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V 000	INITIAL COMMENTS An annual and follow up survey was completed July 31, 2023. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL 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.	V 108		

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V 108	Continued From page 1 (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, interview, and observation the facility failed to ensure staff training to meet client specific needs for 2 of 3 staff audited (Staff #3, Staff #7) and ensure at least 1 staff was present with clients at all times who had been trained in cardiopulmonary resuscitation (CPR) and the Heimlich maneuver as required, affecting 1 of 3 staff audited (Staff #3). The findings are: Review on 7/27/23 and 7/28/23 of Staff #3's record revealed: -Paraprofessional hired on 5/25/22. -American Red Cross First Aid/CPR card dated 7/13/22; the name of the Licensee was listed as the instructor. -No documentation of training on client needs pertaining to Intellectual /Developmental Disabilities (I/DD) except for "Vital Signs Training for Caregivers of Individuals with I/DD." Review on 7/27/23 and 7/28/23 of Staff #7's record revealed: -Paraprofessional hired on 5/3/23. -No documentation of training on client needs pertaining to I/DD except for "Vital Signs Training for Caregivers of Individuals with I/DD." -No documentation of training on client needs	V 108		

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pertaining to Schizophrenia, Bipolar Disorder, or Traumatic Brain Injury (TBI).
-No additional training documented about the needs of client #3 following this client's 7/1/23 elopement.

Review on 7/27/23 the House Manager's (HM) record revealed:
-Paraprofessional hired was 5/25/20.
-American Red Cross First Aid/CPR training dated 3/18/22.
-No documentation of CPR/FA Instructor certification by the American Red Cross.

Review on 7/26/23 of the clients' records revealed:
-Client #1:
-52 year old male admitted 8/12/19.
-Diagnoses included unspecified Schizophrenia Spectrum and Unspecified I/DD.
-Client #2:
-22 year old male admitted 11/28/19.
-Diagnoses included Autism, Disruptive Mood Dysregulation Disorder; Oppositional Defiant Disorder, and Bipolar, Unspecified.
-Client #3:
-52 year old male admitted 5/2/22.
-Diagnoses included Schizophrenia, Bipolar Disorder; and Traumatic Brain Injury (TBI).

Observations on 7/26/23 and 7/27/23 at approximately 4pm each day revealed:
-The HM was the only direct care staff on duty during the day shift and left around 4 pm.
-Staff #3 replaced the HM on each day as the only direct care staff on duty.

Interview on 7/26/23 and 7/28/23 Staff #3 stated:
-She had learned about client specific needs by reviewing the client books and by her peers

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verbally telling her about the clients.
-When hired she "shadowed" the HM on "day 1" and a peer on "day 2."
-CPR training was "online" and by the HM. The HM had a training guide, and Staff #3 looked at pictures and watched videos on the computer.
-She had not practiced or demonstrated CPR skills on a manikin.
-The HM watched her perform CPR using the lung bag.

Interview on 7/27/23 Staff #7 stated:
-When trained about the clients, he had not been informed that client #3 was an elopement risk.
-On 7/1/23 he allowed client #3 to go sit on the front porch alone, and after 15 minutes it was discovered he had eloped.

Interview on 7/28/23 the HM stated:
-Documentation of client specific needs were documented in each staff personnel notebook.
-Staff completed training during their orientation "on boarding" process.
-She printed certificates and filed them in the staff personnel notebooks for the training completed.
-Staff had completed training on Schizophrenia and TBI.
-The staff had not completed training about bipolar disorder.
-She was not certified as a CPR instructor.
-The plan was for her to become a certified CPR instructor.
-Staff #3 had taken CPR on the computer and she (the HM) had watched Staff #3 perform CPR using the lung bag.
-She knew when the staff was performing the CPR skills correctly because she could see the bag movement.

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V 109	Continued From page 4	V 109		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.	V 109		

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This Rule is not met as evidenced by:
Based on interview and record review, 1 of 1 Qualified Professional (QP) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are:

Review on 7/28/23 of the QP's file revealed:
-Hire date was 1/1/2019.
-Promoted to QP position 3/14/19.
-QP job description responsibilities included:
-Provide on-site leadership.
-"Oversee" the operation of the group home to "ensure a productive 'person-centered' experience for residents."
-Orientation and training of staff.
-"Determining better ways for staff and resident processes."

Refer to V108 regarding staff training.
-Staff #3 had not been trained by a certified CPR (cardiopulmonary resuscitation) instructor for CPR/First Aid.
-Staff #3 and Staff #7 lacked client specific trainings.

Refer to V110 regarding staff competency and supervision by a QP.
-House Manager (HM) provided CPR training for Staff #3 without being a certified instructor.
-Staff #7 demonstrated a lack of competency when he delegated his supervision responsibility to client #2 on 7/1/23 to "check" on client #3.

Refer to V112 regarding treatment plans for client #2 and client #3.
-No unsupervised time documented in client

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#2's plan.
-No behavior plan for client #3; no changes in his plan/strategies following incidents that were detrimental to client #3's health and safety.
-Client #3's treatment plan dated 5/2/22 was signed and dated by the Qualified Professional on 5/2/22.
-No one other than client #3 had signed the clients treatment plan dated 6/1/23.

