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V 000	INITIAL COMMENTS An annual and complaint survey was completed on February 8, 2024. The complaint was substantiated (Intake #NC00212191). 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 six and currently has a census of six. The survey sample consisted of two current clients, one former client and one deceased client.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid	V 108		

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techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.
(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure one of three audited staff (#2) received training to meet the needs of the client as specified in the treatment/habilitation plan. The findings are:

Review on 1/25/24 of Deceased Client #3's (DC #3) record revealed:
-Admission date of 12/22/23.
-Diagnoses of Paranoid Schizophrenia, Dementia, Type 2 Diabetes Mellitus and Thrombocytopenia.
-Date of death was 12/26/23.

Review on 1/25/24 of staff #2's personnel record revealed:
-Staff was hired 8/19/22.
-There was no documentation of orientation or training to work with DC #3 before being admitted to the facility.

Interview on 1/25/24 and 1/31/24 with staff #2 revealed:
-He was informed by the Facility Director/Qualified Professional (FD/QP) of DC #3

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V 108	Continued From page 2 being discharged from a hospital approximately 104 miles away and coming to the facility for admission. -DC #3 arrived at the facility around 5pm on 12/22/23. -DC #3 was transported to the facility by Department of Social Services legal guardian (DSSLG) and guardian's co-worker. -After arriving to the facility, he showed DC #3 what was going to be his bedroom and checking inventory of his personal items. -DSSLG stated DC #3 was not provided any medications from the hospital. -DSSLG did not provide any documentation for DC #3. -The DSSLG stated he was going to purchase personal items and Christmas gifts for DC #3 at a local store near the facility. -DC #3 was left alone with staff #2. -DSSLG did not give any instructions on the supervision of DC #3. -DC #3 "appeared anxious and nervous". -"I kinda sensed he was a runner." -He proceeded to prepare dinner and assist other clients in the facility. -DC #3 requested to use the telephone. -While cooking, he noticed DC #3 had walked down the path and headed to the main road. -He redirected DC #3 to come back in the facility with the telephone and he complied. -DC #3 ate dinner with the other clients. -"Another client requested to use the phone and I was helping the other client make his call." -DC #3 requested to go sit out back at the picnic table. -"I saw him walk out the back door and sit at the picnic table and I looked up he was gone." -He had checked on DC #3 within 5-10 minutes before and he was gone. -"He had to have gone in the woods because I	V 108		

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V 108	Continued From page 3 would have seen him if he was walking around the other side of the house." -The DSSLG and co-worker arrived back from the store and he made them aware that DC #3 had eloped. -"The search lasted at least 3- 4 hours." Interview on 1/25/24, 1/31/24, 2/1/24 and 2/6/24 with the FD/QP revealed: -He was not sure of the reason for DC #3 stay at the hospital. -He did not receive any discharge documentation or medication prescriptions from the DSSLG when they arrived at the facility. -The Person-Centered Plan (PCP) was completed prior to the arrival of DC #3 on 12/22/23. -The PCP was developed with the DSSLG and DC #3. -A notebook was created with all documentation received about the client. -Staff #2 was instructed to read the notebook. -Staff #2 was not in-serviced about DC #3's diagnoses and behaviors. -He did not inform staff #2 of DC #3's history of elopement. -He failed to train staff #2 on the diagnoses, behaviors and needs of DC #3 as specified in the treatment/habilitation plan. This deficiency is cross referenced into 10A NCAC .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 violation and must be corrected within 23 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF	V 109		

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

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This Rule is not met as evidenced by:
Based on record reviews and interviews, one of one Facility Director/Qualified Professional (FD/QP) failed to demonstrate knowledge, skills and abilities required by the population served.
The findings are:

Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (Tag 108)
Based on record reviews and interviews, the facility failed to ensure one of three audited staff (#2) received training to meet the needs of the client as specified in the treatment/habilitation plan.

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 of clients affecting one of one audited former current client (FC#4).

Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements (Tag 366)
Based on record reviews and interviews, the facility failed to implement policies governing their response to Level II incidents.

Cross Reference; 10A NCAC 27G .0604 Incident Reporting Requirements (Tag 367)
Based on record reviews and interviews, the facility failed to report all critical incidents, notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment areas where services were provided within 72 hours of becoming aware of the incident.

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Review on 1/25/24 of the FD/QP's personnel record revealed:
-Hire date of 1/12/11.
-Education of Bachelor of Arts in Sociology.

