STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411222	A. BUILDING: _____ B. WING _____	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE, LLC	310 FIELDS STREET GREENSBORO, NC 27405

(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 000	INITIAL COMMENTS A complaint and follow up survey was completed on January 29, 2024. The complaint was substantiated (intake #NC00211425 and #NC00210846). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge;	V 110		

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V 110	Continued From page 1 (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 5 paraprofessionals (Director #1) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Refer to V132 for specific information on failing to report or investigate client #2's allegations and injuries of an unknown source. Refer to V289 for details of a client (A1) from a sister facility being placed at the 310 Fields Street facility. Refer to V291 for specific information of the failure to notify the Qualified Professional (QP) about client #2's injuries and admission to the hospital. Review on 1/10/24 of Director #1's record revealed: -A hire date of 4/12/17	V 110		

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V 110	Continued From page 2 -A job description of Director The Director #1 failed to demonstrate competence by: -Failed to communicate with the QP about client #2's injury of an unknown cause and client #2's admission to the hospital -Made the decision to have client A1 brought from the sister facility to the 310 Fields Street facility while suspended from school and without access to his room and personal belongings -Failed to seek medical treatment for client #2's black eye and failed to investigate the cause of the injury. Interview on 1/29/24 with Director #1 revealed: -Was responsible for the overall operations of the facility and clients' care This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 days.	V 110		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.	V 132		

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V 132	Continued From page 3 b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report allegations of abuse and harm including injuries of an unknown source to the Health Care Personnel Registry (HCPR), failed to provide evidence that all alleged acts	V 132		

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V 132	Continued From page 4 were investigated, failed to protect the client from harm while the investigation was in process, and failed to report within 5 working days of the initial notification, the results of the investigation to the Department. The findings are: Review on 1/10/24 of the House Manager (HM)'s record revealed: -A hire date of 5/29/23 Review on 1/10/24 of Director #1's record revealed: -A hire date of 4/12/17 Review on 1/10/24 of Director #2's record revealed: -A hire date of 4/12/17 Reviews on 1/24/24 and 1/26/24 of client #2's medical records from a local emergency room, dated 12/1/23 to 12/6/23 revealed: -" ... Chief complaint: Patient presents with Suicidal Ideation. Patient brought in by EMS (Emergency Medical Services) from shopping center. Patient was out in the street. Reporting suicidal ideation ...also reports physical altercations at the group home not getting along with people there. Has a black eye to the left eye. Has some scratches to the right face area. He says that these things happened since Thanksgiving. He also got beat on today as well ..." -Review of Systems: HEENT (Head, Eyes, Ears, Nose and Throat): Positive for facial swelling ..." -" ...Patient states he was assaulted today and sometime around Thanksgiving at the group home ..." -" ...BIB (Brought In By) EMS from the street by a shopping center ...physical altercation at the group home, not getting along with people over	V 132		

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there, bruising and black eye is about 1 week old. Similar issues on Thanksgiving ..."
-" ...Group Home called and reports pt (patient) had gotten violent last night and thrown a chair around his room and kicked an air conditioner out of the window and that is where they (facility staff) think that he injured himself. The black eye is from a previous fight with another client ..."
-" ...Patient reports that he does not like his current group home. He states that he has been there for approximately one month. Stated that he does not get along well with the other residents. States that he has been getting into altercations with people at his group home. He does have some bruising below the left eye and some scratches on the right side of his face ..."
-"He abruptly voices his strong resistance to returning to the same group home, citing past abuse ..."
-"10:10am contacted [local county]'s APS (Adult Protective Services) to file alleged abuse report. Waiting a return call ...10:35am Contacted by [local county]'s APS. Informed of alleged abuse. Investigation pending ...12/3/23 Patient was seen by this provider this morning ...he does not want to go back to the group home and was able to show superficial injury marks on his face from the group home staff ...patient reports attack by group home staff ..."
-" ...12/2/23 Reason for Consult: Abuse and Neglect ...order comments: Patient is reporting this morning that group home staff are abusing him ..."
-" ...12/1/23 ...Diagnoses: Suicidal Ideation, injury of head ...facial injury ..."