Refer to V513 regarding client rights restrictions.

Interview on 7/27/23 the QP stated:
-He was familiar with the licensure rules as he had set up the original facility.
-He had "overall program responsibility."
-He did not provide supervision of the paraprofessional staff other than the HM, a paraprofessional.
-The HM provided direct supervision of the other paraprofessional staff.
-He visited the facility quarterly and had phone discussions with the HM weekly.
-During his quarterly site visits he reviewed client files, observed for "overall cleanliness," and met with the HM to ensure the program was in compliance with the rules.
-He was aware of the recent incidents with client #3.
-The internal investigation of client #3's elopement on 7/1/23 identified some "evidence" of neglect on the part of Staff #7.
-Staff #7 was to go through elopement and expectations training.
-He did not provide staff training.
-The HM provided staff training unless there was a need for an "external trainer."
-Client specific training was done by the HM and it should be documented in each staff's file.
-The plan was for the HM to become a certified

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V 109	Continued From page 7 CPR instructor; at present she was not a certified instructor. -He did not believe client #2 had an order to self-administer his medication, but the client was capable. -He was not sure if client #2 had unsupervised time in his plan. -Client restrictions could not be implemented unless approved by the client's treatment team. -The restrictions of food and beverage in client rooms was needed for pest control. -He agreed the restriction to prohibit a bottle of water in a client room was a restriction. -Restrictions of food and water had not been presented to the clients' treatment teams.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills;	V 110		

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V 110	Continued From page 8 (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure paraprofessionals were supervised by an Associate or Qualified Professional (QP) effecting 2 of 3 direct care staff audited (Staff #3 and #7), and 2 of 3 direct care staff failed to demonstrate competency (House Manager (HM), Staff #7). The findings are: Review on 7/27/23 and 7/28/23 of Staff #3's record revealed: -Paraprofessional hired on 5/25/22. Review on 7/27/23 and 7/28/23 of Staff #7's record revealed: -Paraprofessional hired on 5/3/23. Review on 7/27/28 the HM record revealed: -Paraprofessional hired was 5/25/20. -3/18/22: Certified in basic First Aid/CPR (cardiopulmonary resuscitation). -Job description listed responsibilities for conducting training as needed and maintain program records and prepare reports as required and requested.	V 110		

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Finding #1:
Interview on 7/28/23 the Assistant Program Director stated:
-She had reviewed staff files during her on-site visit that started 7/26/23.
-There was no documentation the QP had provided any supervision of the paraprofessional staff.
-She supervised the HM and the HM supervised the other paraprofessional staff.

Interview on 7/27/23 the QP stated:
-He did not provide supervision of the paraprofessional staff other than the HM.
-The HM provided direct supervision of the paraprofessional staff.

Finding #2:
Review on 7/27/23 of the "Internal Investigation Report" dated 7/21/23 of client #3's elopement on 7/1/23 revealed:
-Staff #7 was on duty at the time of the elopement.
-15 minutes after he observed client #3 go out to the front porch, Staff #7 delegated his supervision responsibility to client #2 when he asked him to go "check on" client #3. Client #3 had eloped.

Interview on 7/27/23 Staff #7 stated:
-On 7/1/23 client #3 asked to go to the front porch.
-The supervision routine was to check clients every 15 minutes.
-He and the other 2 clients were inside and the clients were watching television and playing video games.
-About 15 minutes after client #3 went to the front porch he asked client #2 to go check on client #3.
-Client #2 returned and reported client #3 was not

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V 110	Continued From page 10 on the porch. Finding #3: Interview on 7/27/23 and 7/28/23 the HM stated: -She provided client specific training for staff during their "on boarding" (orientation). -She had completed trainings about Schizophrenia and Traumatic Brain Injury, but not about Bipolar Disorder. -She was not a certified CPR instructor but had conducted the skills training and validation for Staff #3's CPR. -She was responsible to complete IRIS (Incident Response and Improvement System) reports and had been trained by her prior Director. -She could not access the IRIS report for client #3's 7/1/23 elopement because she could not remember the incident report number.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;	V 112		

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V 112	Continued From page 11 (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to develop and implement a treatment plan based on the assessment affecting 2 of 3 clients (#2, #3). The findings are: Finding #1: Review on 7/26/23 and 7/27/23 of client #3's record revealed: -52 year old male admitted 5/2/22. -Diagnoses included Schizophrenia, Bipolar Disorder; and Traumatic Brain Injury (TBI). -TBI resulted in partial paralysis, poor behavior, and personality changes. -Was unable to live with his sibling listed as his emergency contact because they "argued." -No documentation of a formal behavior plan developed by a licensed or certified mental health professional. Review on 7/26/23 and 7/27/23 of client #3's physician history and physical dated 11/25/21 revealed:	V 112		