Interview on 1/25/24, 1/31/24, 2/1/24 and 2/6/24 with the FD/QP revealed:
-Deceased Client #3 (DC #3) was scheduled for admission on 12/22/23.
-He received the FL 2 medical screening tool document from Department of Social Services legal guardian (DSSLG) prior to admission.
-The agreed time of arrival for the new admission was 1pm.
-He contacted the DSSLG and was informed they were running behind.
-He informed the DSSLG he had another meeting but would return back to the facility upon their arrival.
-He informed staff #2 to call him once DC #3 and DSSLG arrived at the facility to complete the admission/intake process.
-He did not give staff #2 any orientation or training on DC #3 diagnoses, behaviors or history of the Person Centered Plan (PCP).
-"The admission packet was with me to complete upon their arrival to the facility."
-Staff role during a client admission was to welcome clients, check inventory of belongings and provide tour of the facility.
-His role during admission of clients was to do admission paperwork, completing of consents, check in medications, create Medication Administration Records and ensure appointments and services are coordinated all while guardian is present.
-DC #3 notebook with his PCP was left on the desk for staff to review.

Interview on 1/24/24 with DC #3's DSSLG

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revealed:
-Confirmed the admission date for DC #3 was scheduled for 12/22/23.
-"DC #3 main behavior was elopement."
-He and a co-worker transported DC #3 from the hospital to the facility.
-He and his co-worker arrived at the hospital around 11:30am and DC #3 was not ready for discharge until 2:30pm.
-He contacted the FD/QP to make him aware they were running behind.
-"[FD/QP] said it was still OK for [DC #3] to be admitted to the facility. Had [FD/QP] said no, we would not have brought him."
-"[FD/QP] stated there would be staff on duty to welcome us in the facility."
-"The staff member called facility management to make them aware that we had arrived with [DC #3]."
-Informed staff #2 he and his co-worker were heading to a local store near the facility to purchase personal items and Christmas gifts.
-He and his co-worker were gone no more than an hour and half.
-He requested to speak with DC #3 and was informed by staff #2 that DC #3 had left the facility.
-"I believe staff said he had just did rounds in the facility and realized [DC #3] was gone."

Interview on 1/25/24 with the local police officer revealed:
-A call was received from the facility on 12/22/23 from a staff member that DC #3 was missing.
-He was informed by the staff on shift DC #3 arrived at the facility around 5:30pm.
-DC #3 walked away from the facility around 7pm.
-"We had dogs, drones and firefighters all out there from 7:30pm until midnight."
-He received a call on 12/26/23 from a concrete

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company not far from facility of a deceased male found on the premises.
-He arrived at the location, found the male face down with some scars and bruises and pants down by his knees.
-A medical bracelet was on DC #3 wrist that confirmed his identity.
-The concrete company provided video footage that showed DC #3 wandering back and forth on the property on 12/24/23.
-The video footage showed DC #3 stand up and fall down several times and rolling around on the ground for hours in the same spot.

Review on 2/8/24 of a Plan of Protection written by the Facility Director/Qualified Professional (FD/QP) dated 2/2/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? QP will ensure staff are aware of history, behaviors and techniques for all consumers and provide documentation for staff to review to have better insight of consumer. QP will seek additional sources and trainings to improve ways of planning strategies and developing interactions with consumer and staff. Describe your plans to make sure the above happens. QP will register for trainings/seminars for planning of treatment for consumer and additional services to aid with improving staff knowledge and consumer care."

DC #3 had diagnoses of Paranoid Schizophrenia, Dementia, Type 2 Diabetes Mellitus and Thrombocytopenia. DC #3 had been discharged from the hospital and transported to the facility for admission on 12/22/23. The FD/QP was unable to be at the facility at the time of admission but instructed staff #2 to accept responsibility for DC #3 upon arrival. The PCP was developed prior to the client admission. One of the goals of the PCP

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V 109	Continued From page 9 addressed the client's history of elopement. The FD/QP did not train staff on DC #3's treatment needs and strategies. DC #3 eloped from the facility within hours of admission and was found deceased four days later. Furthermore, numerous calls were made to the local police department from 2023 to 2024. Nine of the thirty-eight calls were the elopement of FC #4. The treatment plan for FC #4 did not have goals or strategies to address the elopement behavior. The FD/QP did not ensure incident reports and risk/cause analyses of each incident was completed. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 109		
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	V 112		