Review on 1/26/24 of a local county's EMS record for client #2 dated 12/1/23 revealed:
-" ...HEENT and the narrative ...Pt on scene in shopping center with [local city]'s Police

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Department (PD). [Local city]'s police department advises pt was in a recent altercation at group home ...pt (patient) reports following a physical altercation with another member of the group home 4 or 5 days prior ...pt has yellowing bruise under L (left) eye and several healing superficial lacerations on his face, arms and hands ...Representative (Director #1) met EMS and [local police department] at the shopping center and explained there have been difficulties with the pt as of recent ..."

Review on 1/26/24 of the "Emergency Room Department's Entire Encounter" documentation dated 12/6/23 for client #2 revealed:
-" ...Admission Diagnoses/Reasons for Visit ...Unspecified injury of head ...final diagnoses ...Contusion of other part of head ...External Causes of Injury ...Assault by unarmed brawl or fight ..."

Interview on 1/9/24 with client #2 revealed:
-"There was a time when my eye got black .The hospital staff saw me with a black eye. It was from a staff."
-Identified the staff as the House Manager (HM)
-"We had both got into it and got in each other's face."
-"It happened I think in December (2023)."
-Stated the next day he kicked the air conditioning unit out of the window
-"That's when [Director #2] and [Director #1] came here ...they told me not to tear up the house. [Director #1] hit me 5 times in the face. It was a slap and not a punch. Then her husband (Director #2) hit me 5 times. He took his fists and hit me on the top of the head."
-The police did not come to the facility
-"I left the facility (was unable to recall the date) and walked up the road to the coffee shop. That's

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where the police picked me up. They are the ones that took me to the hospital. The police saw my black eye but did not ask me what happened."
-Denied getting into a fight with another client at the facility

Further interview on 1/10/24 with client #2 revealed:
-"The window unit (incident) started when I got mad about not being able to have a cigarette ...I did get into a fight with [client #3], but he did not hit me in the face. It was [HM]. He got into my face and I told him to stop. I hit him first and then I grabbed him around the stomach. We were in my room and that is when he hit me in the eye. I am saying [HM] hit me in the eye."
-The incident where he was hit by Director #1 and Director #2 occurred on a different day than when he was hit by the HM
-"It was a different day (was unable to recall the date) when [Director #2] hit me. It was like the second or third night later. I punched him and he tried to defend himself. I was mad because I could not have a cigarette."

Interview on 1/9/24 with the HM revealed:
-Had never punched any client in the face
-"When I work here (at the facility) there are always 2 staff here because one of the clients has a 1:1."
-"I did not work that shift when [client #2] kicked the ac (air conditioner) unit out. I was off that day."
-Was not sure if client #2 had a black eye or not
-Was not sure if client #2 was taken to the hospital or not
-Was unable to recall if client #2 and client #3 got into a physical confrontation

Interview on 1/10/24 with the QP revealed:

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V 132	Continued From page 8 -Was not aware client #2 had a black eye and was admitted to the hospital -"I get called after the fact a lot of times. We have talked about this previously and maybe it needs to be readdressed (communication between the facility staff and the QP)." -Did not feel any of the facility staff would physically assault any client -Was not aware of the allegation client #2 was punched in the eye by the HM -Was not aware of client #2's allegation he was slapped by Director #1 and punched in the head by Director #2 -Would immediately notify the HCPR of the allegations and would begin her investigations Interview on 1/10/24 with the APS worker revealed: -Received information of the alleged abuse on client #2 and screened the report out -Made a referral to the Division of Health Service Regulation Interview on 1/10/24 with Director #1 revealed: -"[Director #2] and I got to the facility and [client #2] charged at me. He had also gotten into a fight (on 11/26/23) with [client #3] from what I was told. [Client #2] had a black eye from my understanding, when he threw a chair at his door and it bounced back and hit him in the face. [Director #2] sat him down on his bed and told him he could not tear up the house. I did not slap him and [Director #2] never punched anyone in the head." -"I believe [client #3] hit him in the eye ...[Client #2] has aggressive behaviors ...we keep them separated ..." -Was not aware of the allegation the HM punched client #2 in the eye.	V 132		

