (Referring to DC #6) "We did everything we could do, it was just one of those things that happened." This deficiency is cross-referenced into 10A 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 291		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client	V 364		

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V 364	Continued From page 18 who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;	V 364		

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V 364	Continued From page 19 b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10)Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with	V 364		

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the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise.
Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to:
(1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;
(2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and
(3) Contact and consult with a client advocate, if there is a client advocate.
The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times.
(d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to:
(1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;
(2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;
(3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;

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V 364	Continued From page 21 (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10)Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated	V 364		

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V 364	Continued From page 22 by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure 1 of 2 deceased clients (DC #6) was able to make and receive telephone calls without restriction. The findings are: Review on 3/10/23 of deceased client (DC) #6's record revealed: - 29 year old male admitted 5/11/14. - Date of death 3/02/23. - Diagnoses included Schizoaffective Disorder and Paraphilia. - No clients rights restrictions documented as part of DC #6's treatment plan. Review on 3/21/23 of "Edwards Group Home Rules" revealed: - "A phone is available for all residents to use in a private area." - "All residents are encouraged to limit phone calls to 15 minutes." Observation on 3/21/23 at 3:20 pm revealed a desk style phone (not portable) with attached	V 364		

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receiver was located on the staff desk in the kitchen.

Interview on 3/9/23 DC #6's mother/Guardian stated:
- She was not able to visit DC #6 often because of the distance from her home to the facility.
- In the past she and her husband made calls from their phones and got no answer. A call was made from her younger son's phone and she (the Registered Nurse/Qualified Professional/Licensee (RN/QP/L)) answered, "like she (the RN/QP/L) was screening calls."
- When she called the facility no one would answer the phone. Sometimes she would be told the "ringer is turned off" or the phone was "unplugged."
- They were "never" able to call the house and reach DC #6. They had to call the RN/QP/L and sometimes that was "hard."
- They would call the RN/QP/L and leave a message. On average the RN/QP/L would call them back 2 to 3 days later.
- The longest time before the RN/QP/L returned their call was 3 days. This was after her husband had called the RN/QP/L back and left another message that their first call had not been returned.
- They had to depend on the RN/QP/L calling the facility and telling the staff to answer the phone in order to talk with DC #6.
- When they were able to speak with DC #6 on the phone they were limited to 15 minutes.
- She could hear the staff tell him to "get off the phone."
- She could tell there was someone near enough by to over hear the conversation; the calls "sounded like it was on speaker phone."
- When DC #6 first moved in she was told staff had to monitor his phone calls for psychiatric

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reasons.
- Her other family members who called DC #6 had similar experiences when they tried to reach DC #6 on the phone.
- When she was able to speak to DC #6 he was usually "real chipper."
- The last time she spoke with DC #6 he was excited because his family was planning on visiting him on his birthday in May.
- There were times DC #6 would be "a little down," but when she would talk with him he would "perk up."
-The last time she spoke with her son was "a couple of weeks" prior to his suicide.

Interview on 3/13/23 the Licensed Clinical Social Worker - Associate/Therapist stated:
- She was DC #6's therapist when he received Community Support Team (CST) services ending in July 2022.
- She provided her clients with her phone number and a copy of their Crisis Plan that included all phone number contacts.
- DC #6 had the capacity to independently make phone calls, but she was not sure the clients in the facility had "free access" to use the phone.
- She never received calls from her clients that resided in the facility.

During interview on 3/20/23 the HM very loudly stated:
- "You need to talk to her (the RN/QP/L) about that."
- "We're frustrated right now."
- "You're really annoying us right now."
- "I gave my statement to the police, if you need it, go get it."
- "Did she (the RN/QP/L) explain that we've had a very busy day?"
- The HM refused to answer further questions.