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V 112	Continued From page 12 -Presented to the Emergency Room (ER) on 11/22/21 after police found him on the side of the road complaining of chest pain. -Had been "emergently discharged" from his assisted living facility because of his behaviors. -Admitted to the hospital for behavior stabilization and to secure long term placement. -Abnormal behaviors that resulted in the emergency discharge from the assisted living facility included threats of self-harm, masturbating in front of other residents, verbal and physical altercations. -Used a wheelchair to ambulate due to right sided paralysis. Review on 7/26/23 and 7/27/23 of client #3's admission "Support Needs Assessment Profile (SNAP)... Behavior Supports" dated 4/26/22 revealed: -"Direct Intervention: Intervention necessary using routine techniques... May require additional supervision and monitoring." -"Mental Health Services: Licensed or certified mental health professional needed to develop and monitor a formal behavior intervention program." -"Behavior Severity: Injurious to self and/or others or severely disruptive." Review on 7/27/23 and 7/28/23 of client #3's SNAP assessment dated 6/1/23 revealed no changes from the SNAP assessment dated 4/26/22. Review on 7/26/23 and 7/27/23 of client #3's Person-Centered Profile (PCP) and treatment plans effective 5/2/22 and 6/1/23 revealed: -No changes had been made on the PCP or plan dated 6/1/23 compared to the initial plan dated 5/2/22.	V 112		

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-No goals or strategies were listed for elopement risks or exposing himself in public.
-Crisis Prevention and Intervention Plan:
-Prevention strategies: Observation of his mood... redirect as he may be sexually inappropriate. Female staff must be firm and direct so he will not think he can display himself inappropriately in staff's presence.
-Strategies for crisis response and stabilization: "Reminding [client #3] that he does not want to go back to the hospital to find another placement will help him keep his behavior in line. A review of his medications may be needed..."
-Specific recommendations for interacting with client #3: "... give him time to calm down, because arguing back does not get the best results."
-There were no signatures on the plan dated 6/1/23 by the person responsible for the PCP, service orders, Qualified Professional, or other team members who participated in the developement of the plan.

Review on 7/27/23 and 7/28/23 of client #3's internal incident reports from 5/1/23 - 7/26/23 revealed:
-6/9/23: Client #3 exposed his penis to a hotel housekeeper as the House Manager was removing luggage from the van. The House Manager and the 3 clients were out of town for a weekend vacation.
-6/27/23: There was an altercation between client #1 and client #3 while in the van. When client #1 objected to client #3's request for staff to turn up the radio volume, client #3 started "fussing" and pulled client #1's hair. Client #1 "swung back" and client #2 "got between the 2 residents."
-6/28/23: Client #3 broke his own television and stated he was going to "blame" his housemate to get this peer in "trouble."

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-6/28/23: Staff #3 and the 3 clients were in the community when client #3 started calling "strangers" over to the van asking for cigarettes. One man gave 2 cigarettes to client #3. After returning to the facility client #3 offered to give the cigarettes to Staff #3, but when she approached he called her "a stupid black fat b----h" and hit her 3 times.
-7/1/23: Client #3 was permitted to sit alone on the front porch. When checked after 15 minutes, it was discovered client #3 had eloped. A neighbor found client #3 sitting on his porch and returned the client to the facility.

Review on 7/27/23 and 7/28/23 of the Internal Investigation Report dated 7/21/23 of client #3's elopement on 7/1/23 revealed:
-It was approximately 1 hour from the time client #3 was discovered missing and his return to the home.
-He was returned to the facility by a man from a nearby mobile home park.
-Client #3 had a history of "manipulating staff."
-Client #3 had a history of eloping from his family's home.

Review on 7/28/23 of "[Client #3] - Elopement Protocol" revealed:
-Date of plan: 7/28/23.
-Staff were to "grab a phone" and go outside to search the property for client #3.
-If found on site, staff were to follow and monitor the client.
-Call the manager.
-If client #3 left the property and there was 1 staff on duty, and no other clients present, the staff could use the van to begin searching. Staff were to call the manager and "911."
-If client #3 left the property and there were multiple staff on duty, and other clients present,

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staff could use the van to begin searching and another staff would stay at the facility with the other clients.

Observation on 7/27/23 at approximately 3pm revealed:
-The distance between the nearby mobile home park and the facility measured 0.8 miles.
-The road in front of the facility was a 2 lane paved public road.

Interview on 7/27/23 Staff #7 stated:
-He was the staff on duty when client #3 eloped on 7/1/23.
-He was not aware client #3 was an elopement risk.
-The supervision routine was to check clients every 15 minutes.

Finding #2:
Review on 7/26/23 of client #2's record revealed:
-22 year old male admitted 11/28/19.
-Diagnoses included Autism, Disruptive Mood Dysregulation Disorder (DMDD); Oppositional Defiant Disorder (ODD), and Bipolar, Unspecified.

Review on 7/26/23 of client #2's treatment plan dated 3/1/23 revealed:
-No documentation of unsupervised time in his treatment plan.
-History of needing support to manage his emotional outbursts, potential for physical aggression, self-harm, and may leave supervised settings when most escalated.
-Goals included the following:
-Improve his independent living skills.
-Manage his mental health, to include compliance with medical appointments and medications.
-Improve his interpersonal skills.

