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ABSOLUTE HOME-ROXBORO STREET	2826 SOUTH ROXBORO STREET DURHAM, NC 27707

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on February 2, 2024. The complaints were substantiated (intake #NC00211542 and NC00211689). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 5 current clients.	V 000		
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; (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.	V 112		

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This Rule is not met as evidenced by:
Based on observation, record reviews and interviews, the facility failed to develop and implement strategies to meet the needs of five of five clients (#1, #2, #3, #4 and #5) and failed to obtain written consent or agreement by the client or responsible party for two of five clients (#1 and #4). The findings are:

1. The following is evidence clients had no strategies to address their needs.

Review on 1/25/24 of client #1's record revealed:
-Admission date of 4/25/23.
-Diagnoses of Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder with psychotic features, Cannabis Use Disorder, Alcohol Use Disorder and Type II Diabetes.
-Admission summary dated 4/25/23-He assaulted another client at a facility owned by the agency and was transferred to current location on 4/25/23. He had a history of substance abuse, suicidal attempts, physical aggression/assault with a weapon, auditory and visual hallucinations, delusions, persecutory ideation and poor judgement. He can be violent. When disagreeing with him it is important not to debate, justify or explain your position if it is not necessary.
-Copy of house rules signed and dated 10/1/21 to indicate smoking cigarettes was not allowed in

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the facility.
-Person Centered Plan (PCP) dated 4/25/23 had no strategies to address smoking marijuana at the facility, smoking cigarettes in the facility, panhandling in the community and begging neighbors for food.

Observation on 1/26/24 of facility driveway area at approximately 9:35 AM revealed
-Client #1 returned to the facility and was sitting on the passenger side of a car driven by a female.
-Client #1 got out of the female's car with a bag of food.

Review on 1/25/24 of client #2's record revealed:
-Admission date of 8/2/21.
-Diagnoses of Schizoaffective Disorder, PTSD and Cannabis Use Disorder in remission.
-Admission summary dated 8/2/21-He had a history of legal issues. The legal issues included: wantonly injury to property in 2013, felony breaking and entering, larceny from a merchant, larceny after breaking and entering, possession of a firearm by a felon and robbery with a dangerous weapon. His parole was scheduled to end at the end of August 2021. He also has a history of substance abuse, aggression, agitation, delusions and treatment noncompliance.
-Copy of house rules signed and dated 9/29/21 to indicate smoking cigarettes was not allowed in the facility.
-PCP dated 8/4/23 had no strategies to address smoking marijuana at the facility, smoking cigarettes in the facility, panhandling in the community and begging neighbors for food.

Review on 1/25/24 of client #3's record revealed:
-Admission date of 11/8/20.
-Diagnoses of Schizophrenia and Tobacco Use

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V 112	Continued From page 3 Disorder. -Admission summary dated 11/8/20-He had a history of aggression, assault, agitation, delusions, hallucinations, mood swings and depression. In previous facility he assaulted another client and had to go to court. -Copy of house rules signed and dated 11/8/20 to indicate smoking cigarettes was not allowed in the facility. -PCP dated 10/27/23 had no strategies to address smoking marijuana at the facility, smoking cigarettes in the facility and begging neighbors for food. Review on 1/25/24 of client #4's record revealed: -Admission date of 5/13/21. -Diagnoses of Schizoaffective Disorder-bipolar type and Type II Diabetes, Major Depressive Disorder and Mild Cognitive Impairment. -Admission summary dated 5/13/21-He had a history of extreme violence. He was in the state hospital for 15 years after it was determined he was incompetent to stand trial for the murder of his father. He had a history of aggressive sexual behavior. The behaviors are verbal and involve statements made towards females. He also had a history of auditory hallucinations, threatening/intimidating behaviors, poor judgement, agitation and poor insight into his mental illness. -Copy of house rules signed and dated 5/20/21 to indicate smoking cigarettes was not allowed in the facility. -PCP dated 5/10/23 had no strategies to address smoking marijuana at the facility, vaping/smoking cigarettes in the facility, panhandling in the community and begging neighbors for food. Review on 1/25/24 of client #5's record revealed: -Admission date of 3/30/17.	V 112		

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V 112	Continued From page 4 -Diagnoses of Schizophrenia-Paranoid type and End Stage Renal Disease. -Admission summary dated 8/16/17-He took dialysis treatments 3 days a week. He had a history of arrests for larceny, assault and possession of "a schedule II drug." -Copy of house rules signed and dated 10/2/23 to indicate smoking cigarettes was not allowed in the facility. -PCP dated 12/23/23 had no strategies to address smoking marijuana at the facility and smoking cigarettes in the facility. Interviews on 1/24/24, 1/26/24 and 1/30/24 with client #1 revealed: -He got the marijuana from a male neighbor in the community. -He also got marijuana from people at a convenience store in the area. -He last smoked marijuana at the facility about a month ago. -He smoked marijuana at the facility "quite" a few times. -"Staff probably don't know we are smoking marijuana." -They normally go into the back yard area or on the front porch. -He and client #2 were the two clients who smoked marijuana more often. -Client #3 didn't smoke but he had seen the other 3 clients smoking marijuana at the facility. -They also smoked marijuana when staff was away from the facility during the day. -He had been smoking cigarettes in his bedroom for the last 4-5 months. -He just smoked a cigarette in his bedroom last night. -He smoked cigarettes in his bedroom a few days each week throughout the day. -He thought staff knew he was smoking	V 112		

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cigarettes in his bedroom.
-The Qualified Professional (QP) talked to the clients about a month ago about not smoking cigarettes in their bedrooms.
-He had gone to a convenience store in the area and asked strangers for food and money a few times.
-He walked to the convenience store 1-2 days a week and asked for food and money.
-He started doing that about 2-3 months ago.
-He also asked a female neighbor in the community for food several times.
-He last asked that neighbor for food about 1 or 2 days ago.

Interviews on 1/24/24 and 1/30/24 with client #2 revealed:
-He lived at facility for over 2 years and smoked "weed" since he has lived at the facility.
-He walked to a neighbor's home in the community during his unsupervised time and bought "weed."
-He got the "weed" from "a weed man."
-He bought "weed" from "the weed man" about once a week.
-They normally smoked in the backyard area outside of the facility.
-He just smoked "weed" at the facility about a day or two ago.
-Staff doesn't know they are smoking, "we get away with it."
-"I will not say the other clients names who are smoking, I will say every client in the house has smoked weed at some point."
-They would smoke in the facility whenever staff left them unsupervised during the day.
-He smoked cigarettes in his bedroom daily.
-He had been smoking cigarettes in his bedroom for several months.
-The QP talked to them about not smoking

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V 112	Continued From page 6 cigarettes in the facility, "I did it anyway." Interview on 1/24/24 with client #3 revealed: -He had been smoking cigarettes in his bedroom for several months. -The brown spots on his floor were burn marks. -There were several burn marks on his floor because he dropped an ashtray on the floor a few weeks ago and the ashes spread everywhere. -He last smoked cigarettes in his bedroom about a month ago. Interview on 1/24/24 with client #4 revealed: -He didn't smoke cigarettes anymore. -"I can't remember the last time I smoked a cigarette." -When he was smoking cigarettes, he smoked them in his bedroom a few times. -He had been smoking a vape pen for about a month. -He smoked the vape pen in his bedroom a few times just recently. Interview on 1/30/24 with client #5 revealed: -He smoked cigarettes in his bedroom almost daily because "I don't feel like going outside." -He had been smoking cigarettes in his bedroom for about six months or longer. Interview on 1/26/24 with a Neighbor in the community revealed: -She lived down the street from the facility. -She knew all of the clients at the facility. -She just returned client #1 to the facility today (1/26/24). -Client #1 walked over to her home and said he was hungry and she gave him a bag of food. -Her and her husband gave clients at the facility food "all the time." -Most of the clients at that facility asked for food	V 112		

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whenever they came over to her home.
-She gave clients food from that facility several times a week.
-Client #1 came to her home more frequently than the other clients.
-The clients had been walking to her home asking for food for several months.
-Client #5 was the only client from the facility who didn't come over and ask for food.

Interviews on 1/29/24 and 2/1/24 with client #1's guardian revealed:
-She visited client #1 at the facility in July 2023.
-During that visit she saw 3 of the clients sitting in the living room area smoking marijuana.
-"They didn't try to hide it."
-Client #1 wasn't smoking marijuana during that visit.
-Client #1 had a history of smoking marijuana.
-Client #1 admitted he smoked marijuana a few times since he lived at the facility.
-It was 3 other clients and she didn't know their names.
-They were all at the facility unsupervised by staff.
-She talked to the QP and/or texted her about the issue with clients smoking marijuana the same day or next day after the incident.
-The QP said she would address that issue.
-One of the neighbors just recently called about her concerns with that facility.
-The neighbor said she gave clients "food consistently because they were constantly begging."

Interviews on 1/24/24 and 1/26/24 with staff #1 revealed:
-She had never seen any of the clients smoking cigarettes in their bedrooms.
-She "knew" clients were smoking in their bedrooms, however when she asked them about

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it they said they were not smoking.
-She knew they were smoking cigarettes in their bedrooms because their bedrooms smelled like cigarette smoke.
-The QP talked to the clients about not smoking in the facility a few weeks ago.
-Client #4 was panhandling in the community.
-She was at a restaurant in the area a few weeks ago and heard a familiar voice.
-She heard client #4 begging one of the workers for food at the restaurant.
-"On Wednesday (1/24/24) when you (the Division of Health Services Regulation surveyor) arrived [client #4] was probably out in the community panhandling."
-Client #4 would be out for several hours at a time.
-Client #4 would stay out for about 6 hours or more daily.
-She made the QP aware of client #4 panhandling in the community about a month or two ago.