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V 132	Continued From page 9 Interview on 1/11/24 with the Director #2 revealed: -Did not work at the facility on a regular basis just when "someone calls out sick, "but I have all my trainings. I only go over there with [Director #1]." -Worked on maintenance repairs at the facility -Was not present when client #2 broke the bedroom door and kicked out the ac unit -"The next day (unable to recall the date), I went over there to repair the door. He had also poured detergent all over the bathroom. He was still aggressive and charged towards [Director #1]. I put my hands on his shoulders and told him to just calm down and I would get him a cigarette ..." -Client #2 did not have a black eye or injuries to his face when he saw him. -Had never restrained a client at the facility. -Denied he punched client #2 in the face. -"I have never had contact with a client like that." -Had never seen any facility staff harm a client when he was at the facility. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 days.	V 132		
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	V 289		

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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 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);

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V 289	Continued From page 11 (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 alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to operate within the scope of the program. The findings are: Cross-Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on record reviews and interviews, 1 of 5 paraprofessionals (Director #1) failed to demonstrate the knowledge, skills and abilities required by the population served. Cross-Reference: General Statute 131E-256(G) Health Care Personnel Registry (V132). Based on record reviews and interviews, the facility failed to report allegations of abuse and harm including injuries of an unknown source to the Health Care Personnel Registry (HCPR), failed to provide evidence that all alleged acts were investigated, failed to protect the client from harm while the investigation was in process, and failed to report within 5 working days of the initial notification, the results of the investigation to the Department.	V 289		

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V 289	Continued From page 12 Cross-Reference: 10A NCAC 27G .5603 Operations (V292). Based on observations, record reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the clients' treatment affecting 1 of 3 audited clients (#2). Cross-Reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record reviews and interviews, the facility failed to implement written policies governing their response to incidents as required. Cross-Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record reviews and interviews, the facility failed to report all Level II incidents to the LME (Local Management Entity) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. Observations on 1/9/24 at 8:49am of the facility revealed: -The License was on the wall in the living room -The facility was licensed as a 5600C, Supervised Living for Adults with Developmental Disabilities. -The Licensed capacity was for 6 clients. Review on 1/9/24 of the Client and Staff Identifier Form revealed: -There were 6 current clients admitted to the facility -Client A1 was not listed Review on 1/9/24 of client A1's record revealed: -An admission date of 5/3/23 to sister facility A -Diagnoses of Autism Disorder and	V 289		

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V 289	Continued From page 13 Post-Traumatic Stress Disorder -Age 18 Interview on 1/9/24 at 1:42pm with Client A1 revealed: -Lived at sister facility A with 3 other clients -Had been over to the 310 Fields Street facility (which was licensed for 6 clients) -"When I do bad in school, I get sent over to the other facility (310 Fields Street) and someone has to pick me up from school ..." -"The school (staff) would say there were going to call [Director #1] or [Qualified Professional (QP)] and then they would send a staff to pick me up from school and take me to the other house (310 Fields Street facility.)" -"I just hated that place (310 Fields Street facility). I don't like going over there. Some of the clients there hit the walls and it scares me. I hope I don't have to ever go back there again...over there, we can only go in the day area." -"I said [client #4] f****d me so I would not have to go back over there (310 Fields Street facility). That is what I said to the school ...I made up the allegation so I would not have to return to the other place." -Had not told his Legal Guardian, Director #1 or the QP about the sexual allegation. Interview on 1/10/24 with Client A1's Legal Guardian revealed: -Client A1's case worker from the local management entity had just called her and "They asked me if I knew anything about it (inappropriate touching allegation). I told her that I did not know. I was aware he was suspended and taken to another group home in November (2023). They did tell me that ...[Director #1] had told me he (Client A1) would have to go over there (310 Fields Street facility) because no one	V 289		

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would be at the facility (sister facility A). It is a 24-hour facility. He had no reason to be over there (310 Fields Street facility) ...his facility is supposed to have 24-hour care. If he is suspended from school, he needs to be where his room and board is, at [sister facility A's street name]."

