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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on April 20, 2023. The complaints were unsubstantiated (Intake #NC00195217, NC00200720, NC00200789). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disabilities. This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients. This survey originally closed on 4/11/23 but was reopened on 4/17/23 due to additional complaints.	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; (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	V 105		

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V 105	Continued From page 1 (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 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;	V 105		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement written policies regarding admissions affecting 1 of 5 audited clients (#4). The findings are:

Review on 3/23/23 of client #4's record revealed:
- Admission date 3/4/23;
- Age 10;
- Diagnoses: Moderate Intellectual Developmental Disorder, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder Combined Type, Other Persistent Mood Disorders;
- No admission assessment.

Review on 4/11/23 of the facility's Admission Policy, titled Evaluation & Admission Assessment revealed:
- "Once a client referral is accepted into the agency the following additional information will be requested from the referring agency. This information must be submitted to (Licensee) prior to admission for services. Medication evaluation will conform to acceptable medical practice. The information requested is listed below and is only requested as applicable and with appropriate valid consent to exchange information ..."
- "Assessment and Screenings will be conducted prior to the admission of clients and will include

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V 105	Continued From page 3 the following: An assessment of the individual's presenting problem or need. An assessment of whether or not the facility can provide services to address the individual's needs ..." Interview on 3/22/23 with the Qualified Professional revealed: -There was no admission assessment for the current group home (Fort Henry) placement, due to client #4 already receiving services at a previous licensed Alternative Family Living (AFL) home placement through the Licensee; - Client #4 was staying at the group home "temporarily", until another AFL placement could be identified. Interview on 4/11/23 with the Chief Executive Officer (CEO) revealed: - Client #4's assessments were from previous placement at a licensed AFL home through [Licensee]; - On 2/26/23, while at the AFL home client #4 went to the local hospital during an internal investigation, due to making allegations against the AFL home provider; - Client #4 did not want to return to the AFL home; - Client #4's "mother stated that she was not coming to pick him up from the hospital"; - "Felt bad" and informed the client's care coordinator "I have a licensed bed"; - Client #4's mother "agreed" for client to come to the group home (Fort Henry) until another AFL placement could be identified. - It was only a "temporary placement" for client #4.	V 105		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL	V 108		

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REQUIREMENTS
(f) Continuing education shall be documented.
(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:
(1) general organizational orientation;
(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;
(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and
(4) training in infectious diseases and bloodborne pathogens.
(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.
(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan

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affecting 2 of 3 audited staff(#1, #2,). The findings are:

Review on 3/22/23 of Staff #1's personnel record revealed:
- Date of Hire 1/20/21;
- Job title Direct Support Professional;
- No evidence staff #1 had completed training to meet the mh/dd/sa needs of client #4 as specified in the treatment/habilitation plan.

Review on 3/27/23 of staff #2's personnel record revealed:
- Date of Hire 9/8/20;
- Job title Direct Support Professional;
- No evidence staff #2 had completed training to meet the mh/dd/sa needs of the client #4 as specified in the treatment/habilitation plan.

Interview on 4/11/23 with staff #1 revealed:
- All trainings were up to date;
- Worked with client #4 a few times;
- "Not sure if I reviewed his treatment plan."

Interview on 3/27/23 with staff #2 revealed:
- All trainings were up to date;
- " I don't know" anything about client 4's treatment plan.

Interview on 4/11/23 with Chief Executive Officer revealed:
- Client #4 was "only going to be at the group home until another Alternative Family Living (AFL) placement was identified."

V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan	V 111		

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10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN
(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:
(1) the client's presenting problem;
(2) the client's needs and strengths;
(3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission;
(4) a pertinent social, family, and medical history; and
(5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs.
(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to have an assessment that reflected

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the presenting problem and needs of the client was completed prior to the delivery of services affecting 1 of 5 audited clients (#4). The findings are:

Review on 3/23/23 of client #4's record revealed:
- Admission date 3/4/23;
- Age 10;
- Diagnoses: Moderate Intellectual Developmental Disorder, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder Combined Type, Other Persistent Mood Disorders;
- No admission assessment.

Review on 3/23/23 of a facility document labeled [Licensee] Transitional Meeting Minutes dated 2/28/23 revealed:
-" ...The team addressed leaving the goals the same as it can be run both in an Alternative Family Living (AFL) and group home setting ..."

Review on 4/11/23 of the facility's Admission Policy, titled Evaluation & Admission Assessment revealed:
- "Assessment and Screenings will be conducted prior to the admission of clients and will include the following: An assessment of the individual's presenting problem or need. An assessment of whether or not the facility can provide services to address the individual's needs ..."

Interview on 3/27/23 with client #4 revealed:
- Been in the home for a week;
- "Like" the group home and wanted to continue to live in the group home.

Interview on 3/22/23 with the Qualified Professional revealed:
-There was "no new assessment" completed due

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V 111	Continued From page 8 to client #4 already receiving services from [Licensee]; - Client #4 was staying at the group home "temporarily"; Interview on 3/23/23 and 4/11/23 with the Chief Executive Officer revealed: - Client #4's assessments were from previous placement at a licensed AFL home through [Licensee]. - It was only a "temporary placement" for client #4; - Client #4 would "continue to work on the same goals as previous AFL" placement in the group home.	V 111		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address	V 113		

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and telephone number of the client's preferred physician;
(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;
(7) documentation of services provided;
(8) documentation of progress toward outcomes;
(9) if applicable:
(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);
(B) medication orders;
(C) orders and copies of lab tests; and
(D) documentation of medication and administration errors and adverse drug reactions.
(b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.