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V 364	Continued From page 25 Interview on 3/21/23 the RN/QP/L stated: - Clients could use the phone, "Usually anywhere from, well because it was 6 clients, usually 15 - 30 minutes, unless no one else is having a phone call they can talk as long as they want to." - "... If they need to have privacy they can close this door (the kitchen door)." - The ringer is turned off "...sometimes, especially if [client #2], he likes to play with the phone and he likes to turn the ringer off; all parents know they can call and reach me and I'll say okay, let me call the staff, ask them to check the ringer, then call parent back to let them know to call the facility back." - "Whenever, they (guardians and family members) know that if they can't get through, they can call me, they all have my number." - "DC #6's family would very seldom call, so if they did call and could not get through, I told him (DC #6's father) to call me and I wanted him to be able to talk to him; sometimes I'll call staff and tell them to make sure the ringer is on; the staff say that the ringer is on and he hasn't called." This deficiency is crossed referenced into 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 364		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their	V 366		

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V 366	Continued From page 26 response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal	V 366		

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review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;

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V 366	Continued From page 28 (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to meet all elements of response as required for level I, II and III incidents. The findings are: Review on 3/10/23 of deceased client (DC) #6's record revealed: - 29 year old male admitted 5/11/14. - Date of death 3/02/23. - Diagnoses included Schizoaffective Disorder and paraphilia. Review on 3/21/23 of DC #6's "QP (Qualified Professional) Monthly Summary" documentation from 6/1/22 - 2/28/23 signed by the Registered Nurse/Qualified Professional/Licensee (RN/QP/L) revealed: - 10 specific references to property destruction in the facility. - February 2023 summary documented, "He was caught stealing cigarettes and smoking in the facility x 3."	V 366		

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V 366	Continued From page 29 - Inappropriate sexual behaviors were documented as follows: -August 2022 summary, "... he (DC#6) admitted to touching someone inappropriately. Verbal report by staff indicated that the staff had to redirect him on August 22 for shouting out offensive sexual remarks toward an underaged child at [fast food restaurant]." -January 2023 summary, "Member anger outbursts decreased during this month as evidenced by having only three anger outbursts. The anger outbursts would only occur when he was redirected from having inappropriate sexual behaviors at home and in the community." Review on 3/21/23 of the facility incident report log for incidents between 6/1/2022 and 3/17/23 revealed: - No incidents documented for DC#6's property destruction, stealing, or inappropriate sexual behaviors. - Level II incident on 7/13/22 documented DC#6, "Stealing from roommate & injuries occurred." -No level II incident documented on the log for the former client who caused DC#6's injuries on 7/13/22. - Level 1 incident on 2/5/23 documented client #2 complained of a headache after DC#6 punched client #2 in the head and face. Client was transported to the emergency department, tested positive for COVID-19 (coronavirus). - No level II incident documented on the log for DC#6 who punched client #2 in the head and face on 2/5/23. - Level III incident (documented on log as a level II) on 3/2/23 when DC#3 committed suicide. Review on 3/21/23 of facility incident response documentation between 6/1/2022 and 3/17/23 revealed:	V 366		

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- Incident response documented for the level II incident on 7/13/22 did not include corrective or preventive measures for DC #6's stealing behavior.
- Incident response documented for the 2/5/23 incident did not include corrective or preventive measures for DC #6's physical aggressive behaviors.
- Incident response to the level III incident on 3/2/23 did not include:
  -convening an internal review team within 24 hours made up of individuals who were not involved in the incident, not responsible for the client's direct care, or with direct professional oversight of the client's services at the time of the incident.
  -submission of a written preliminary findings of fact within five working days of the incident to the LME/MCO (Local Management Entity/Managed Care Organization) in the catchment area of the facility or the client's residence.

Interview on 3/21/23 the RN/QP/L stated:
- The facility Director, the RN/QP/L, and the Home Manager had discussed the level III incident on 3/2/23.
- There was no other internal review team convened.
- There had been no 5 day report submitted to the LME/MCO as required.
- On 2/05/23 "[DC#6] punched him (client #2) in the head and face ... It was an injury but did not require any stitches. That's the category I was looking at ... categorized as a level I because it only required first aide." Client #2 was taken to the hospital because he complained of a headache, but he tested positive for COVID and the doctor said that was the reason for his headache.
- She had not identified the former client's and

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V 366	Continued From page 31 DC #6's aggressive behaviors on 7/13/22 and 2/5/23 respectively, as being level II incidents when they each hit a peer.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that	V 367		

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information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III