Interview on 1/29/24 with staff #2 revealed:
-He had never seen any of the clients smoking cigarettes in the facility.
-He thought clients were smoking in the facility because he smelled cigarette smoke.

Interview on 1/30/24 with staff #3 revealed:
-She just returned to this facility on 1/26/24.
-She was previously employed with this facility and left in March 2023.
-She just saw client #5 smoking a cigarette in the living room area a day or two ago.

Interviews on 1/25/24, 1/26/24, 1/29/24 and 1/30/24 with the QP revealed:
-She didn't know clients were smoking marijuana at the facility.

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V 112	Continued From page 9 -The clients never said anything to her about smoking marijuana at the facility. -Staff never said anything to her about witnessing clients smoking marijuana at the facility. -Client #1's guardian did not tell her she witnessed clients smoking marijuana at the facility during the summer of 2023. -She knew clients #1 and #2 had a substance abuse history. -She knew client #2 talked to his Psychiatrist about a month or so ago about taking Cannabidiol (CBD). -She told the Psychiatrist and Assertive Community Treatment team it wasn't a good idea because of client #2's history of substance abuse. -The clients are not supposed to be smoking cigarettes or vaping in the facility. -The clients were told at admission smoking was not allowed in the facility. -They all signed the house rules which indicated smoking was not allowed in the facility. -She had never seen any of the clients smoking or vaping in the facility. -She "suspected" clients were smoking because she smelled cigarette smoke in the facility. -She talked to the clients about six months ago about not smoking in the facility. -Staff had not said anything to her in the last couple of weeks about any of the clients smoking or vaping in the facility. -She wasn't aware of any clients panhandling in the community. -She was aware some of the clients were going to a neighbor's home in the community and asking for food. -The Administrator/Licensee brought that to her attention. -She couldn't remember how long ago that was brought to her attention by the Administrator/Licensee.	V 112		

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V 112	Continued From page 10 -She was informed clients #1 and #4 were asking the neighbor for food. -She didn't know clients #2 and #3 were asking the neighbor for food. -The Administrator/Licensee said she asked the neighbor to stop giving those clients food. -She acknowledged clients #1, #2, #3, #4 and #5 had no strategies to address smoking marijuana. -She acknowledged clients #1, #2, #3, #4 and #5 had no strategies to address smoking cigarettes in the facility. -She acknowledged clients #1, #2 and #4 had no strategies to address panhandling in the community. -She acknowledged clients #1, #2, #3 and #4 had no strategies to address begging neighbors for food. Interviews on 1/26/24 and 1/30/24 with the Administrator/Licensee revealed: -She knew client #2 had history of substance abuse. -She wasn't sure if she was aware client #1 had a substance abuse history. -None of the staff said anything to her about clients smoking marijuana at the facility. -None of the staff said they ever witnessed clients smoking marijuana at the facility. -Client #4 was smoking cigarettes in the facility when he was admitted a couple of years ago. -They addressed that issue with client #4. -She thought client #4 mainly smoked a vape pen. -She didn't know the other clients were smoking cigarettes in the facility. -Staff had not brought it to her attention recently that clients were smoking cigarettes in the facility. -She was not aware of any of the clients panhandling in the community. -She knew some of the clients were asking a	V 112		

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couple in the neighborhood for food.
-She talked with those neighbors about not giving the clients food a couple of months ago.
-Clients #1 and #4 were the main two clients begging those neighbors for food.
-She talked with all of the clients about not going out to neighbors home and asking them for food.
-She talked to all of the clients when it came to her attention a couple of months ago.
-She thought the clients stopped asking those neighbors for food.
-She acknowledged clients #1, #2, #3, #4 and #5 had no strategies to address smoking marijuana.
-She acknowledged clients #1, #2, #3, #4 and #5 had no strategies to address smoking cigarettes in the facility.
-She acknowledged clients #1, #2 and #4 had no strategies to address panhandling in the community.
-She acknowledged clients #1, #2, #3 and #4 had no strategies to address begging neighbors for food.

2. The following evidence the facility failed to obtain written consent or agreement by the client or responsible party.

Review on 1/25/24 of client #1's record revealed:
-The PCP dated 4/25/23 had no written consent or agreement by the client or responsible party.

Review on 1/25/24 of client #4's record revealed:
-The PCP dated 5/10/23 had no written consent or agreement by the client or responsible party.

Interview on 1/25/24 with the QP revealed:
-Client #1's guardian refused to give written consent for his PCP.
-"They sent it to her when it was completed a few months ago and she refused to sign it."

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V 112	Continued From page 12 -Client #4's PCP was not signed because she never sent it to his guardian. "That was my fault." -She confirmed the facility failed to obtain written consent or agreement by the client or responsible party. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A rule violation and must be corrected within 23 days.	V 112		
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 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;	V 113		

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ABSOLUTE HOME-ROXBORO STREET	2826 SOUTH ROXBORO STREET DURHAM, NC 27707

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V 113	Continued From page 13 (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 reviews and interview, the facility failed to maintain required documentation in the client records affecting three of five clients (#1, #2 and #3). The findings are: Review on 1/25/24 of client #1's record revealed: -Admission date of 4/25/23. -Diagnoses of Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder with psychotic features, Cannabis Use Disorder, Alcohol Use Disorder and Type II Diabetes. -No identification face sheet which included: (a) name (last, first, middle, maiden); (b) client record number; (c) date of birth; (d) race, gender and marital status; (e) admission date Review on 1/25/24 of client #2's record revealed:	V 113		

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V 113	Continued From page 14 -Admission date of 8/2/21. -Diagnoses of Schizoaffective Disorder, PTSD and Cannabis Use Disorder in remission. -No identification face sheet which included: (a) name (last, first, middle, maiden); (b) client record number; (c) date of birth; (d) race, gender and marital status; (e) admission date Review on 1/25/24 of client #3's record revealed: -Admission date of 11/8/20. -Diagnoses of Schizophrenia and Tobacco Use Disorder. -No identification face sheet which included: (a) name (last, first, middle, maiden); (b) client record number; (c) date of birth; (d) race, gender and marital status; (e) admission date Interview on 1/25/24 with the Qualified Professional revealed: -She didn't realize those clients didn't have a face sheet in their client records. -The Administrator/Licensee was generally responsible for putting the clients' record together at admission. -She confirmed the facility failed to maintain completed records for clients #1, #2 and #3.	V 113		
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.	V 114		

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V 114	Continued From page 15 (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 interviews, the facility failed to ensure fire and disaster drills were conducted quarterly and on each shift. The findings are: Review on 1/26/24 of the facility's fire and disaster drill log from January 2023-January 2024 revealed: -There were no fire drills conducted for the 1st quarter (January, February, March) of 2023. -One of the scheduled staff failed to conduct a fire drill for the 2nd quarter (April, May, June) of 2023. -There was no documentation of disaster drills being conducted by facility staff. Interview with client #1 on 1/24/24 revealed: -They did one or two fire drills with staff. -The last fire drill was done about a month ago. -They walked outside to the mailbox for the fire drill. -Staff never did disaster drills with them. Interview with client #2 on 1/24/24 revealed: -They did a fire drill about a month ago. -They went out the front or back doors and	V 114		

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V 114	Continued From page 16 walked to the mailbox. -Never did "any type" of disaster drill with staff. Interview with client #3 on 1/24/24 revealed: -They never did disaster drills with staff. -They did one fire drill with staff about a month ago. -They went out the front door and walked over to the mailbox. Interview on 1/26/24 with staff #1 revealed: -She did two or three fire drills since working at the facility over the last 4-5 months. -She didn't document all of those drills because there was no form for the drills. -She never did a disaster drill with clients. -"I knew I was supposed to do disaster drills, I just didn't do them." Interview on 1/30/24 with staff #2 revealed: -He did fire and disaster drills with the clients once a month. -They did a fire and disaster drill about a month ago. -He did fire and disaster drills on the same day but at different times. -They did the fire drill first and then did the disaster drill. -He didn't realize he failed to "distinguish" the fire and disaster drills on the form. Interview on 1/26/24 with the Qualified Professional revealed: -Facility staff worked two weeks on and two weeks off. -She didn't realize the fire and disaster drills were not completed until she looked at the drill log today on 1/26/24. -She didn't have a chance to talk to staff about the reason the drills were not completed as	V 114		

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V 114	Continued From page 17 required. -She confirmed the facility failed to ensure fire and disaster drills were conducted quarterly on each shift. This deficiency has been cited 3 times since the original cite on 3/20/22 and must be corrected within 30 days.	V 114		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observations, record review and	V 120		

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V 120	Continued From page 18 interviews, the facility failed to ensure medications were in a securely locked cabinet affecting one of five clients (#5). The findings are: Observation on 1/24/24 at approximately 1:45 PM of client #5's bedroom revealed: -The door to the bedroom was locked and staff used a butter knife to open the door. -A bottle of Trazodone 50 milligrams (mg) (Sleep). The dispensed date was 11/30/23. -A bottle of Hydralazine HCL 25 mg (High Blood Pressure). -The labels for both medications had client #5's name listed. -The dispensed date was 11/30/23 for both medications. -Both bottles of medication were on top of the dresser. Observation on 1/30/24 at approximately 10:17 AM of client #5's bedroom revealed: -The bedroom door was locked and client #4 unlocked his door. -A bottle of Calcium Acetate 667 mg (Renal Osteodystrophy). -A bottle of Acetaminophen 325 mg (Pain Relief). -The labels for both medications had client #5's name listed. -The dispensed date was 11/30/23 for both medications. -Both bottles of medication were on top of the dresser. Reviews on 1/25/24 and 2/2/24 of client #5's record revealed: -Admission date of 3/30/17. -Diagnoses of Schizophrenia-Paranoid type and End Stage Renal Disease. -Admission summary dated 8/16/17-He took	V 120		