This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to ensure a client record was maintained with all required documents affecting 1 of 5 clients (#4). The findings are:

Review on 3/23/23 of the facility's document titled [Licensee] revealed:
- Admission date 3/4/23;
- Diagnoses: Moderate Intellectual Developmental Disorder, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder Combined Type, Other Persistent Mood Disorders;

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V 113	Continued From page 10 - There was not a record for client #4; - Client #4 did not have documentation on site that included: A face sheet, documentation of mental illness, documentation of screening and assessment, treatment/habilitation plan, documentation of progress towards outcomes, emergency information, documentation of service provided, a signed statement for the client or legally person granting permission to seek emergency care. Interview on 3/22/23 with the Qualified Professional revealed: -There was no record in the home; - Client #4 was staying at the group home "temporarily"; Interview on 4/1//23 with the Chief Executive officer revealed: - Had a record for client #4 for services with Alternative Family Living; - The group home was only a "temporary placement" for client #4.	V 113		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;	V 366		

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(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 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

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V 366	Continued From page 12 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; (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	V 366		

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applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement, written policies governing their responses to level II incidents affecting 2 of 5 audited clients (#2, #3). The findings are:

Review on 3/22/23 of Incident Response Improvement System (IRIS) from 10/06/22-1/6/23 revealed:
- No IRIS report, Risk Cause/Analysis , or documentation to support submission of the written preliminary findings of fact to the Local Management Entity (LME)/ Managed Care Organization (MCO) within 5 working days for client #2, attacked residents and staff in the home. Placed holes in the wall of living room, kitchen and hallway on 12/29/22;
- No IRIS report, Risk Cause/Analysis, or documentation to support submission of the written preliminary findings of fact to the LME/MCO within 5 working days of client #3, who had self-injurious behaviors that required a trip to the emergency room. Client #3 cut his middle finger by hitting the living room window on 12/27/22;
- No IRIS report, Risk Cause/Analysis, or documentation to support submission of the written preliminary findings of fact to the LME/MCO within 5 working days of when client #2 hit and broke window and injured her right

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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 366	Continued From page 14 wrist on 12/24/22; - No IRIS report, Risk Cause/Analysis, or documentation to support submission of the written preliminary findings of fact to the LME/MCO within 5 working days of when client #3 physically attacked a client in the car on 11/14/22; - No IRIS report, Risk Cause/Analysis, or documentation to support submission of the written preliminary findings of fact to the LME/MCO within 5 working days of when client #3 who tried to lock staff in the medication closet and property destruction on 11/1/22. Interview on 3/22/23 with the Qualified Professional (QP) revealed: - Responsible for completing IRIS reports; - The "[Chief Executive Officer] completed IRIS reports" too. Interview on 4/11/23 with the Chief Executive Officer revealed: - The QP was responsible for IRIS reports; - "We are getting better at putting in the IRIS reports."	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	V 367		

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	MHL036-366	A. BUILDING: ______ B. WING ______	R 04/20/2023

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V 367	Continued From page 15	V 367		

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 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

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V 367	Continued From page 16 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 incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all critical incidents in the	V 367		

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V 367	Continued From page 17 Incident Response improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment areas where services were provided within 72 hours of becoming aware of the incident affecting 2 of 5 audited clients (#2, #3). The findings are: Review on 3/22/23 of the IRIS from 10/06/22-1/06/23 revealed: - No IRIS report submitted for the allegation of client #2 attacked residents and staff on the home. Placed holes in the wall of living room, kitchen and hallway on 12/29/22; - No IRIS report submitted of allegations of client #3, who had self-injurious behaviors that required a trip to the emergency room. Client #3 cut his middle finger by hitting the living room window on 12/27/22; - No IRIS report submitted for allegations of client #2 hit and broke window and injured her right wrist on 12/24/22; - No IRIS report submitted for the allegation of client #3 physically attacked a client in the car on 11/14/22; - No IRIS report submitted for the allegation of client #3 who tried to lock staff in the medication closet and property destruction on 11/1/22. Review on 3/22/23 of the facility's records revealed: - No documentation of the LME/MCO notification of client #2, who attacked residents and staff on the home. Client #2 placed holes in the wall of living room, kitchen and hallway on 12/29/22; - No documentation of the LME/MCO notification of client #3, who had self-injurious behavior that required trip to the emergency room. Client #3 cut his middle finger by hitting the living room window on 12/27/22.	V 367		

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V 367	Continued From page 18 - No documentation of the LME/MCO notification of client #2 hit and broke window and injured her right wrist on 12/24/22; - No documentation of the LME/MCO notification of client #3 physically attacked a client in the car on 11/14/22; - No documentation of the LME/MCO notification of client #3 who tried to lock staff in the medication closet and property destruction on 11/1/22. Interview on 3/2223 with the Qualified Professional (QP) revealed: - Responsible for completing IRIS reports; - The "[Chief Executive Officer] completed IRIS reports" too. Interview on 4/11/23 with the Chief Executive Officer revealed: - The QP was responsible for IRIS reports; - "We are getting better at putting in the IRIS reports."	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews the facility	V 736		

Division of Health Service Regulation

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V 736	Continued From page 19 was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 3/22/23 at approximately 1:12pm of the facility revealed: - Kitchen- 9 brown burn spots ranging in size from approximately a dime size to 1 ½ inches long; - Bedroom on the left side of the hallway- headboard missing 2 of 3 panels; - Back screened door in the kitchen missing top glass in top portion of the screen	V 736		