Interview on 1/9/24 with Staff A1 revealed:
-Worked 7am to 5pm at sister facility A, but had a break from 9am to 12:30pm daily
-"[Client A1] was suspended from school before Christmas. Actually, I think before Thanksgiving ...he could not return (to school) for a week or 10 days. I was told by [Director #1] to take him to (310 Fields Street facility) ..."

Interview on 1/9/24 with the House Manager revealed:
-Client A1 only came to the 310 Fields Street facility "if he gets out of school early or if he gets in trouble at school."
-Client A1 was suspended from school "a few months back for 4 or 5 days."
-"[Director #1] asked us to pick him up."
-Client A1 was at the 310 Fields Street facility during his suspension
-"We have two staff here at all times. There are only female staff at the other facility (sister facility A) ...here (310 Fields Street facility) he will be around only males and will listen better ..."

Interview on 1/10/24 with the QP revealed:
-Was not aware of client A1's allegation of client #4 touching him inappropriately until today (1/10/24).
-"I will ensure they are not around each other ...I am not 100% sure why [client A1] was at the (310 Fields Street) facility. I don't know if it is due to cost effectiveness. Theoretically, it should not

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happen...all the clients (at sister facility A) are around the same age and are at different stages of their lives. That is why the older clients are here (310 Fields Street facility)."

Interview on 1/10/24 with Director #1 revealed:
-Was not aware of client A1's allegation of being touched inappropriately by client #4.
-"This is the first I am hearing about it."
-Confirmed that client A1 was suspended from school for 5 days around Thanksgiving
-"The staff (at sister facility A) leaves by 9am every day. Then she will come back at 12:30pm to pick up a client from the community college ...When the school called me that day, I called [Assistant House Manager (AHM)] to pick [client A1] up from school. The school is up the street and is not even a mile away. They said he needed to be picked up immediately."
-The 310 Fields Street facility was licensed for 6 clients and sister facility A was licensed for 4 clients
-"One of the clients here (310 Fields Street facility) had gone to the day program. So, it was only 5 clients here with two staff. I told [AHM] to bring him (client A1) here."
-"[QP] and I will start our investigation into [client A1]'s allegations."

Review on 1/11/24 of the facility's Plan of Protection, dated 1/11/24 and written by the QP revealed:
-"What immediate plan will the facility take to ensure the safety of the consumers in your care? Effective immediately any consumers that reside in the sister facility will not be allowed in any other facilities. In the event that there is an emergency, on-call staff will be notified and alerted to go to the appropriate facility to cover shifts, provide additional coverage, etc. All personnel, director

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V 289	Continued From page 16 and maintenance personnel will communicate immediately with the Qualified Professional concerning any incidents that occurs on the premises. This includes any transportation issues, client issues, complaints, staffing issues and any other provider concerns. Effectively immediately, should anyone come to the premises, regardless if they are scheduled to work or not, intoxicated, overly medicated, or demonstrating inappropriate behavior, will be asked to leave the premises pending an investigation by the Qualified Professional and an incident will be completed for any clients that is present on the premises at the time of the incident. For any injury that a client sustains while on the premises, returning to the premises or even any injuries that occur off the premises that aren't assessed prior to returning back to the premises will be documented and a follow up appointment will be made with the appropriate provider. All HCPR reports will be completed within 24 hours of learning of any allegations of abuse, neglect or exploitation. Effective immediately, [Director #1] and [Director #2] is currently not allowed on the premises until Qualified Professional completes an internal investigation of incidents discussed in complaint survey conducted 01/09/2024-01/11/2024. -Described your plans to make sure the above happens. Schedule a staff meeting alerting them of the new changes in procedures when client's structured day (school, day treatment, etc.) schedule must be amended for any reason. Address clients staying at least six feet apart from one another. Review the appropriate NCI (National Crisis Intervention) techniques for prevention and crisis management. Effective next schedule release, schedule an additional staff to work during the wake hours of the facility. Schedule a focus group with the clients at the	V 289		