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V 120	Continued From page 19 dialysis treatments 3 days a week. Interview on 1/24/24 with staff #1 revealed: -She didn't know client #5 had those medications in his bedroom. -Client #5 went to the hospital last week (1/16/24). -She had not gone into his bedroom since he left for the hospital a few days ago. -She confirmed the facility failed to ensure medications were in a securely locked cabinet. Interview on 1/29/24 with staff #2 revealed: -He never saw any medication in client #5's bedroom. -He knew client #5 would sometimes get medication from dialysis after his appointments. -Client #5 was supposed to give staff those medications or paperwork from his dialysis or other medical appointments. -In the past client #5 returned from appointments and didn't tell them about medication changes right away. Interview on 1/30/24 with staff #3 revealed: -She didn't know client #5 had those medications in his bedroom this morning (1/30/24) until it was just brought to her attention. -Client #5 kept his bedroom door locked "at all times." Interviews on 1/25/24 and 1/30/24 with the Qualified Professional revealed: -She was aware client #5 had medication unlocked in his bedroom. -Staff #1 sent her a picture of the medication for client #5 after it was brought to her attention. -Staff #1 said she didn't know those medications were in client #5's bedroom unlocked until it was brought to her attention on 1/24/24.	V 120		

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V 120	Continued From page 20 -She couldn't believe client #5 left his medication out in his bedroom unlocked again on 1/30/24. -Staff #3 did not say anything to her about those medications being found in client #5's bedroom. -She wasn't sure why client #5 was leaving those medications unlocked. -She confirmed the facility failed to ensure medications were in a securely locked cabinet. Interview on 1/26/24 with the Administrator/Licensee revealed: -She visited the facility about every 2 weeks. -She wasn't aware of client #5 leaving medication unlocked in his bedroom. -She had never seen any of the clients medication out and unlocked whenever she visited the facility. -She confirmed the facility failed to ensure medications were in a securely locked cabinet.	V 120		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as	V 289		

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

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V 289	Continued From page 22 alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure five of five clients (#1, #2, #3, #4 and #5) had a home environment where the primary purpose of these services were the care and rehabilitation of individuals who have a mental illness. The findings are: Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (Tag 112) Based on record reviews and interviews, the facility failed to develop and implement strategies to meet the needs affecting five of five clients (#1, #2, #3, #4 and #5) and obtain written consent or agreement by the client or responsible party for two of five clients (#1 and #4). Cross Reference: 10A NCAC 27G .5602 STAFF (Tag 290) Based on observations, record reviews and interviews, the facility failed to assess the continued capability for five of five clients (#1, #2, #3, #4 and #5) to be unsupervised in the home and community. Cross Reference: 10A NCAC 27G .5603 OPERATIONS (Tag 291) Based on record reviews and interviews, the facility failed to ensure coordination was	V 289		

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V 289	Continued From page 23	V 289		

maintained between the facility operator and other qualified professionals who are responsible for treatment/habilitation affecting one of five clients (#1) and failed to ensure clients had activity opportunities based on their choices and needs affecting five of five clients (#1, #2, #3, #4 and #5).

Review on 2/2/24 of a Plan of Protection written by the Qualified Professional (QP) dated 2/2/24 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care? 290-[The QP] will contact all team members and guardians today to suspend all unsupervised time. 112-[The QP] will obtain guardian signatures for treatment plans. [The QP] will assemble the team to develop strategies to address smoking cigarettes, smoking marijuana, vaping, panhandling on the community and begging for food from neighbors. 291-[The Administrator/Licensee] will contact the Physician to inform him or her that [client #1] is not completing blood sugar checks as ordered by his physician. [The Administrator/Licensee] will provide transportation to enable staff to assist residents with engaging in community activities and events. Describe your plans to make sure the above happens. 290-[The QP] will assemble meeting with team to determine whether each client is engaging in his unsupervised time appropriately. At this time the team will decide whether 4 out of 5 should be approved for unsupervised. Each client will be reassessed. 112-[The QP] will send via certified mail no later than 2/5/24. Receipt of transaction will be added to clients record. Team will meet by 2/9/24 to develop strategies and update treatment needs/plans. 291-Staff will report all refusals to comply with orders for blood sugar checks to the

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V 289	Continued From page 24 Physician [the Administrator/Licensee] and [The QP]. The information, directions or orders given by the Dr (Doctor) will be implemented as ordered by that Dr. The staff will conduct monthly meetings with clients and will address activities, events and preferred activities for each client as well as the group. The staff will document participation in the scheduled activities on the daily communication log." Clients diagnoses included Post Traumatic Stress Disorder, Major Depressive Disorder, Schizoaffective Disorder, Schizophrenia, Mild Cognitive Impairment, End Stage Renal Disease, Type II Diabetes, Cannabis Use Disorder, Alcohol Use Disorder and Tobacco Use Disorder. Clients #1 and #2 were getting marijuana during their unsupervised time in the community. All five clients were smoking marijuana at the facility. All five clients were smoking cigarettes and/or using a vape pen in the facility. Clients #1, #2 and #4 were panhandling in the community during their unsupervised time. Clients #1, #2, #3 and #4 were asking a neighbor for food in the community during their unsupervised time. None of the clients had strategies to address smoking marijuana, smoking cigarettes in the facility, panhandling and asking a neighbor for food. Clients were getting marijuana, panhandling and asking a neighbor for food during their unsupervised time in the community. Client #4 was exceeding the unsupervised time allowed in the community. Clients were not assessed for their continued capability of having unsupervised time in the community. Clients #1 and #2 were allowed to stay at the facility unsupervised during the day. Clients #1 and #2 had not been assessed for their capability of having unsupervised time in the facility. Client #1 refused to check his blood sugar per the physician's	V 289		

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V 289	Continued From page 25 order. Client #1's physician was not informed of his refusal to check his blood sugar as ordered. Client #1 refused to check his blood sugar 189 times between June 1, 2023 and January 25, 2024. Staff did no activities with the clients at the facility and/or in the community. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or	V 290		

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V 290	Continued From page 26 (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assess the continued capability for five of five clients (#1, #2, #3, #4 and #5) to be unsupervised in the home and community. The findings are: Review on 1/25/24 of client #1's record revealed: -Admission date of 4/25/23. -Diagnoses of Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder with psychotic features, Cannabis Use Disorder, Alcohol Use Disorder and Type II Diabetes. -Admission summary dated 4/25/23-He assaulted another client at a facility owned by the agency and was transferred to current location on 4/25/23. He had a history of substance abuse,	V 290		

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suicidal attempts, physical aggression/assault with a weapon, auditory and visual hallucinations, delusions, persecutory ideation and poor judgement. He can be violent.
-Unsupervised Time Assessment dated 4/25/23-Client #1 had 0 hours of unsupervised time in the facility and 4 hours of unsupervised time in the community.

Review on 1/25/24 of client #2's record revealed:
-Admission date of 8/2/21.
-Diagnoses of Schizoaffective Disorder, PTSD and Cannabis Use Disorder in remission.
-Admission summary dated 8/2/21-He had a history of legal issues. The legal issues included: wantonly injury to property in 2013, felony breaking and entering, larceny from a merchant, larceny after breaking and entering, possession of a firearm by a felon and robbery with a dangerous weapon. His parole was scheduled to end at the end of August 2021. He also has a history of substance abuse, aggression, agitation, delusions and treatment noncompliance.
-Unsupervised Time Assessment dated 8/4/23-Client #2 had 0 hours of unsupervised time in the facility and 8 hours of unsupervised time in the community.

Review on 1/25/24 of client #3's record revealed:
-Admission date of 11/8/20.
-Diagnoses of Schizophrenia and Tobacco Use Disorder.
-Admission summary dated 11/8/20-He had a history of aggression, assault, agitation, delusions, hallucinations, mood swings and depression. In previous facility he assaulted another client and had to go to court.
-Unsupervised Time Assessment dated 10/27/23-Client #3 had 2 hours of unsupervised time at the facility and 2 hours of unsupervised

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V 290	Continued From page 28 time in the community. Review on 1/25/24 of client #4's record revealed: -Admission date of 5/13/21. -Diagnoses of Schizoaffective Disorder-bipolar type and Type II Diabetes Major Depressive Disorder and Mild Cognitive Impairment. -Admission summary dated 5/13/21-He had a history of extreme violence. He was in the state hospital for 15 years after it was determined he was incompetent to stand trial for the murder of his father. He had a history of aggressive sexual behavior. The behaviors are verbal and involve statements made towards females. He also had a history of auditory hallucinations, threatening/intimidating behaviors, poor judgement, agitation and poor insight into his mental illness. -Unsupervised Time Assessment dated 5/9/23-Client #4 had 3 hours of unsupervised time at the facility and 5 hours of unsupervised time in the community. Review on 1/25/24 of client #5's record revealed: -Admission date of 3/30/17. -Diagnoses of Schizophrenia-Paranoid type and End Stage Renal Disease. -Admission summary dated 8/16/17-He took dialysis treatments 3 days a week. He had a history of arrests for larceny, assault and possession of "a schedule II drug." -Unsupervised Time Assessment dated 12/23/23-Client #5 had 1 hour of unsupervised time at the facility and 0 hours of unsupervised time in the community. Observation on 1/24/24 between 12:37 PM and 1:22 PM and interview with client #2 revealed: -Client #2 answered the door and said staff #1 was not available	V 290		