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V 112	Continued From page 10 outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement goals and strategies to meet the needs of clients affecting one of one Former Client (FC #4). The findings are: Review on 1/23/24 of FC#4's record revealed: -Admission date of 8/18/23. -Diagnoses of Schizoaffective Disorder-Depressive Type and Bipolar Disorder. -Person Centered Plan (PCP) dated 8/11/23 had no strategies to address leaving the facility unsupervised. -Discharge Date of 12/6/23. Review on 1/30/24 of police reports from the local police department revealed: -11/28/23- Staff contacted 911 to report FC #4 missing. -11/24/23- Staff contacted 911 to report FC #4 missing. -11/18/23- Staff contacted 911 to report FC #4 missing. -11/17/23- Staff contacted 911 to report FC #4	V 112		

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V 112	Continued From page 11 missing. -11/13/23- Staff contacted 911 to report FC #4 missing. -11/3/23- Staff contacted 911 to report FC #4 missing. -10/23/23- Staff contacted 911 to report FC #4 missing. -9/26/23- Staff contacted 911 to report FC #4 missing. -8/21/23- Staff contacted 911 to report FC #4 missing. Interview on 1/30/24 with staff #4 revealed: -FC #4 would leave the facility often. -He would go across the street to the store. -He would ask customers at the store for money for food. -He was banned from the store due to panhandling. Interview on 1/31/24 with staff #5 revealed: -"[FC #4] would leave the facility." -"He would get easily agitated and like to have the rules bent in his favor." -If things did not happen fast enough or he didn't like the response, FC #4 would become upset. -FC#4 would get physical with staff and other clients in the facility. Interview on 1/31/24 and 2/6/24 with the FD/QP revealed: -He was responsible for creating the PCP for clients in the facility. -"[FC #4] would want to preach to people." -"[FC #4] wants to get out and about." -"[FC #4] would at times leave and go to the store and church across the street to pray." -FC #4 would return back to the facility but staff are trained when clients are out of eyesight longer than 15 minutes to call 911.	V 112		

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V 112	Continued From page 12 -He confirmed FC #4 had no strategies to address his elopement from the facility. This deficiency is cross referenced into 10A NCAC .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 violation and must be corrected within 23 days.	V 112		
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 (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	V 366		

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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 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

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	MHL047-140	A. BUILDING: ______ B. WING ______	02/08/2024

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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 facility failed to implement policies governing their response to Level II incidents. The findings are:

Review on 1/30/24 of police call log from the local police department revealed:

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V 366	Continued From page 15 -The call log was from the timeframe of January 2023 to January 2024. -A total of 58 phone calls were made from this facility for the year of 2023. -Of the 58 phone calls, 38 of the calls were identified as Level II incidents. Review on 1/30/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There were 33 Level II incident reports that were not submitted and responded to by the facility. -There were no IRIS reports, no risk cause/analysis, or documentation to support the written preliminary findings of fact to the LME/MCO within 5 working days for incidents listed above. Interview on 1/31/24 with the FD/QP revealed: -He was responsible for completing, submitting into IRIS and responding to incident reports. -"Our priority is to ensure the client is safe." -"The incidents that I am made aware of, an incident report is completed based on the situation." -He failed to implement policies governing their response to Level II incidents. This deficiency is cross referenced into 10A NCAC .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 violation and must be corrected within 23 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 367		

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(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that 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

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

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V 367	Continued From page 18 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all critical incidents, notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment areas where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 1/30/24 of police call log from the local police department revealed: -The call log was from the timeframe of January 2023 to January 2024. -A total of 58 phone calls were made from this facility for the year of 2023. -Of the 58 phone calls, 38 of the calls were identified as Level II incidents. Review on 1/30/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -There were 33 Level II incident reports that were not submitted by the facility. Interview on 2/6/24 with the FD/QP revealed: -He would complete incident reports when staff notified him of the incidents. -Staff were to complete the daily communication log regarding behaviors and incidents. -Staff were trained to call the police when a client is out of eyesight for longer than 15 minutes and when the client has left the facility unsupervised. -He was responsible for completing and submitting Level II and Level III incident reports.	V 367		

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V 367	Continued From page 19 -He was not aware an incident report needed to be completed each time police were contacted and came to the facility. -He failed to ensure incidents were reported within 72 hours of becoming aware of the incident. This deficiency is cross referenced into 10A NCAC .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 violation and must be corrected within 23 days.	V 367		