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V 112	Continued From page 16 -Increase access to community; look for a job and/or choose an individual leisure activity. -Develop job skills. Interview with client #2 on 7/27/23 between 9am and 9:25am revealed: -He was preparing for independent living. -He had a job at a local restaurant and was supervised by cameras and his manager. -He was not supervised by facility staff while at work. -He worked 2nd shift on Mondays and Tuesdays, and 1st shift on the weekends. -He had worked "on and off" since moving into the facility 3 years prior. Interview on 7/28/23 the House Manager stated: -It was her responsibility with the Assistant Program Director to develop treatment plans with each client's treatment team. -Treatment team members were the Qualified Professional (QP), Assistant Program Director, the client's Local Management Entity/Managed Care Organization Care Coordinator, the client, and/or their guardian. -Her role in developing treatment plans was to identify a client's progress to determine if their goals would be discontinued, continued, or modified. -The SNAP assessments were used to develop and evaluate goals. -They used a specific community crisis prevention and intervention program to develop behavior plans. -No behavior plan had been developed for client #3. -She took the 3 clients on 6/9/23 out of town for a weekend vacation. She was the only staff with the 3 clients. -When she was removing their luggage from the	V 112		

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van to check in, client #3 exposed himself to the hotel staff.
-She and the 3 clients stayed in 2 adjoining rooms, with client #1 and #2 in 1 room and client #3 in the other room. She supervised overnight by keeping the door open between the 2 rooms and sleeping in a chair positioned in the doorway.
-The facility procedure was to check on clients at least every 15 minutes.
-This procedure was in place prior to 6/9/23 and had not changed for client #3.
-She would monitor client #3 more closely when any new person visited the home because he would masturbate outside of his bedroom.
-There had been no changes to client #3's treatment plan goals or strategies as a result of his incidents and behaviors after 6/9/23.
-She had told client #3 it was better for him to sit on the back porch for his safety rather than the front porch.
-Client #2 was not supervised by facility staff while he was at work.

Interview on 7/27/23 the QP stated:
-Had been the QP since May or June 2019.
-He was not sure if client #2 had approved unsupervised time.
-He was aware of client #3's elopement.
-He knew client #3 had a history of attempting to elope.
-He had overall program responsibility and when on site would review client records.

Review on 7/28/23 and 7/31/23 of the Plan of Protection dated 7/31/23 written by the Assistant Program Director revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
1. An elopement Plan was created on 7/28/23 and sent to Paraprofessionals for review

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and acknowledgement through adobe eSign. House Manager will follow up and inform each staff prior to them working their shift about the elopement plan.

2. Individual will be encouraged to use the Back porch for safety. The porch is in direct line of sight from the office desk. If the individual chooses to leave the back porch or sit in the front porch, staff must increase supervision to keep the individual in line of sight.

3. Maladaptive behaviors such as striking others and exposing themselves will be addressed by staff being reminded to utilize their Crisis De escalation and Interventions Training. Staff will immediately verbally redirect the individual as needed. While in the community, an additional staff will be provided to ensure the individual is supervised, until an assessment and a more permanent plan is developed.

4. A reassessment of the individuals Risk Assessment will be completed with the Qualified Professional and Operations Team. A immediate Support Team Meeting will be called to involve the Care coordinator in getting a behavioral assessment and plan developed. The PCP will be revised to incorporate a new treatment plan.

-Describe your plans to make sure the above happens.

1. House Manager will follow up and inform each staff prior to them working their shift about the elopement plan. Assistant Program Director has already sent out the eSign, but will follow up with each staff to ensure compliance.

2. House Manager will ensure that the Elopement protocol is being followed unannounced site visits.

3. House Manager will conduct a retraining on CDI (Communication and De-Escalation Interventions) within 30 days, but PAMCO Care (Licensee) will give immediate refresher for staff

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working with the individual on strategies and techniques applicable to redirection and de-escalation of maladaptive behaviors.

4. A debrief with PAMCO are (care) team will be completed by 07/31/2023, a reassessment of the individuals Risk needs, and PCP will be done with the team and implemented into the program with retraining by 08/10/2023. The care coordinator will be informed about the Type B violation and immediate supports will be needed."

The facility currently served clients with diagnoses including Intellectual/ Developmental Disorder, Autism, DMDD, ODD, Schizophrenia, Bipolar Disorder, and TBI. Client #2 worked 4 days a week without staff supervision. Client #2 had a history of behaviors, i.e. to leave supervised settings when escalated, but had no assessment or strategies in his treatment plan for unsupervised time. Client #3 had a history of aggressive behaviors (verbal and physical), sexual exposure in public, and elopement behaviors, but had no strategies in his treatment plan for inappropriate sexualized or elopement behaviors. Between 6/1/23 and 7/1/23 client #3 had 5 incidents documented for property destruction, physical aggression against a peer and staff, exposing his genitals in public, and elopement via his wheelchair down a 2 lane paved public road traveling 0.8 miles from the facility. As of 7/28/23 there had been no changes made in client #3's treatment/crisis plan or strategies to prevent or lower the risks of client #3's behaviors. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety, and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.