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V 290	Continued From page 29 -Clients #1, #2 and #3 were at the facility unsupervised. -He stated staff #1 left about 20 minutes ago to pick up lunch. -He stated he didn't have staff #1's telephone number. Observation on 1/26/24 at approximately 10:00 AM of street adjacent to the facility revealed: -The posted speed limit was 30 to 35 miles per hour. -There was a lot of vehicle traffic driving along the street. -Cars seemed to be driving faster than the posted speed limit. Interviews on 1/24/24, 1/26/24 and 1/30/24 with client #1 revealed: -He had unsupervised time daily at the facility. -He could stay at the facility unsupervised for 5-6 hours each day. -He could stay out in the community unsupervised for 5-6 hours each day. -He normally didn't stay out for 5-6 hours during his unsupervised time in the community. -He stayed out in the community unsupervised for about an hour or two. -He normally walked to a convenience store in the area 1-2 days each week during his unsupervised time. -He asked strangers for food and money at the convenience store a few times. -He started doing that about 2-3 months ago. -He smoked marijuana at the facility. -He got the marijuana from a male neighbor in the community. -He also got marijuana from people at the convenience store in the area. -He asked a female neighbor in the community for food several times.	V 290		

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V 290	Continued From page 30 -He last asked that neighbor for food about 1 or 2 days ago. Interviews on 1/24/24 and 1/30/24 with client #2 revealed: -He had about 8 hours in the facility unsupervised. -He would be at facility without staff 6-8 hours some days. -He had about 8 hours of unsupervised time in the community. -He didn't spend 8 hours in the community, he only used about 1-2 hours in the community unsupervised. -He walked to a convenience store in the neighborhood. -He also took the bus to the mall and other stores. -He walked to a convenience store a couple of days a week. -He lived at facility for over 2 years and smoked "weed" since he lived at the facility. -He walked to a neighbor's home in the community during his unsupervised time and bought "weed." -He got the "weed" from "a weed man." -He bought "weed" from "the weed man" about once a week. Interview on 1/26/24 with a Neighbor in the community revealed: -She lived down the street from the facility. -She knew all of the clients at the facility. -She just returned client #1 to the facility today (1/26/24). -Client #1 walked over to her home and said he was hungry and she gave him a bag of food. -Her and her husband gave clients at the facility food "all the time." -Most of the clients at that facility asked for food	V 290		

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whenever they came over to her home.
-She gave clients food from that facility several times a week.
-Client #1 came to her home more frequently than the other clients.
-The clients had been walking to her home asking for food for several months.

Interview on 1/26/24 with staff #1 revealed:
-All of the clients had unsupervised time at the facility and could be left alone.
-She would occasionally leave the facility during the day to get food or run an errand.
-She normally didn't stay away from the facility for several hours.
-She would only be gone for about 1 to 1 ½ hours.
-Client #4 was panhandling in the community.
-She was at a restaurant in the area a few weeks ago and heard a familiar voice.
-She heard client #4 begging one of the workers for food at the restaurant.
-"On Wednesday when you arrived [client #4] was probably out in the community panhandling."
-Client #4 would be out for several hours at a time.
-Client #4 would stay out for about 6 hours or more daily.
-Client #4 would leave the facility and return to the facility when it was dark outside.
-Client #4 had been doing that since she worked with him when she started about 4-5 months ago.
-She made the Qualified Professional (QP) aware of client #4's panhandling in the community about a month or two ago.

Interview on 1/29/24 with staff #2 revealed:
-He suspected clients #2 and #4 were panhandling at a convenience store in the area.
-He had never seen them at the convenience

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store asking for anything.
-He overhead them at the facility saying we got them at the convenience store today.
-He assumed they were talking about getting something from people when they are at the convenience store.

Interview on 1/30/24 with staff #3 revealed:
-Clients #1 and #2 walked to the convenience store down the street unsupervised.
-They returned to the facility within about 30 minutes.
-Client #4 left the facility early in the morning unsupervised and would stay gone all day long.
-Client #4 would leave around 8:00 am and return around 5 pm or 6 pm.

Interview on 1/29/24 with client #1's guardian revealed:
-Client #1 said he was staying at the facility without staff during the day.
-Client #1 said he was staying at the facility with the other clients for about 8 hours daily.
-She talked to the QP and the Administrator/Licensee several times over the last few months about client #1 being unsupervised at the facility.
-She never approved unsupervised time for client #1 to stay at the facility without staff.
-She talked with the QP several times about her concern with client #1 being unsupervised at the facility.
-"[The QP] did not care about my concerns."
-The QP continued to allow staff to leave clients unsupervised all day.
-The QP kept saying the clients didn't require supervision all day long and they could have unsupervised time in the facility.
-Client #1 needed supervision because he could be aggressive and had two separate incidents

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with other clients.
-When client #1 lived at a facility in another city he attacked another client because he was upset with staff.
-She had to go to court with client #1 for that incident.
-Client #1 also got into a physical altercation with another client at another facility.
-Both of those facilities were owned by the Administrator/Licensee.
-The QP and Administrator/Licensee knew client #1's history of violence towards other clients.
-They continued to allow staff to leave client #1 in the facility unsupervised.
-"My concern with the clients being at the facility unsupervised is if there is an emergency. There is no staff available."
-Staff #2 told her a few months ago most of the clients in that facility were panhandling during the day.
-Staff #2 said they were walking to one of the convenience stores in the area and panhandling.

Interviews on 1/25/24, 1/26/24, 1/29/24 and 1/30/24 with the QP revealed:
-All the clients had unsupervised time at the facility except for client #1.
-Client #1 required supervision by staff at the facility.
-She thought client #2 had 1-2 hours at the facility without staff supervision.
-She didn't realize client #2 had no unsupervised time at the facility.
-On 1/24/24 staff #1 told her she had gone out to buy food. She said she left the clients at the facility unsupervised for a few minutes.
-All of the clients had unsupervised time in the community, except for client #5.
-The hours each client was allowed in the community unsupervised varied.

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V 290	Continued From page 34 -She didn't recall staff saying anything to her about client #4 exceeding his unsupervised time in the community. -She knew clients #1 and #2 had a substance abuse history. -She didn't know clients #1 and #2 were getting marijuana in the community during their unsupervised time. -She wasn't aware of any clients panhandling in the community. -She was aware some of the clients were going to a neighbor's home in the community and asking for food. -The Administrator/Licensee brought that to her attention. -She couldn't remember how long ago that was brought to her attention by the Administrator/Licensee. -She was informed clients #1 and #4 were asking the neighbor for food. -She didn't know clients #2 and #3 were asking the neighbor for food. -She acknowledged the facility failed to assess the capability for clients #1, #2, #3, #4 and #5 to be unsupervised in the home and community. Interviews on 1/26/24 and 1/30/24 with the Administrator/Licensee revealed: -She was aware most of the clients in the facility had unsupervised time in the community. -She knew client #2 had history of substance abuse. -She wasn't sure if she was aware client #1 had a substance abuse history. -She didn't know clients #1 and #2 were getting marijuana in the community during their unsupervised time. -She was not aware of clients panhandling in the community. -She knew some of the clients were asking a	V 290		

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V 290	Continued From page 35 couple in the neighborhood for food. -She talked with those neighbors about not giving the clients food a couple of months ago. -Clients #1 and #4 were the main two clients begging those neighbors for food. -She talked with all of the clients about not going out to neighbors and asking for food. -She acknowledged the facility failed to assess the capability for clients #1, #2, #3, #4 and #5 to be unsupervised in the home and community. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A rule violation and must be corrected within 23 days.	V 290		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's	V 291		

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V 291	Continued From page 36 progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure coordination was maintained between the facility operator and other qualified professionals who are responsible for treatment/habilitation affecting one of five clients (#1) and failed to ensure clients had activity opportunities based on their choices and needs affecting five of five clients (#1, #2, #3, #4 and #5). The findings are: The following is the evidence the facility failed to coordinate with the physician. Review on 1/25/24 of client #1's record revealed: -Admission date of 4/25/23. -Diagnoses of Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder with psychotic features, Cannabis Use Disorder, Alcohol Use Disorder and Type II Diabetes. -Admission summary dated 4/25/23-He assaulted another client at a facility owned by the agency and was transferred to current location on 4/25/23. He had a history of substance abuse, suicidal attempts, physical aggression/assault with a weapon, auditory and visual hallucinations, delusions, persecutory ideation and poor judgement. He can be violent.	V 291		

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V 291	Continued From page 37 -Physician's orders dated 12/2/22 and 11/13/23 for blood sugar to be checked daily. -Physician's order dated 12/21/23 for blood sugar to be checked on Monday, Wednesday and Friday. Review on 1/25/24 of client #1's blood glucose meter revealed blood sugar was only checked the following times per month: -January 2024-x2 with the last check on 1/18/24 -December 2023-x2 -November 2023-x0 -October 2023-x4 -September 2023-x4 -August 2023-x6 -July 2023-x4 -June 2023-x7 -Blood sugars ranged between 79 and 154 -There were a total of 189 missed blood sugar checks Interview on 1/26/24 with client #1 revealed: -He was required to check his blood sugar daily. -His Physician just decreased his days to check his blood sugar to 3 days a week "about a month ago." -He was not checking his blood sugar daily prior to his blood sugar checks being decreased to 3 days a week. -He was not consistently checking his blood sugar because he was "tired" of pricking his fingers. -"It was painful pricking my fingers every day." -Staff #1 and staff #2 monitored him whenever he checked his blood sugar and they knew he refused to check his blood sugar some days. Interview on 1/26/24 with staff #1 revealed: -Staff sat with client #1 whenever he checked his blood sugar.	V 291		