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V 367	Continued From page 33 incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to submit level II and level III incident reports to the Local Management Entity (LME) within 72 hours as required. The findings are: Review on 3/10/23 of deceased client (DC) #6's record revealed: - 29 year old male admitted 5/1/14 and died by suicide on 3/2/23. - Diagnoses included Schizoaffective Disorder and paraphilia. Review on 3/21/23 of DC #6's hospital record for his 7/13/22 admission revealed: - Emergency admission on 7/13/22 following an altercation with his roommate that resulted in a closed head injury and intracranial hemorrhage with transient loss of consciousness. - Physician documented, "Patient was apparently kicked in the head several times. He required several minutes to regain consciousness and was unable to stand independently. He did have significant left lateral eye hematoma and laceration requiring sutures."	V 367		

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V 367	Continued From page 34 - Discharged on 7/15/23 for Intraparenchymal hematoma of the brain. Review on 3/21/23 of deceased client (DC) #5's record revealed: - 66 year old male admitted 5/14/21 and died on 3/15/23. - Diagnoses included Schizoaffective Disorder. Review on 3/17/23 of the Emergency Medical Services (EMS) call report for response to the facility on 3/15/23 revealed: - Call received at 7:07 pm. - At 7:29 pm comment documented DC #5 "Fell in the bathroom. Hit his head went into arrest and passed away." Review on 3/21/23 of DC #6's "QP (Qualified Professional) Monthly Summary" documentation from 6/1/22 - 2/28/23 signed by the RN/QP/L revealed: -August 2022 summary, "... he (DC#6) admitted to touching someone inappropriately. Verbal report by staff indicated that the staff had to redirect him on August 22 for shouting out offensive sexual remarks toward an underaged child at [fast food restaurant]." Review on 3/21/23 of the facility incident report log for incidents between 1/1/2022 and 3/17/23 revealed: - Level II incident on 7/13/22 documented DC#6, "Stealing from roommate & injuries occurred." -No level II incident documented on the log for the former client who caused DC#6's injuries on 7/13/22. - Level 1 incident on 2/5/23 documented client #2 complained of a headache after DC#6 punched client #2 in the head and face. Client was transported to the emergency department, tested	V 367		

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positive for COVID-19 (coronavirus).
- No level II incident documented on the log for DC#6 who punched client #2 in the head and face on 2/5/23.

Review on 3/8/23 and 3/21/23 of the facility Incident Response Improvement System (IRIS) reports from 6/1/22 - 3/21/23 revealed:
- No level II incident report for DC#6's admission to the hospital on 7/13/22 for his injuries sustained during the altercation with his peer.
- No level II incident report for the discharged client's acts on 7/13/22 that caused DC#6's serious injuries. (The roommate was no longer a client in the facility.)
- No level II incident report for DC #6's touching someone inappropriately in August 2022.
- No level II incident report for the DC #6 shouting out offensive sexual remarks toward a child at [fast food restaurant] in August 2022.
- No level II incident report for DC#6's aggressive behavior on 2/5/23 when he hit client #2 in the head and face.
- The following additional information requested on 3/6/23 for DC#6's IRIS report dated 3/5/23 (incident dated 3/2/23) had not been submitted:
  -"Did the individual receive any other services in addition to medication management?"
  -"Please complete internal findings report and indicate safety measures that have been implemented."
- The following information was not completed on DC#6's level III IRIS report submitted on 3/5/23:
  -Time of incident.
  -Incomplete consumer information (i.e. height, weight, last 2 medical exams).
- Level II incident report for DC#5's death on 3/15/23 was submitted on 3/19/22.
- The following information was not completed on DC#5's level II IRIS report submitted on 3/19/23:

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V 367	Continued From page 36 -Time of incident. -"Did the incident occur while the consumer was on these premises?" -Incomplete consumer information (i.e. height, weight, last 2 medical exams). -"When did the consumer last receive a mental health service?" Interview on 3/21/23 the RN/QP/L stated: - Staff #8 always completed the IRIS reports. - If something was missing from an IRIS report the facility would "usually" get feedback. - She had not gotten any feedback to supply additional information on DC#6's IRIS report for his death on 3/2/23. - The RN/QP/L entered the IRIS report for DC#5's death on Saturday (3/18/23) starting at 11:30 pm. "It (the IRIS report) does have the 19th but I started it on the 18th so evidently the system, it went past midnight. It says here 12:43. I marked it on my calendar. I started it around 11:30 that night, so evidently when it went in it was past midnight..." - "[Staff #8] told me she entered it (IRIS report 7/13/22) ... she does the paper version first and then the electronic submission..." - She had not identified the former client's and DC #6's aggressive behaviors on 7/13/22 and 2/5/23 respectively, as being level II incidents when they each hit a peer. - Following review of the IRIS level II category definition for "Consumer act" with the surveyor, "Okay, I guess I looked at it differently than you (surveyor). That was one of the reasons why with [DC#6] the PA (Physician's Assistant) said (referring to the 7/13/22 incident) there should be charges filed. I called his (DC#6's) father and he said "He got exactly what he deserved. He needs to stop stealing."	V 367		