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V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: Review of fire and disaster drills from 7/1/2022 - 6/30/23 revealed: -No disaster drills documented between 7/1/2022 - 6/30/23. -Quarter 7/1/22 - 9/3/22: -No fire drills documented on the weekend day or night shift. -No fire drills documented on weekday night shift. -Quarter 10/1/22 - 12/31/22: -No fire drill documented on the weekend night shift. -No fire drill documented on weekday night	V 114		

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V 114	Continued From page 21 shift. -Quarter 1/1/23 - 3/31/23: -No fire drills documented on the weekend day or night shift. -No fire drill documented on weekday night shift. -Quarter 4/1/23 - 6/30/23: -No fire drills documented on the weekend day or night shift. -No fire drill documented on weekday night shift. Interview on 7/26/23 the House Manager stated: -The facility shifts were as follows: -Monday through Friday: day shift, 7am-3pm; evening shift, 3pm-11pm; night shift, 11pm-7am. -Saturday and Sunday: day shift, 7am-7pm; night shift, 7pm-7am. -Disaster drills were not done. It was her understanding they were not required in this state. -She had informed the clients they were to go to the laundry room in the event of a tornado. -The laundry room was the only room in the home without windows.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be	V 118		

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V 118	Continued From page 22 administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to administer medications as ordered for 3 of 3 clients (#1, #2, #3) and allow medications to be self-administered by clients only when authorized in writing by the client's physician for 1 of 3 clients (#2). The findings are: Finding #1: Review on 7/26/23 of client #1's record revealed: -52 year old male admitted 8/12/19. -Diagnoses included unspecified Schizophrenia Spectrum and Unspecified I/DD.	V 118		

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V 118	Continued From page 23 Review on 7/26/23 and 7/27/23 of client #1's medication orders and MARs for May, June, and July 2023 revealed: -The following medications were administered but there were no orders on hand: -Aripiprazole 20 mg administered nightly at 8pm. -Cetirizine 10mg daily at 8am. (allergies) -Farxiga 10 mg daily at 8am. (type 2 diabetes) -Fenofibrate 160 mg daily at 8am. (lower cholesterol) -Junuvia 100 mg daily at 8am. (type 2 diabetes) -Lisinopril 2.5 mg daily at 8am. (blood pressure control) -Protonix 40 mg daily at 8am. (acid reflux) -Prevident 5000 tooth paste 1.1% twice daily. (oral hygiene/health) Finding #2: Review on 7/26/23 of client #2's record revealed: -22 year old male admitted 11/28/19. -Diagnoses included Autism, Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, and Bipolar, Unspecified. -No order to self-administer his medications. Review on 7/26/23 and 7/27/23 of client #2's medication orders and MARs for May, June, and July 2023 revealed: -Prevident 5000 tooth paste 1.1% was documented twice daily but there was no order on hand. -Order dated 7/21/22 for Lithium 300 mg 3 times daily with meals. -Lithium 300 mg was scheduled to be administered at 8am, 12pm, and 8pm. -Lithium 300 mg 12 pm dose was documented as not given because client #2 was out of the facility	V 118		

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on the following Mondays, Tuesdays, Saturdays, and Sundays:
-May 2023: Every Monday, Tuesday, Saturday, and Sunday except for 5/23/23 (Tuesday) and 5/29/23 (Monday).
-June 2023: Every Monday, Tuesday, Saturday, and Sunday except for 6/6/23 (Tuesday), 6/12/23 (Monday), 6/17/23 (Saturday), and 6/20/23(Tuesday).
-July 2023: Not administered on 7/2/23, 7/8/23, 7/12/23, 7/18/23 and 7/19/23.

Interview on 7/27/23 client #2 stated:
-He had a job at a local restaurant.
-He worked 2nd shift on Mondays and Tuesdays and first shift on the weekends.
-When working the staff would give him his 12 noon medication wrapped in foil to self-administer.
-Staff administered his medications unless it was given to him to self-administer while at work or given to his father when he was on therapeutic leave.

Finding #3:
Review on 7/26/23 of client #3's record revealed:
-52 year old male admitted 5/2/22.
-Diagnoses included Schizophrenia, Bipolar Disorder, and Traumatic Brain Injury (TBI).