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V 291	Continued From page 38 -Client #1 checked his blood sugar most days. -Client #1 refused to check his blood sugar a few days. -Client #1 would tell her "I'm not Diabetic" and then refuse to check his blood sugar. -She couldn't remember if she said anything to the Qualified Professional (QP) and the Administrator/Licensee about client #1 refusing to check his blood sugar. Interview on 1/29/24 with staff #2 revealed: -Client #1 was supposed to check his blood sugar daily. -Client #1's physician's order just recently changed to check his blood sugar 3 times a week -Client #1 refused to check his blood sugar some days. -Client #1 said his fingers hurt and "I don't feel like checking my blood sugar." -He didn't think he brought it to the QP and the Administrator/Licensees' attention whenever client #1 refused to check his blood sugar. Interview on 1/26/24 with the QP revealed: -Client #1 checked his own blood sugar. -Staff were required to monitor client #1 whenever he checked his blood sugar. -Client #1 had a history of not wanting to check his blood sugar. -She just asked client #1 about his blood sugar checks on 1/25/24. -Client #1 said he was not checking his blood sugar daily. -Client #1 said he might check his blood sugar 1-3 days a week. -Client #1's Physician was not contacted by staff. -Client #1's Physician was not aware client #1 refused to check his blood sugar. Interview on 1/26/24 with the	V 291		

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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 291	Continued From page 39 Administrator/Licensee revealed: -They talked with client #1's Physician about him refusing to acknowledge he had Diabetes in the past. -Client #1 was on Metformin about a year ago but refused to take it and it was discontinued by the Physician. -Staff never said anything to her about client #1 refusing to check his blood sugar. -Client #1 never said anything to her about not wanting to check his blood sugar and pricking his finger being painful. The following is evidence the facility failed to ensure clients participated in activities. Interview on 1/24/24 with client #1 revealed: -He lived at the facility for about 8 months. -He didn't like living at the facility because they didn't do any activities. -He talked to staff about doing more activities a few months ago, however "they ignored me." -The only thing clients did was sit in the house every day. "It's not good for my mental health to sit in the house all day." -Staff never took them out in the community to do any activities. Interview on 1/24/24 with client #2 revealed: -They never did activities with staff at the facility. -Staff also don't take them out into the community to do any activities. -They sat around the facility most days unless they walked to the store or took the bus to go places on their own. -"I talked to the QP and [the Administrator/Licensee] about this issue and they won't address any of it."	V 291		

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	MHL032-611	A. BUILDING: _____ B. WING _____	R 02/02/2024

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V 291	Continued From page 40 Interview on 1/24/24 with client #3 revealed: -Staff never did activities with them at the facility or in the community. -Staff had not done activities at the facility or in the community with them in over a year. -He stayed in his bedroom and took naps throughout the day most days. Interview on 1/24/24 with client #4 revealed: -Staff had not done any activities in the facility or community with them for several months. -He would like to go out in the community with staff occasionally and do activities with "the other guys." Interview on 1/30/24 with client #5 revealed: -Staff did no activities with them out in the community or at the facility. -Staff had not done any activities with them in about a year or longer. -He talked with some of the staff about doing activities and they said they "would look into it." Interview on 1/26/24 with staff #1 revealed: -The tags on the facility van expired in September 2023. That's the reason she did not do activities in the community with the clients. -She did not drive clients around in her personal car. -She knew staff #2 did not do activities in the community with clients either because he did not drive at all. Interview on 1/26/24 with staff #4 revealed: -He did transportation for the agency. -He took client #5 to his dialysis appointments three days a week. -He also did medical appointments occasionally with some of the other clients. -He didn't do any other outings or activities with	V 291		

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V 291	Continued From page 41 clients in the community. Interview on 1/25/24 with the QP revealed: -Staff #4 worked with the agency and provided transportation as needed for clients. -Staff #4 would occasionally take the clients out in the community to do activities. -She wasn't sure how often staff #4 was taking those clients out in the community for activities. Interview on 1/26/24 with the Administrator/Licensee revealed: -She thought the clients were doing activities with staff. -Staff #3 just recently took clients to the park. -Staff #4 also did activities with clients in the community. -Staff #4 took the clients out in the community shopping as needed. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A rule violation and must be corrected within 23 days.	V 291		
V 366	27G .0603 Incident Response Requirements 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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V 366	Continued From page 42 (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	V 366		

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V 366	Continued From page 43 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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V 366	Continued From page 44 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 a policy governing their response to Level II incidents as required. The findings are: Review on 1/26/24 of police reports from the local police department revealed: -1/6/24-Police Officers responded to facility due to a physical altercation between clients #3 and #4. -7/31/23-Police Officers responded to facility due to a physical altercation between clients #2 and #5. Review on 1/26/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There were no level II incident reports submitted by the facility for the two incidents above. -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 1/29/24 with staff #2 revealed:	V 366		

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V 366	Continued From page 45 -He was working during the incident with clients #3 and #4 in January 2024. -The police department was called during that incident. -The police department was called because client #3 hit client #4. -Client #4 also went to the hospital because his lip was "a little" bloody. -There was also an altercation in July 2023 between clients #2 and #5. -The police department was also called during that incident. -Client #2 hit client #5 in his eye because he said he felt threatened. -Client #5's eye was a little swollen. -Emergency Medical Services also responded but client #5 refused to go to the hospital. Interview on 1/29/24 with the Qualified Professional revealed: -She was aware of incident with clients #2 and #5 in July 2023. -She was also aware of incident with clients #3 and #4 from January 2024. -She confirmed the facility failed to implement a policy governing their response to Level II incidents as required.	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	V 367		

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V 367	Continued From page 46 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 of all level III incident reports to the Division of Mental Health, Developmental Disabilities and	V 367		

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V 367	Continued From page 47 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. This Rule is not met as evidenced by:	V 367		

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V 367	Continued From page 48 Based on record reviews and interviews, the facility failed to ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 1/26/24 of police reports from the local police department revealed: -1/6/24-Police Officers responded to facility due to a physical altercation between clients #3 and #4. -7/31/23-Police Officers responded to facility due to a physical altercation between clients #2 and #5. Review on 1/26/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There were no level II incident reports submitted by the facility for the two incidents above. Interview on 1/29/24 with staff #2 revealed: -He was working during the incident with clients #3 and #4 in January 2024. -The police department was called during that incident. -The police department was called because client #3 hit client #4. -Client #4 also went to the hospital because his lip was "a little" bloody. -There was also an altercation in July 2023 between clients #2 and #5. -The police department was also called during that incident. -Client #2 hit client #5 in his eye because he said he felt threatened. -Client #5's eye was a little swollen. -Emergency Medical Services also responded but client #5 refused to go to the hospital.	V 367		

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V 367	Continued From page 49 Interview on 1/29/24 with the Qualified Professional revealed: -She was aware of incident with clients #2 and #5 in July 2023. -"I was on vacation or had a family situation and that was why the IRIS was not done for that incident." -She was also aware of incident with clients #3 and #4 from January 2024. -She found out about the incident about 10 days later. -"I felt like it would be late reporting and I decided not to put that incident into IRIS." -She confirmed the facility failed to report the above incidents to LME/MCO within 72 hours.	V 367		
V 369	G.S. 122C-6 Smoking Prohibited § 122C-6 SMOKING PROHIBITED; PENALTY (a) Smoking is prohibited inside facilities licensed under this Chapter. As used in this section, "smoking" means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, "inside" means a fully enclosed area. (b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall: (1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. (2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product. (3) Provide written notice to individuals upon admittance that smoking is prohibited inside the	V 369		

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V 369	Continued From page 50 facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice. (c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section. A violation of this section constitutes a civil offense only and is not a crime. (d) This section does not apply to State psychiatric hospitals. (2007-459, s. 3.) This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to prohibit smoking inside the facility. The findings are: Observation on 1/24/24 at approximately 1:45 PM revealed: -There were no "no smoking" signs posted in the facility. -Living room area-4 cigarette butts and cigarette ashes in a pile on the floor near the couch. -Empty bedroom-2 cigarette butts on the floor. -Clients #2 and #4's bedroom-7 cigarette butts on the floor. -Bathroom near client #1's bedroom-4 cigarette butts on the floor. -Hallway near client #5's bedroom-4 cigarette butts on the floor. -Client #5's bedroom-3 cigarette butts and a pile of cigarette ashes on the floor. -Client #3's bedroom-3 cigarette butts on the floor. Approximately 100 pea sized brownish	V 369		

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V 369	Continued From page 51	V 369		

spots on the laminate wooden floor.
-Storage Room in hallway-5 cigarette butts on the floor. 7 cigarette butts and pile of cigarette ashes near window sill.

Observation on 1/26/24 at approximately 9:00 AM revealed:
-Client #5's bedroom-He was sitting on his bed smoking a lit cigarette. Staff #1 never redirected client #5 when she saw him smoking the lit cigarette in his bedroom.

Interview on 1/24/24 with client #1 revealed:
-He had been smoking cigarettes in his bedroom for the last 4-5 months.
-He just smoked a cigarette in his bedroom last night.
-He smoked cigarettes in his bedroom a few days each week throughout the day.
-He thought staff knew he was smoking cigarettes in his bedroom because the Qualified Professional (QP) talked to the clients about a month ago about not smoking cigarettes in their bedrooms.