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home and address remaining six feet from their peers, how to complete a grievance and discuss the important of discussing concerns one on one with Qualified Professional. Director (#1) will meet with Qualified Professional on a weekly basis to discuss decision-making, cultural competence, interpersonal skills and leadership skills. Director (#1) and Qualified Professional will discuss staffing, facility repairs and client grievances and concerns."

Review on 1/11/24 of the facility's Addendum to the Plan of Protection, dated 1/11/24 and written by the QP revealed:
-"Addendum: Qualified Professional will meet with Director (#1) on a weekly basis. The Qualified Professional will provide oversight to ensure the plan is implemented."

The facility served 6 male clients with diagnoses including Mild to Moderate Intellectual Disability Disorder, Autism Spectrum Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Combined Type and Schizophrenia. Client A1 had been suspended several times from school. Director #1 made the decision for Client A1 to spend his suspension at the 310 Fields Street facility instead of sister facility A where he resided. While Client A1 was at 310 Fields Street, he made an allegation that Client #3 touched him inappropriately. On 11/16/23, at 4:40pm the Former House Manager was intoxicated at the facility resulting in a 911 call to law enforcement while six clients were present. On 11/16/23, at 11:45pm, the Former House Manager returned to the facility, broke in, stole the keys to the facility's van and wrecked it down the street, resulting in law enforcement being called a second time. On an unknown date, Client #2 alleged the House Manager punched

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V 289	Continued From page 18 him in the eye. On 12/1/23 Director #1 saw Client #2 with a black eye, but she did not investigate the source of his injury or notify the QP. Client #2 made additional allegations that Director #1 had slapped him in the face 5 times and Director #2 punched him in the head 5 times. On 12/1/23 Client #2 was admitted to a local hospital for suicidal ideation and a potential assault. Client #2 had facial swelling and bruising below his left eye which appeared to be about 1 week old. From 12/1/23-12/6/23 Client #2 reported being abused by group home staff to Emergency Medical Services, the local police department and hospital staff who then made a report to Adult Protective Services. Director #1 failed to notify the Qualified Professional of client #2's injuries, hospital admission, or allegations. There was no documentation of incident reports having been submitted into Incident Response Improvement System for the 11/16/23 law enforcement responses, or for Client #2's injuries and hospitalization. There was no evidence of an investigation being conducted for Client #2's allegations, no preventive measures put in place, no efforts to protect Client #2 and no notification to HCPR. Director #1 did not maintain coordination with the Qualified Professional, did not determine the cause of Client #2's eye injury, did not report law enforcement's involvement at the facility, did not investigate an injury to Client #2's eye and made the decision to have Client A1 at the facility. This constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an adminstrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 289		

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V 291	Continued From page 19	V 291		
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 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 maintain coordination between the facility operator and the professionals responsible	V 291		