Review on 7/26/23 and 7/27/23 of client #3's medication orders and MARs for May, June, and July 2023 revealed:
-The following medications were documented but there were no orders on hand:
-Depakote 500 mg ER (extended release) daily at 8am. (seizure control; symptoms of bipolar disorder)
-Depakote 1,000 mg ER daily at 8pm.
-Fluoxetine 60 mg daily at 8am from 5/1/23 -

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V 118	Continued From page 25 7/11/23. "DC'd" (discontinued) documented on the July 2023 MAR. (depression) -Fluoxetine 40 mg twice daily starting 7/12/23. -Levothyroxin 25 mcg (micrograms) daily at 8am. (hormone replacement) -Loratadine 10mg daily at 8am. (allergy symptoms) -Melatonin 5 mg daily at 8pm. (sleep aid) -Quetiapine 200 mg daily at 8pm. (regulate mood, behaviors, thoughts) -Quetiapine 50 mg daily at 8am. -Vitamin D3 25mcg daily at 8am. (supplement) -The following PRN (given as needed) medications were on the MAR, had not been documented as given, but had no orders on hand: -Hydroxyzine 25mg 1-2 tablets 3 times daily as needed for anxiety/agitation. -Temazepam 15 mg every night as needed for sleep. Interview on 7/26/23 client #3 stated staff administered his medications and always had the medications ordered. Interview on 7/26/23 the House Manager stated: -Orders were sent directly to the pharmacy from the physician. -She would contact the physicians and the pharmacy to obtain copies of the orders. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This is a recited deficiency and must be corrected within 30 days.	V 118		

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V 121	Continued From page 26	V 121		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to assure that the client's physician was informed of the results by the on-site manager when indicated and corrective actions recorded, if applicable affecting 2 of 3 clients (#2, #3). The findings are: Finding #1: Review on 7/26/23 of client #2's record revealed: -22 year old male admitted 11/28/19. -Diagnoses included Autism, Disruptive Mood Dysregulation Disorder; Oppositional Defiant Disorder, and Bipolar, Unspecified. -No documentation client #3's physician had been informed of the results of the 3/19/23 Pharmacy Review.	V 121		

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Review on 7/28/23 of client #2's Pharmacy Review dated 3/19/23 revealed:
-Acetaminophen was not available on the medication cart, but there was an order on the MAR. Please discontinue the order ... or replace the medication, "(work with prescriber as necessary)."

Review on 7/26/23 and 7/27/23 of client #2's MARs (medication administration records) for May, June, and July 2023 revealed transcription for acetaminophen 325 mg (milligrams), take 2 tablets every 6 hours as needed for headache or pain.

Observation of client #2's medications on hand between 2pm and 3pm on 7/27/23 revealed no acetaminophen on hand.

Finding #3:
Review on 7/26/23 of client #3's record revealed:
-52 year old male admitted 5/2/22.
-Diagnoses included Schizophrenia, Bipolar Disorder, and Traumatic Brain Injury (TBI).
-No documentation client #3's physician had been informed of the results of the 3/19/23 Pharmacy Review.

Review on 7/28/23 of client #3's Pharmacy Review dated 3/19/23 revealed:
-Temazepam 15 mg every night as needed for sleep was on the MAR but there was no Temazepam on hand.
-Contact pharmacy to reorder or contact MD to discontinue if the resident no longer needed the medication.
-"Note to Attending Physician/Prescriber" read:
-Please clarify the order for Hydroxyzine 25mg, 1-2 tablets, 3 times daily as needed. (anxiety/agitation)

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-Ranges are not recommended unless accompanied by specific parameters for when to use.
-Discontinue medication since client #3 had not received it for over 6 months.
-The communication form, formatted for the physician to respond and sign, had not been completed by the physician.

Review on 7/26/23 and 7/27/23 of client #3's MARs for May, June, and July 2023 revealed:
-Temazepam 15 mg at bedtime as needed for sleep was transcribed on the MARs.
-No documentation client #3 had received Temazepam from 5/1/23 - 7/26/23.

Observation of client #3's medications on hand between 2pm and 3pm on 7/27/23 revealed no Temazepam 15 mg on hand.

Interview on 7/27/23 the House Manager stated:
-The memo, "Note to Attending Physician/Prescriber," was sent to the physician by the pharmacist who completed the review.
-The pharmacist could electronically access which physician should receive the communication.

Interview on 7/27/23 the Assistant Program Director stated:
-The memo to inform the physicians about pharmacy review results was prepared by the pharmacist, then given to the facility to send to the physician.
-The communication to the physician from the 3/19/23 review had not been sent to the physician.
-This process was the same for all sister facilities operated by the licensee.

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V 132	Continued From page 29	V 132		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 30	V 132		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that allegations against staff and results of investigations were reported to the Health Care Personnel Registry (HCPR) affecting 1 of 3 direct care staff audited (Staff #7). The findings are:

Review on 7/27/23 of Staff #7's personnel file revealed:
-Hired on 5/3/23 as a Direct Support Professional.
-No documentation Staff #7 had been reported to the HCPR for an allegation of neglect on 7/1/23 of client #3.

Review on 7/26/23 of client #3's record revealed:
-52 year old male admitted 5/2/22.
-Diagnoses included Schizophrenia, Bipolar Disorder, and Traumatic Brain Injury (TBI).

Review on 7/27/23 of the facility's internal incident reports between 5/1/23 and 7/26/23 revealed client #3 eloped from the facility on 7/1/23 while Staff #7 was on duty.