Interview on 1/24/24 with client #2 revealed:
-He smoked cigarettes in his bedroom daily.
-He had been smoking cigarettes in his bedroom for several months.
-The QP talked to the clients about not smoking cigarettes in the facility, "I did it anyway."

Interview on 1/24/24 with client #3 revealed:
-He had been smoking cigarettes in his bedroom for several months.
-The brown spots on his floor were burn marks.
-There were several burn marks on his floor because he dropped an ashtray on the floor a few weeks ago and the ashes spread everywhere.
-He last smoked cigarettes in his bedroom about

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V 369	Continued From page 52 a month ago. Interview on 1/24/24 with client #4 revealed: -He didn't smoke cigarettes anymore. -"I can't remember the last time I smoked a cigarette." -When he was smoking cigarettes, he smoked them in his bedroom a few times. -He had been smoking a vape pen for about a month. -He smoked the vape pen in his bedroom a few times just recently. Interview on 1/30/24 with client #5 revealed: -He smoked cigarettes in his bedroom almost daily because "I don't feel like going outside." -He had been smoking cigarettes in his bedroom for about six months or longer. Interview on 1/24/24 with staff #1 revealed: -She had never seen any of the clients smoking cigarettes in their bedrooms. -She "knew" clients were smoking in their bedrooms, however when she asked them about it they said they were not smoking. -She knew they were smoking cigarettes in their bedrooms because their bedrooms smelled like cigarette smoke. -The QP talked to the clients about not smoking in the facility a few weeks ago. Interview on 1/29/24 with staff #2 revealed: -He had never seen any of the clients smoking cigarettes in the facility. -He thought clients were smoking in the facility because he smelled cigarette smoke. Interview on 1/30/24 with staff #3 revealed: -She just returned to this facility on 1/26/24. -She was previously employed with this facility	V 369		

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V 369	Continued From page 53	V 369		

and left in March 2023.
-She just saw client #5 smoking a cigarette in the living room area a day or two ago.

Interviews on 1/25/24 and 1/29/24 with the QP revealed:
-The clients are not supposed to be smoking cigarettes or vaping in the facility.
-The clients were told at admission smoking was not allowed in the facility.
-They all signed the house rules which indicated smoking is not allowed in the facility.
-She had never seen any of the clients smoking or vaping in the facility.
-She "suspected" clients were smoking because she smelled cigarette smoke in the facility.
-She talked to the clients about six months ago about not smoking in the facility.
-Staff had not said anything to her in the last couple of weeks about any of the clients smoking or vaping in the facility.

Interview on 1/26/24 with the Administrator/Licensee revealed:
-Client #4 was smoking cigarettes in the facility when he was admitted a couple of years ago.
-They addressed that issue with client #4.
-She thought client #4 mainly smoked a vape pen.
-She didn't know the other clients were smoking cigarettes in the facility.
-Staff had not brought it to her attention recently that clients were smoking cigarettes in the facility.

Review on 2/2/24 of a Plan of Protection written by the QP dated 2/2/24 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care? [The Administrator/Licensee] has met with each resident on 1/26/24 and 1/31/24 to discuss no

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V 369	Continued From page 54 smoking statue. [The Administrator/Licensee] review discussed rules, expectations and possible consequences for resistance or failure to comply with not smoking in the group home up to and including discharge. Describe your plans to make sure the above happens. Staff will report all situations where a resident is observed smoking or vaping in the home to [the Administrator/Licensee] and/or [the QP] immediately. The staff will document the occurrence on the daily log as well as complete an incident report. [The Administrator/Licensee] or [the QP] will follow up by meeting with the individual client, guardian and other team members to discuss consequences. This might include immediate discharge." Clients diagnoses included Post Traumatic Stress Disorder, Major Depressive Disorder, Schizoaffective Disorder, Schizophrenia, Mild Cognitive Impairment, End Stage Renal Disease, Type II Diabetes, Cannabis Use Disorder, Alcohol Use Disorder and Tobacco Use Disorder. There were cigarette butts and cigarette ashes on the floors throughout the facility. On 1/26/24 client #5 was observed smoking a lit cigarette in his bedroom. Staff #3 also observed client #5 smoking a cigarette in the living room area of the facility. Other staff suspected clients were smoking in the facility because they smelled cigarette smoke. All five clients admitted they were smoking cigarettes or using a vape pen in the facility. The Qualified Professional spoke with clients about 6 months ago about not smoking in the facility, however clients continued to smoke cigarettes or use a vape pen in the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 369		

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V 512	Continued From page 55	V 512		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, one of five audited staff (#1) neglected five of five clients (#1, #2, #3, #4 and #5). The findings are: Review on 1/25/24 of the personnel record for staff #1 revealed: -Date of hire was 8/31/23.	V 512		

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V 512	Continued From page 56 -Hired as a Habilitation Technician. Review on 1/25/24 of client #1's record revealed: -Admission date of 4/25/23. -Diagnoses of Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder with psychotic features, Cannabis Use Disorder, Alcohol Use Disorder and Type II Diabetes. -Admission summary dated 4/25/23-He assaulted another client at a facility owned by the agency and was transferred to current location on 4/25/23. He had a history of substance abuse, suicidal attempts, physical aggression/assault with a weapon, auditory and visual hallucinations, delusions, persecutory ideation and poor judgement. He can be violent. -Unsupervised Time Assessment dated 4/25/23-Client #1 had 0 hours of unsupervised time at the facility. Review on 1/25/24 of client #2's record revealed: -Admission date of 8/2/21. -Diagnoses of Schizoaffective Disorder, PTSD and Cannabis Use Disorder in remission. -Admission summary dated 8/2/21-He had a history of legal issues. The legal issues included: wantonly injury to property in 2013, felony breaking and entering, larceny from a merchant, larceny after breaking and entering, possession of a firearm by a felon and robbery with a dangerous weapon. His parole was scheduled to end at the end of August 2021. He also has a history of substance abuse, aggression, agitation, delusions and treatment noncompliance. -Unsupervised Time Assessment dated 8/4/23-Client #2 had 0 hours of unsupervised time at the facility. Review on 1/25/24 of client #3's record revealed: -Admission date of 11/8/20.	V 512		

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V 512	Continued From page 57 -Diagnoses of Schizophrenia and Tobacco Use Disorder. -Admission summary dated 11/8/20-He had a history of aggression, assault, agitation, delusions, hallucinations, mood swings and depression. In previous facility he assaulted another client and had to go to court. -Unsupervised Time Assessment dated 10/27/23-Client #3 had 2 hours of unsupervised time at the facility. Review on 1/25/24 of client #4's record revealed: -Admission date of 5/13/21. -Diagnoses of Schizoaffective Disorder-bipolar type and Type II Diabetes Major Depressive Disorder and Mild Cognitive Impairment. -Admission summary dated 5/13/21-He had a history of extreme violence. He was in the state hospital for 15 years after it was determined he was incompetent to stand trial for the murder of his father. He had a history of aggressive sexual behavior. The behaviors are verbal and involve statements made towards females. He also had a history of auditory hallucinations, threatening/intimidating behaviors, poor judgement, agitation and poor insight into his mental illness. -Unsupervised Time Assessment dated 5/9/23-Client #4 had 3 hours of unsupervised time at the facility. Review on 1/25/24 of client #5's record revealed: -Admission date of 3/30/17. -Diagnoses of Schizophrenia-Paranoid type and End Stage Renal Disease. -Admission summary dated 8/16/17-He took dialysis treatments 3 days a week. He had a history of arrests for larceny, assault and possession of "a schedule II drug." -Unsupervised Time Assessment dated	V 512		

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V 512	Continued From page 58 12/23/23-Client #5 had 1 hour of unsupervised time at the facility. Observation on 1/24/24 between 12:37 PM and 1:22 PM and interview with client #2 revealed: -Client #2 answered the door and said staff #1 was not available -Clients #1, #2 and #3 were at the facility unsupervised. -He stated staff #1 left about 20 minutes ago to pick up lunch. -He stated he didn't have staff #1's telephone number. Interview on 1/24/24 with client #1 revealed: -When staff #1 worked with them, they would stay at the facility unsupervised during the day sometimes. -He and the other clients stayed at the facility during the day for 6 or more hours unsupervised. -Staff #1 also left them unsupervised at the facility a few times during sleeping hours. -He wasn't sure what time she was leaving at night. -He wasn't sure how many times it occurred. -He woke up a few times and noticed there was no staff in the facility when staff #1 was supposed to be working. -She was away about 6-8 hours because he would see her return the next morning. -He thought she last left them at the facility overnight and/or during the day unsupervised was about a month ago. Interview on 1/24/24 with client #2 revealed: -Staff #1 left them at the facility unsupervised several times during the day and at night. -During the day she might leave them unsupervised for about 6-8 hours. -She left them at facility unsupervised during the	V 512		

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day earlier today (1/24/24).
-She just left them unsupervised overnight last night on 1/23/24.
-Whenever she left them at night staff #1 would not return to the facility until the next morning.
-She would leave when it is dark outside.
-They don't always know she left the facility.
-They would be looking for her and not see her in the facility.
-He was not sure what time staff #1 was leaving the facility.
-He thought she was gone for at least 8 hours overnight.
-He thought she started leaving them unsupervised at the facility during the day and at night a few months ago.