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V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on observation, record reviews and interviews 1 of 1 Qualified Professional (the Registered Nurse/Qualified Professional/Licensee (RN/QP/L)) neglected 1 of 2 deceased clients (DC #6). The findings are: Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE	V 512		

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V 512	Continued From page 38 PLAN (Tag V112). Based on record reviews and interviews the facility failed to develop and implement strategies based on assessment for 1 of 2 deceased clients (DC #6). Cross Reference: 10A NCAC 27G .5603 OPERATIONS (Tag V291). Based on record review and interview the facility failed to ensure service coordination with the qualified professionals who were responsible for treatment/habilitation for 1 of 2 deceased clients (DC #6). Cross Reference: 122C-62 ADDITIONAL RIGHTS IN 24-HOUR FACILITIES (Tag V364). Based on observation, record review, and interview, the facility failed to ensure 1 of 2 deceased clients (DC #6) was able to make and receive telephone calls without restriction. Review on 3/10/23 of the RN/QP/L's personnel record revealed: - Date of Hire 2000. - Registered Nurse Permanent License approved by the North Carolina Board of Nursing 8/23/76, expiration date 12/31/24. Review on 3/21/23 of a Plan of Protection completed 3/21/23 and signed by the RN/QP/L revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? QP will meet with the residential staff today to discuss the cited rule violations. The QP and residential staff provided [DC #6] with a therapeutic & (and) caring family oriented environment the entire time he was with us. Everyone was in a state of shock when he committed suicide. Edwards Group Home does not provide outpatient therapy. [DC #6] never	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040-027	A. BUILDING: _____ B. WING _____	03/21/2023

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V 512	Continued From page 39	V 512		

requested to see a therapist, but knew his therapist was available to see him if needed. The therapist made informal visits to the facility regularly and talked to all residents. [DC #6] never showed any signs of emotionally instability. If needed, the therapist was accessible 24/7. After CST (Community Support Team) ended a PCP (Person Centered Plan) (residential plan) was completed but could not be used because the signature page was not returned to the facility. Clients are encouraged to talk to family members. I gave [DC #6]'s father my cell phone # (number) so he could call me if he was not able to contact him on the facility phone. He called twice and I made sure he could talk to [DC #6]. According to the residential staff, his family rarely called him. It hurts me to my core that these violations were cited because they are not true!"
- "Describe your plans to make sure the above happens. Staff will provide frequent room checks and will encourage clients to verbalize their feelings/concerns. Therapy appointments will be scheduled if requested or needed. Staff will continue to encourage clients to contact family members/significant others. Staff will continue to ensure that client rights are protected."
- RN/QP/L's signature was not dated.

DC #6 was a 29 year old male who was admitted to the facility on 5/11/14 and committed suicide by hanging on 3/2/23. His diagnoses were Schizoaffective Disorder and Paraphilia. DC #6 had a history of inappropriate sexual behaviors with children and animals. CST services ended on 7/06/22 with a recommendation for enrollment in either Psychosocial Rehabilitation or outpatient therapy. DC #6 continued to have adverse behaviors including a physical assault of a peer in February 2023. The facilty did not provide or request authorization for outside services to

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V 512	Continued From page 40 support DC #6, nor was his treatment plan updated to include contacts with his family or his identified behaviors of stealing, elopement attempts, inappropriate sexual behaviors, inappropriate sexual comments, property destruction, and anger issues. DC #6's family depended on phone communication to stay in touch with DC #6 but experienced repeated delays to reach him when they called the facility. There were no strategies in DC #6's treatment plan to support him in being able to communicate with his family without barriers. This deficiency constitutes an A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $8000.00 is imposed. If the violation is not corrected within 23 day, 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 512		