Review on 7/27/23 of the Internal Investigation Report dated 7/21/23 revealed:
-The report summarized an investigation of client #3's elopement on 7/1/23.
-"After a thorough investigation in the matter, it

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V 132	Continued From page 31 has been determined that the allegations of neglect were founded." Review of the facility's IRIS (Incident Response Improvement System) reports between 4/26/23 and 7/26/23 revealed no level III incident reports. Interview on 7/28/23 the House Manager stated: -She had completed an IRIS report for client #3's elopement. -She was unable to access the IRIS report because she could not recall the incident number. Interview on 7/27/23 the Qualified Professional stated: -There was some evidence of neglect by Staff #7 identified during the investigation of client #3's elopement. -He thought the HM had submitted an IRIS report for client #3's elopement on 7/1/23.	V 132		
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; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;	V 366		

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(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 review team shall complete all of the activities as follows:
(A) review the copy of the client record to

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V 366	Continued From page 33 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 applicable; and (F) any other authorities required by law.	V 366		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to implement policies governing their response to level II or III incidents as required. The findings are:

Review on 7/26/23 of client #3's record revealed:
-52 year old male admitted 5/2/22.
-Diagnoses included Schizophrenia, Bipolar Disorder, and Traumatic Brain Injury (TBI).
-Client #3 used a wheelchair to ambulate due to right sided paralysis.

Review on 7/27/23 of client #3's incident report dated 6/19/23 revealed:
-On 6/9/23 client #3 exposed his penis to a hotel housekeeper as the House Manager (HM) was removing their luggage from the van.
-The hotel management asked the HM to leave, but after talking with the manager on duty they were allowed to remain.
-The incident, indecent exposure, was not reported or responded to as a level II incident.

Review on 7/27/23 of client #3's incident report dated 7/3/23 revealed:
-On 7/1/23 client #3 eloped from the home and was returned by a community member who lived in a mobile home park.
-Police were called and responded to the facility.
-The incident with police involvement was not reported as a level II incident.

Review on 7/27/23 of the Internal Investigation

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V 366	Continued From page 35 Report dated 7/21/23 revealed: -The report summarized an investigation of client #3's elopement on 7/1/23. -"[Staff #7] and [client #2] were sitting in the common area socializing and engaged in various activities. [Staff #7] asked [client #2] to check on [client #3]. [Client #3] was discovered missing." -Staff #7 took client #2 and client #3 in the van and drove to a nearby store looking for client #3. -Staff #7 returned to the facility and called police after he did not find client #3. -A person from the community returned client #3 to the facility and reported he had found the client on his front porch. -"After a thorough investigation in the matter, it has been determined that the allegations of neglect were founded." -Internal allegation of neglect did not include the required response and immediate reporting as required for a level III incident. Interview on 7/27/23 the Qualified Professional stated: -There was some evidence of neglect by Staff #7 identified during the investigation of client #3's elopement. -He thought the HM completed the reporting as required to the Local Management Entity/Managed Care Organization.	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	V 367		

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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 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

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V 367	Continued From page 37 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 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.	V 367		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to report all level II and level III incidents to the LME (Local Management Entity) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:

Review of the facility's IRIS (Incident Response Improvement System) reports between 4/26/23 and 7/26/23 revealed no level II incident reports or level III incident reports for allegations of staff neglect on 7/1/23.

Review on 7/27/23 of the facility's internal incident reports between 5/1/23 and 7/26/23 revealed:
-On 6/9/23 client #3 exposed his penis to a hotel housekeeper as the House Manager (HM) was removing their luggage from the van. The internal incident report was dated 6/19/23.
-On 7/1/23 client #3 eloped from the facility and police were called and responded. The internal incident report was dated 7/3/23.

Review on 7/27/23 of the Internal Investigation Report dated 7/21/23 revealed:
-The report summarized an investigation of client #3's elopement on 7/1/23.
-"After a thorough investigation in the matter, it has been determined that the allegations of neglect were founded."

Interview on 7/28/23 the HM stated:
-She had completed an IRIS report for client #3's elopement.
-She was unable to access the IRIS report because she could not recall the incident number.

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V 367	Continued From page 39 Interview on 7/27/23 the Qualified Professional stated: -There was some evidence of neglect by Staff #7 identified during the investigation of client #3's elopement. -It was the responsibility of the HM to complete the IRIS report.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility,	V 500		

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V 500	Continued From page 40 the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all instances of alleged or suspected neglect of clients were reported to the County Department of Social Services (DSS) affecting 1 of 3 clients (client #3). The findings are:	V 500		

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V 500	Continued From page 41 Review on 7/26/23 of client #3's record revealed: -52 year old male admitted 5/2/22. -Diagnoses included Schizophrenia, Bipolar Disorder, and Traumatic Brain Injury (TBI). Review on 7/27/23 of the Internal Investigation Report dated 7/21/23 revealed: -The report summarized an investigation of client #3's elopement on 7/1/23. -"After a thorough investigation in the matter, it has been determined that the allegations of neglect were founded." -Personnel corrective actions listed included the need to retrain the House Manager of reporting to APS (adult protective services). Review on 7/27/23 of the facility's internal incident reports between 5/1/23 and 7/26/23 revealed: -Client #3 eloped from the facility on 7/1/23 while Staff #7 was on duty. -No level III incident reports. -No documentation allegations against Staff #7 for neglect of client #3 on 7/1/23 had been reported to DSS. Interview on 7/27/23 the Qualified Professional stated: -There was some evidence of neglect by Staff #7 identified during the investigation of client #3's elopement.	V 500		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment.	V 513		