Interview on 1/24/24 with client #3 revealed:
-They were staying at the facility during the day without staff 6-8 hours. That happened whenever staff #1 worked with them.
-Staff #1 also left them in the facility unsupervised overnight a few times.
-Staff #1 was away from the facility overnight about 9-10 hours.
-Staff #1 last left them unsupervised overnight about a 1 ½ weeks ago.
-He thought staff #1 started leaving them unsupervised at night and during the day about 1-2 months ago.

Interview on 1/24/24 with client #4 revealed:
-Staff #1 left them alone at the facility overnight.
-She left them at the facility overnight several times.
-He thought they were alone at the facility overnight for about 7 or 8 hours.

Interview on 1/30/24 with client #5 revealed:
-Staff #1 left them at the facility unsupervised for

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about 7 or more hours some days when she worked with them.
-She also left them unsupervised overnight a few times.
-He couldn't remember how recently staff #1 left them at the facility unsupervised during the day or overnight.

Interview on 1/26/24 with a Neighbor in the community revealed:
-She lived down the street from the facility.
-She knew all of the clients at the facility.
-She saw clients #1 and #4 walking up and down the street near the facility as late as 12:00 AM.
-"[Name of street near facility] is busy and dark at night, those two guys should not be out walking that late at night unsupervised."
-She thought she last seen them out walking late at night about a month or two ago.

Interviews on 1/24/24 and 1/26/24 with staff #1 revealed:
-She worked at the facility about 5 months.
-She was a live in staff and worked 2 weeks on and 2 weeks off.
-She would occasionally leave the facility during the day to get food or run an errand.
-She normally didn't stay away from the facility for several hours.
-She would only be gone for about 1 to 1 ½ hours.
-All of the clients had unsupervised time at the facility and could be left alone.
-She never left the clients in the facility overnight unsupervised.
-She was always at the facility with the clients when she was supposed to be working.
-She's normally in the staff office area with the door closed.

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V 512	Continued From page 61 Interview on 1/25/24 with the Qualified Professional (QP) revealed: -She was not aware staff #1 was leaving the clients unsupervised at the facility for several hours during the day and/or overnight. -The clients never said anything to her about staff #1 leaving unsupervised. -"This never came to my attention. If that many people said it happened, it happened." Interview on 1/26/24 with the Administrator/Licensee revealed: -She wasn't aware staff #1 left the clients unsupervised for long periods of time at the facility during the day and overnight. -The clients never said anything to her. Review on 2/2/24 of a Plan of Protection written by the QP dated 2/2/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The staff who was providing coverage in the group home at the time of the survey was initiated has been removed from the facility and will possibly be assigned to another facility. She was removed on 1/26/24. She will be trained prior to reassignment to another facility on supervision needs of each client. A new staff has been hired for that facility. Describe your plans to make sure the above happens. [The Administrator/Licensee] has made daily checks by phone or visits to the facility. Daily contacts will continue. [The QP] will make daily contacts with a resident in the home to corroborate staff's availability and presence in the home." Clients diagnoses included PTSD, Major Depressive Disorder, Schizoaffective Disorder, Schizophrenia, Mild Cognitive Impairment, End Stage Renal Disease, Type II Diabetes, Cannabis	V 512		

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V 512	Continued From page 62 Use Disorder, Alcohol Use Disorder and Tobacco Use Disorder. Staff #1 left clients unsupervised at the facility for extended periods of time during the day and overnight at the facility during her shift. All of the clients stated staff #1 was leaving them unsupervised during day and overnight consistently. A neighbor in the community said she saw clients #1 and #4 walking down the street near the facility as late as 12:00 AM. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 512		
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 interviews, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 1/24/24 at approximately 1:45 PM revealed: -Kitchen area-Drawer missing from cabinet. -Living room area-Couch cushion had 2 tears approximately 1 inch wide and 4 inches long. Love seat had two tears approximately 3 inches long. Two soft drink cans, two pieces of candy paper and two pairs on pants on the floor. 4 cigarette butts and cigarette ashes in a pile on the floor near the couch. The entire area rug was faded and had black stains. Two sets of window blinds had 3 missing slats. No cover over the wall	V 736		

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V 736	Continued From page 63 light switch. -Dining room-Set of window blinds had eight slats missing. -Hallway near living room area-No cover over the wall light switch. Paint on walls was discolored (blue and purple blended). -Client #1's bedroom-A hole in the wall approximately 6 inches wide and 14 inches long. A second hole in the wall was approximately 6 inches wide and 12 inches long. A third hole in the wall was approximately 3 inches wide and 6 inches long. A set of window blinds had 6 slats missing. Mattress was grayish, faded and sunken in the middle. Three metal springs were exposed underneath the mattress. Dirt build up on the entire area rug. Entertainment center was leaning forward. Approximately 60 loose tobacco particles on floor near entertainment center in a pile. Caulking material on the wall approximately 30 inches wide and 20 inches long. -Empty bedroom-A set of blinds with three missing slats. Approximately 20 wood chips on the floor. 2 cigarette butts on the floor. -Clients #2 and #4's bedroom-Client #2's mattress was grayish and had a tear on top approximately 6 inches long. Client #2's mattress also had a tear on the side approximately 16 inches long. Approximately 70 loose tobacco particles, 7 cigarette butts, 7 empty plastic grocery bags, 2 empty plastic tobacco bags, an empty potato chip bag, bag of walnuts and approximately 16 clothing items on the floor. 6 empty plastic two liter soft drink bottles, 2 soft drinks cans, 2 sixty four ounce empty juice containers and empty apple sauce container in a box on the floor. A hole in the wall approximately 12 inches long and 12 inches wide. A second hole in the wall was approximately 6 inches long and 4 inches wide. A third hole in wall behind the bedroom door was approximately 3 inches long	V 736		

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V 736	Continued From page 64 and 3 inches wide. Client #4's mattress had approximately 40 black pin sized markings on one corner and approximately 20 black pin sized markings on a second corner. Approximately 4 clothing items, a cane and umbrella underneath client #4's mattress. Approximately 4 clothing items in a pile, 2 empty plastic grocery bags, 3 empty plastic two liter soft drink bottles and a towel on top of the dresser. Approximately 30 loose tobacco particles, a hat, fan, electronics cord and duffle bag in a pile on top of a small table. -Closet in hallway near clients #2 and #4's bedroom-Approximately 8 clothing items, three sheets, two empty grocery bags and a styrofoam cup on the floor. -Hallway near clients #2 and #4's bedroom-The floor area was spongy and floor gave way when stepped on. -Bathroom near client #1's bedroom-The floor area at entry was spongy and floor gave way when stepped on. The entire toilet seat was faded. Shower curtain had approximate 10 pea sized brown stains. Top of sink had approximately 50 hair particles, 10 brownish pea sized stains and dried toothpaste stains. 4 cigarette butts and an empty toilet roll on the floor. A crack in the floor tiles approximately 12 inches wide and 6 inches long. -Hallway near client #5's bedroom-4 cigarette butts on the floor. -Client #5's bedroom-Chair in the middle of the floor with approximately 8 pieces of mail, playing cards, 2 books, roll of toilet paper and empty soft drink can in a pile. Paint on the wall above the window was peeling. Dresser had 4 knobs missing. A razor, lotion, empty styrofoam cup, hand cream and a shoe box in a pile on top of the dresser. 3 cigarette butts, a pile of cigarette ashes and a cotton bag on the floor.	V 736		

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V 736	Continued From page 65 -Storage Room in hallway-Approximately 20 clothing items, a light cover, lightbulb, plastic bucket, spray bottle, 5 cigarette butts, bathroom rug, 2 empty plastic grocery bags, empty potato chip bag, phone charger block, 2 bed pillows and an empty 2 liter soft drink bottle on the floor. 7 cigarette butts and a pile of cigarette ashes near window sill. -Bathroom near client #3's bedroom-The middle portion of the floor was spongy and floor gave way when stepped on. Approximately 20 brownish pea sized spots and layer of dust on top of sink. Toilet was leaning to the right side. Approximately 50 pieces of hair on the toilet rim and inside the toilet bowl. Build up of dirt on the floor. Soap scum in the tub. The area of tub near faucet was separating from the wall. -Client #3's bedroom-Approximately 25 clothing items in corner of bedroom on top of a brick column. 4 plastic trash bags of clothing, a plastic bag with trash, a suitcase and book bag on the floor. 3 cigarette butts on the floor. Approximately 100 pea sized brownish spots on the laminate wooden floor. 2 pairs of shoes, can of bed bug spray, box of plastic trash bags, hand sanitizer and screwdriver on top of a wooden record player. Bedroom door had 2 cracks both approximately 12 inches long. -Backyard area near client #3's bedroom-Approximately 100 cigarette butts, 2 clumps of human hair, 2 empty soft drink cans and an empty vegetable can on the ground. Interview on 1/24/24 with staff #1 revealed: -She worked at the facility about 5 months. -She was a live in staff and worked 2 weeks on and 2 weeks off. -Most of the clients at this facility "don't like to clean." -She felt the clients were all capable of cleaning	V 736		

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V 736	Continued From page 66 the facility. -She would help them clean the kitchen area. -The clients were responsible for cleaning their own bedrooms. -She acknowledged the facility was not maintained in a safe, clean, attractive and orderly manner. Interview on 1/25/24 with the Qualified Professional revealed: -The Administrator/Licensee went to that facility in December 2023 and cleaned up. -"When I went on 12/21/23 to pick up a client for his appointment the facility was messy, but not in the condition it was in earlier today when I visited." -"I was surprised to see the home looked that way." -She acknowledged the facility was not maintained in a safe, clean, attractive and orderly manner. Interview on 1/26/24 with the Administrator/Licensee revealed: -She went to the facility on 1/13/24 and saw there were some cleanliness issues with the facility. -She saw clothing and other items on floor in some of clients bedrooms. -"Clients in this facility are difficult." -Client #3 had a tendency to be aggressive and will not always cooperate when staff ask him to clean up. -Staff said clients are not listening to them when they ask them to clean up the facility. -Staff were responsible for assisting clients with cleaning the facility. -She acknowledged the facility was not maintained in a safe, clean, attractive and orderly manner.	V 736		