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V 291	Continued From page 20 for the clients' treatment affecting 1 of 3 audited clients (#2). The findings are: Review on 1/9/24 of client #2's record revealed: -An admission date of 10/20/23 -Diagnoses of Intellectual Developmental Disability (IDD), Moderate and Generalized Anxiety Disorder -Age 34 Review on 1/10/24 of the facility's internal incident reports revealed: -"11/26/23, [Client #3] hit [client #2] in the eye ..." -There was no documentation client #2 was seen by a medical professional on 11/26/23 or that first aid was provided. Review on 1/10/24 of the North Carolina Incident Response Improvement System (IRIS) report dated 12/3/23 revealed: -On 11/30/23, "[Client #2] eloped from the facility around 5:15pm. A police officer contacted the group home after locating him about 30 minutes later. While on the way back to the group home facility, [Client #2] expressed that he wanted to harm himself or someone at the group home (a specific person wasn't named). [Client #2] was taken to [a local hospital]. When I (Director #1) contacted the hospital to check on him, I was told that I was not an authorized person on his record and couldn't get any information." Review on 1/26/24 of the Emergency Room Department's Entire Encounter documentation dated 12/6/23 for client #2 revealed: -" ...Admission Diagnoses/Reasons for visit ...Unspecified injury of head ...final diagnoses ...contusion of other part of head ...External Causes of injury ...Assault by unarmed brawl or fight..."	V 291		

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V 291	Continued From page 21 Reviews on 1/24/24 and 1/26/24 of client #2's medical records from a local emergency room, dated 12/1/23 to 12/6/23 revealed: -" ...Has a black eye to the left eye. Has some scratches to the right face area. He says that these things happened since Thanksgiving ..." -Admitted to the hospital from 12/1/23 through 12/6/23 Interviews on 1/9/24 and 1/10/24 with client #2 revealed: -Denied getting into a fight with another client at the facility -The House Manager (HM) gave him a black eye in December 2023 -Was not seen by a medical professional and first aid was not administered on the day the HM allegedly punched him -He eloped from the facility on an unknown date and was taken to the local hospital by police Interview on 1/9/24 with client #3 revealed: -Denied getting into an altercation with client #2 Interview on 1/10/24 with the Qualified Professional (QP) revealed: -Was not aware client #2 had a black eye and was admitted to the hospital -"I get called after the fact a lot of times. We have talked about this previously and maybe it needs to be readdressed (communication between the facility staff and the QP)." Interview on 1/10/24 with Director #1 revealed: -"Around 5 or 5:30 (pm) on the first (December 2023), [client #2] left the facility. The police called me and said they found him at [a local restaurant]. When I got there (to the shopping center), he started to complain about his chest	V 291		

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V 291	Continued From page 22 hurting and EMS (Emergency Management Services) transported him to the hospital." -She was aware client #2 had a black eye -"I believe [client #3] hit him in the eye ...[Client #2] has aggressive behaviors ...we keep them separated ..." -Facility staff did not seek medical treatment or first aid for client #2. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 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; (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	V 366		

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(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to 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

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V 366	Continued From page 24 LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 366		

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V 366	Continued From page 25 facility failed to implement written policies governing their response to incidents as required. The findings are: Review on 1/10/24 of the Former House Manager (FHM)'s record revealed: -A hire date of 7/17/21 -A job description of House Manager -A termination date of 11/16/23 Review on 1/10/24 of the North Carolina Incident Response Improvement System (IRIS) from 11/16/23 to 1/10/24 revealed: -No documentation of an incident on 11/16/23 where the FHM was found intoxicated on the premises of the facility and was charged with Felony Breaking and Entering, Felony Larceny of a Motor Vehicle, Felony Larceny after Breaking and Entering, Felony Possession of a Stolen Motor Vehicle and Misdemeanor Driving While Impaired. -No documentation to determine the cause of the incident -No documentation of an assigned person to be responsible for the implementation or corrections and preventive measures Attempted interviews on 1/10/24 and 1/11/24 with the FHM revealed: -No return telephone calls from the FHM Interview on 1/9/24 with the House Manager revealed: -The FHM was fired from his position at the facility -"I can't really tell you about it but I do know he took the company van. He snuck the keys out and supposedly crashed up the street. I was working a double (shift) that day in November (2023)."	V 366		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 26 -Had seen the FHM earlier in the day "because I asked him to bring me a plate to eat." -The FHM "wasn't himself. He did not work that day. He brought me a plate of food to eat and he was already 'twisted'. I guess he was probably drunk, but I didn't smell alcohol. It was easy to tell. Then he came back that night and took the van. I can't tell you how he got the keys ...one of the clients came and got me. He said 'I think I just saw [FHM] leave with the van.' It was after 11pm. I went to the front and the van was gone. I called [Director #1]." -The police responded to the facility "but I never talked to them. They caught him (the FHM) at the scene (of the accident) ..." Interview on 1/10/24 with the Qualified Professional (QP) revealed: -Was called by the Director #1 on 11/16/23 -There were 2 incidents which involved the FHM -The first incident occurred at 4:40pm on 11/16/23 - Director #1 found the FHM intoxicated at the facility -"She (Director #1) was frantic. I could hear her and [FHM] arguing back and forth over the phone. I was the one that called 911." -The clients were present at the facility when the first incident occurred. -The second incident occurred at 11:45pm on 11/16/23 -FHM broke into the facility, stole the keys to the van, hit a parked car and drove through a church fence. -Had not determined the cause of the incident and had not put corrective and preventive measures in place -Had not documented the incidents Interview on 1/10/24 with Director #1 revealed:	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411222	A. BUILDING: _____ B. WING _____	01/29/2024