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V 513	Continued From page 42 These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to promote a respectful and least restrictive environment for 3 of 3 clients (#1, #2, and #3). The findings are: Review on 7/26/23 of client #1's record revealed: -52 year old male admitted 8/12/19. -Diagnoses included unspecified Schizophrenia Spectrum and Unspecified Intellectual /Developmental Disabilities (I/DD). -No restrictions listed in client #1's treatment plan. Review on 7/26/23 of client #2's record revealed: -22 year old male admitted 11/28/19. -Diagnoses included Autism, Disruptive Mood	V 513		

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V 513	Continued From page 43 Dysregulation Disorder; Oppositional Defiant Disorder, and Bipolar, Unspecified. -No restrictions listed in client #2's treatment plan. Review on 7/26/23 of client #3's record revealed: -52 year old male admitted 5/2/22. -Diagnoses included Schizophrenia, Bipolar Disorder, and Traumatic Brain Injury (TBI). -No restrictions listed in client #3's treatment plan. Review on 7/26/23 of the House Rules revealed: -"No food or drinks in the bedrooms this includes water bottles as well." Interview on 7/27/23 client #1 stated: -Clients were not allowed to eat or drink in their rooms. -The rule for no eating or drinking in his room was too strict. -He would like to be able to have a drink or snack in his room when he watched television. Interview on 7/27/23 client #2 stated: -Clients could access food if they desired but had to ask first. -The reason they had to ask staff first was because food was bought specifically for the menu. -Even if he wanted to get a snack, he had purchased for himself he had to ask first because staff monitored what the clients ate. Interview on 7/26/23 client #3 stated: -Clients were not allowed to eat or drink in their rooms. -He was "ok" with the rule. Interview on 7/26/23 the House Manager stated the reason to restrict food and drink in the bedrooms was to prevent insects and pests.	V 513		

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V 513	Continued From page 44 Interview on 7/27/23 the Qualified Professional stated: -Restrictions on clients' rights would be discussed and approved by the client's treatment team. -The reason for not allowing food and drink in the clients' rooms was to prevent insects and pests in the house. -He agreed the house rule restricting water was too much of a restriction. -The restriction of food or drink in the client rooms had not been approved by anyone's treatment team.	V 513		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive, and orderly manner. The findings are: Observations on 7/26/23 between 11am and 11:30am during the facility tour revealed: -Client #2's room: Musty odor present. -Client #3's bathroom: Dust was accumulated around the top of the sink and along the top edge of the baseboards. Multiple cracks spanned across the surface of the the light switch cover . Black mark along the wall about 10 inches from the floor. -Client #1's room: Musty odor present. -Kitchen:	V 736		

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V 736	Continued From page 45 -Food particles adhered to the sink stopper and collected in the drain. -Dust and particles of debris build up present on the bottom and lazy susan shelves of the base corner cabinet and the upper cabinet shelves and inside the cabinet drawers where eating and utensils were stored. -Stove: Burned on food spatter and spillage covered approximately 70% of the oven's surface to include the door. -Microwave: Food spatters over all inside surfaces and around the perimeter when the door was opened. -Refrigerator/freezer: Dried orange colored spatter from side to side inside the freezer compartment and all shelves inside the refrigerator compartment. -Food particles on the floor in front of the refrigerator. -Dust accumulation was visible on the air return vent in the kitchen. Interview on 7/26/23 the House Manager stated: -The mark on the bathroom wall for client #3 was caused by his wheelchair when he was accessing his shower. -The food spatter inside the refrigerator and freezer was caused by a client who made a daily shake that he stored in the freezer. This was cleaned daily. This is a recited deficiency and must be corrected within 30 days.	V 736		
V 750	27G .0304(b)(3) Maintenance of Elec., Mech., & Water Systems 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT	V 750		

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V 750	Continued From page 46 (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (3) Electrical, mechanical and water systems shall be maintained in operating condition. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical systems were maintained in operating condition. The findings are: Observations on 7/26/23 between 11am and 11:30am revealed: -Client #2's room: 2 of 4 bulbs in the overhead light fixture were not working. -Client #3's room: The overhead ceiling fan with a 3 bulb light kit was not working. -Client #3's bathroom light fixture above the sink was missing the center bulb leaving the socket exposed. Interview on 7/27/23 client #2 stated: -Staff #3 had taken the 3 clients to a local store to purchase light bulbs for the overhead lights. -The bulbs needed were "special bulbs" and not available; therefore, none were purchased. Interview on 7/26/23 client #3 stated: -His ceiling fan and overhead light had not worked for about 2-3 weeks. -The ceiling fan and light stopped working when he unplugged his television. Interview on 7/26/23 the House Manager stated:	V 750		

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V 750	Continued From page 47 -She would replace the light bulbs that were missing or not working. -She was not aware client #3's fixture did not work.	V 750		