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V 736	Continued From page 67 This deficiency has been cited 5 times since the original cite on 4/29/21 and must be corrected within 30 days.	V 736		
V 738	27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility staff failed to maintain an insect free environment. The findings are: Observation on 1/24/24 at approximately 1:45 PM revealed: -Clients #2 and #4's bedroom-Client #4's mattress had approximately 40 black pin sized markings on one corner and approximately 20 black pin sized markings on a second corner. Observation on 1/24/24 of client #3's arms at approximately 3:30 PM: -His left arm had approximately 30 bite marks. -His right arm had approximately 10 bite marks. Observation on 1/30/24 of client #2's arms and back at approximately 11:00 AM: -His left arm had approximately 40 bite marks. -His right arm had approximately 40 bite marks. -His back had approximately 5 bite marks. Review on 1/25/24 of receipts from the pest	V 738		

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V 738	Continued From page 68 control company revealed: -9/22/23-The facility had a steam treatment for bed bugs. -6/16/23-The facility had a chemical treatment for bed bugs. Interview on 1/24/24 with client #1 revealed: -He last saw bed bugs in his bedroom about a month ago. -He had been seeing bed bugs "on and off" since moving into the facility 8 months ago. -He just saw bed bugs today (1/24/24) in clients #2 and #4 bedroom when he lifted client #4's mattress earlier. -He saw about 2-3 small reddish bugs crawling underneath client #4's mattress. Interview on 1/24/24 with client #2 revealed: -He had been at the facility about 2 ½ years. -"This facility had issues with bed bugs since I lived here." -"Someone would spray for the bed bugs and the bed bugs would go away and then reappear." -Staff in the past told them the clients were responsible for those bed bugs because they don't like to clean up and take showers. -At one point he was seeing bed bugs almost everyday for about one or two months. -He took a mattress from the shed outside and was not seeing as many bed bugs. -He last saw bed bugs at the beginning of January 2024 in his bedroom. -He talked to staff #1 and staff #2 about seeing bed bugs several times. -He tried to call the Qualified Professional (QP) and Administrator/Licensee about the bed bugs at the beginning of January 2024 and they did not answer or return his call. -"We all need new mattresses and mattress covers to get rid of these bed bugs."	V 738		

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V 738	Continued From page 69 Interview on 1/24/24 with client #3 revealed: -The facility had bed bugs. -He was bitten and had been scratching. -He had several bite marks on his arms. -He last saw bed bugs in his bedroom at the beginning of January 2024. -The Pest Control company came out a few months ago and sprayed for the bed bugs. -"It didn't help because we kept seeing bed bugs in their bedrooms." -He tried to call the QP and Administrator/Licensee about the bed bugs recently. -He also wanted to talk to them about getting a new mattress in his bedroom. -He wasn't able to get in contact with them. -He goes to a Day Program 2 days a week. -He can't go to the Day Program right now because the Day Program staff refuse to transport him in their car because of the issue with the bed bugs. -He had not been to the Day Program in about 1-2 months. Interview on 1/24/24 with client #4 revealed: -He saw bed bugs in his bedroom. -He saw bed bugs crawling on his mattress almost every day for the last 3-4 months. -He thought someone came out and sprayed for the bed bugs about 3-4 months ago. -He talked to staff #1 about seeing bed bugs in his bedroom. -He talked to the QP and Administrator/Licensee about the bed bugs as well about a month ago. Interview on 1/30/24 with client #5 revealed: -He saw bed bugs in his bedroom on his bed almost daily for about the last 2-3 months. -He didn't think he said anything to staff about	V 738		

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V 738	Continued From page 70	V 738		

seeing bed bugs.
-He was being bitten by the bed bugs in his bedroom throughout the day.

Interview on 1/24/24 with staff #1 revealed:
-The clients were saying the facility had bed bugs, however she never saw bed bugs in the facility since working there for the last 5 months.
-Client #2 showed her bites on his arms from the bed bugs.
-Client #2 took a mattress from the shed and switched out his mattress.
-Client #3 also said he was being bitten by bed bugs.
-She never reached out to the QP and Administrator/Licensee about issues with the bed bugs.

Interview on 1/29/24 with staff #2 revealed:
-He never saw any bed bugs in that facility.
-He knew there were bed bugs because the clients said they were being bitten and seeing bed bugs in their bedrooms.
-He sprayed the beds with bleach and soap water around edges of client beds for bed bugs.
-Someone from the pest control company came out twice to treat for the bed bugs.
-They last treated the facility about 3 months ago.

Interview on 1/30/24 with staff #3 revealed:
-She just returned to the facility on 1/26/24.
-She left for other employment last year in 3/2023.
-She had not seen any bed bugs since she returned.
-She heard clients #2 and #5 saying they being bitten by bed bugs.
-Client #2 had "bites all over his arms."
-The Technician from the pest control company said he saw bed bugs in two of the bedrooms on

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today (1/30/24).
-The Technician said he saw bed bugs in client #5's bedroom and the bedroom clients #2 and #4 share.

Interview on 1/30/24 with the Technician from the pest control company revealed:
-He was doing a chemical treatment for the facility.
-He did the initial treatment for that facility in June 2023 and "it was bad."
-There was bed bug activity in the facility during that treatment.
-One of his co-workers came out in September 2023 and did a follow up treatment.
-He wasn't sure what was found on that service date.
-He saw some bed bug activity in the facility today (1/30/24).
-He saw bed bugs in two of the clients bedrooms.
-In one of the bedrooms he saw some bed bugs crawling across the mattress when it was lifted.
-"If bed bugs are in those bedrooms they are probably throughout the facility."

Interview on 1/31/24 with client #3's Assertive Community Treatment (ACT) team Case Manager revealed:
-Client #3 attended the Day Program 2 days a week.
-They also took client #3 out in the community about once a week for activities.
-She took client #3 out in the community on 1/2/24.
-She visited client #3 at the facility on 1/9/24 and he disclosed to her the facility had bed bugs.
-She told client #3 during that visit she and other Day Program staff could no longer transport him in their personal vehicles.
-Client #3 was also told he could not be

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V 738	Continued From page 72 transported on the Day Program company van due to the issue with the facility having bed bugs. -She tried to contact the QP on 1/9/24, however she did not answer. -She left a voicemail message or texted the Qualified Professional. -She did not talk with the QP until 1/16/24. -She informed the QP about her concerns with the facility having bed bugs. -She also talked with the Qualified Professional about the Day Program staff not transporting client #3 until the issue with the bed bugs was resolved. -She also talked to a female staff at the facility on 1/23/24 and informed her client #3 could not be transported on their personal vehicles due to the issue with bed bugs. -Client #3 had not attended the Day Program or gone out into the community with Day Program staff since 1/2/24. -She continued to visit client #3 at the facility a couple of times a month. -"[Client #3] seems to be moody since he had not been attending the Day Program and/or going out in the community with [Name of Day Program] staff." Interviews on 1/24/24, 1/25/24, 1/30/24 and 1/31/24 with the QP revealed: -The facility had bed bugs, however the facility was being treatment by a pest control company. -On 1/23/24 one of the client's ACT team members said the client complained to her about still being bitten by bed bugs. -The ACT team member was responsible for other clients in that facility and did not specify which client complained to her. -The Administrator/Licensee said the next appointment for bed bug treatment was scheduled for 1/30/24.	V 738		

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V 738	Continued From page 73 -The appointment was scheduled by the Administrator/Licensee or her husband on 1/24/24. -She talked to the Administrator/Licensee about getting new mattresses and mattress covers for clients bed several times to address the bed bug issue. -Client #3 attended a Day Program 1-2 days a week. -Client #3 had not attended the Day Program in about 3 weeks because the Day Program staff refused to transport him due to the issues with the bed bugs. Interview on 1/26/24 with the Administrator/Licensee revealed: -She was aware the facility had bed bugs in the past. -The facility had bed bugs "on and off" for the last 2-3 years. -"They get rid of the bed bugs and they appear again." -The pest control company was scheduled to come to the facility on 1/30/24 to treat for bed bugs. -That was the soonest appointment she could get. -She got a text from the QP a few days ago about one of the clients complaining to an ACT team staff about the facility having bed bugs. -She made the appointment that day or the day after getting that text from the QP. -The clients never said anything about bed bugs in the last 2-3 months. -Each time it came to her attention that the facility had bed bugs she called the pest control company to schedule a service. -She wasn't sure what type of treatment the pest control company was doing for the bed bugs, the pest control company made that decision.	V 738		

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V 738	Continued From page 74 Interview on 1/31/24 with the Administrator/Licensee revealed: -The account for the pest control company was in her husband's name. -She didn't know if the Technicians with the pest control company made any recommendations when they came out to treat the facility in June and September 2023. -She would contact the pest control company. -She would also contact her husband about surveyor's request to do a three way conference with pest control company and call surveyor back later. Review on 2/1/24 of a text message from the the Administrator/Licensee revealed: -"Sorry, I forgot to text earlier. My husband said he doesn't want to do the three way call. Thanks."	V 738		