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V 366	Continued From page 27 -There were 2 incidents which involved the FHM -The first incident occurred at 4:40pm on 11/16/23 -"I stopped by the facility to give out paychecks and he was intoxicated. I could not get through to him. I told him to leave, and he would not." -Had called the QP to let her know of the incident -The second incident occurred at 11:45pm on 11/16/23 -"I was called by [House Manager]. He said the facility van and the keys were missing." -Law enforcement responded to the facility -Failed to complete an IRIS report for the incident with the FHM on 11/16/23 -The clients were present when the incident occurred "but they were asleep." -Had not determined the cause of the incident and had not put corrective and preventive measures in place This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of	V 367		

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V 367	Continued From page 28	V 367		

becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III

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V 367	Continued From page 29 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all Level II incidents to the LME/MCO (Local Management Entity/Managed	V 367		

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V 367	Continued From page 30	V 367		

Care Organization) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:

Review on 1/10/24 of the North Carolina Incident Reporting Improvement System (IRIS) from 11/16/23 to 1/10/24 revealed:
-No documentation law enforcement responded to the facility while clients were present on 11/16/23 when the Former Home Manager (FHM) broke into the facility, stole the facility's van and wrecked the facility's van resulting in charges against the FHM for Felony Breaking and Entering, Felony Larceny of a Motor Vehicle, Felony Larceny after Breaking and Entering, Felony Possession of a Stolen Motor Vehicle and Misdemeanor Driving While Impaired.

Interview on 1/9/24 with the House Manager (HM) revealed:
-The police responded to the facility on 11/16/23
-"[FHM] took the company van. He snuck the keys out and supposedly crashed up the street ..."
-Described the FMH as already "twisted" and "I guess he was probably drunk, but I didn't smell alcohol."

Interview on 1/10/24 with the Qualified Professional revealed:
-Was called by Director #1 on 11/16/23
-"She (Director #1) was frantic. I could hear her and [FHM] arguing back and forth over the phone. I was the one that called 911."
-Had not completed a level II incident report

Interview on 1/10/24 with Director #1 revealed:
-There were 2 incidents which involved the FHM
-The first incident occurred at 4:40pm on

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V 367	Continued From page 31 11/16/23 -"I stopped by the facility to give out paychecks and he was intoxicated. I could not get through to him. I told him to leave, and he would not." -Had called the QP to let her know of the incident -The second incident occurred at 11:45pm on 11/16/23 -"I was called by [House Manager]. He said the facility van and the keys were missing." -Law enforcement responded to the facility -Failed to complete an IRIS report for the incident with the FHM on 11/16/23 -The clients were present when the incident occurred "but they were asleep." -Had not determined the cause of the incident and had not put corrective and preventive measures in place This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 days. :	V 367		