

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL084-093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 03/22/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COGGINS GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>235 COGGINS AVENUE ALBEMARLE, NC 28001</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on March 22, 2024. The complaint was substantiated (intake #NC00213827). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 4 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 former client.</p>	V 000		
V 110	<p><b>27G .0204 Training/Supervision Paraprofessionals</b></p> <p>10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS</p> <p>(a) There shall be no privileging requirements for paraprofessionals.</p> <p>(b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.</p> <p>(c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(e) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> <li>(1) technical knowledge;</li> <li>(2) cultural awareness;</li> <li>(3) analytical skills;</li> <li>(4) decision-making;</li> <li>(5) interpersonal skills;</li> <li>(6) communication skills; and</li> </ol>	V 110		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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V 110	<p>Continued From page 1</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews two of five audited staff (#2 and #3) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are:</p> <p>Review on 3/21/24 of the facility's personnel records revealed:</p> <p>Staff #2 -Date of hire was 8/7/23 -Hired as a Direct Support Associate (DSA)</p> <p>Staff #3 -Date of hire was 11/24/23 -Hired as a DSA</p> <p>Review on 3/21/24 of client #2's record revealed: -Admission date of 3/24/23. -Diagnoses of Mild Developmental Disability, Unspecified Impulse Control Disorder, intermittent Explosive Disorder, Major Depressive Disorder, Morbid Obesity, Constipation, Osteoarthritis, Gingivitis and Vitamin D Deficiency.</p> <p>Review of the North Carolina Incident Response</p>	V 110		

Division of Health Service Regulation

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V 110	<p>Continued From page 2</p> <p>Improvement System (IRIS) on 3/22/24 revealed: -"On Monday March 18, 2024, [client #2] displays a behavior of taking the group home van keys and locking herself in the van. She was threatening to drive herself to the hospital. Staff attempted redirect [client #2], but they were not successful. Staff called 911, [Name of local Police Department] came and assisted with getting [client #2] out of the van."</p> <p>Interview on 3/21/24 with client #2 revealed: -She just had an incident at the facility at the beginning of the week (3/18/24). -She got mad at staff #2 and took the van keys. -She went outside and sat in the van and locked herself inside the van. -She went and sat in the van because she needed some time to herself. -She sat on the 2nd row of the van. -She never started the van. -She got the keys from the computer desk. -The computer desk was unlocked. -The keys to the van are "always" in that computer desk. -The computer desk was "never" locked by staff. -She had seen staff put those keys in that computer desk "several" times. -That was how she knew where to find those van keys.</p> <p>Interview on 3/21/24 with staff #2 revealed: -She was working during the incident when client #2 took the van keys and locked herself in the van on 3/18/24. -She came in around 10:00 pm (3rd shift) that night. -Client #2 was complaining about her stomach hurting. -Staff #3 had worked 2nd shift. -Staff #3 said she never saw client #2 throwing up</p>	V 110		

Division of Health Service Regulation

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V 110	<p>Continued From page 3</p> <p>or using bathroom during her shift.</p> <ul style="list-style-type: none"> <li>-Client #2 was in the kitchen and said her stomach hurt and she was getting agitated.</li> <li>-Client #2 said "I don't want to walk off and make you mad."</li> <li>-Client #2 then went to her bedroom and got her jacket.</li> <li>-Client #2 went outside and set on the porch for about 4 minutes.</li> <li>-Client #2 came back in and stood in front of her as she was watching television in the den area.</li> <li>-She then saw client #2 get the van key from a file cabinet.</li> <li>-She thought staff #3 left the key in the file cabinet.</li> <li>-The keys were supposed to be in a locked box.</li> <li>-Staff #3 was working at the facility prior to her shift.</li> <li>-Client #2 made sure she showed her the keys.</li> <li>-Client #2 then she took off walking fast and got into the van.</li> <li>-She tried to get the keys from client #2.</li> <li>-She got away from her and got in van and locked herself in the van.</li> <li>-Client #2 was sitting in the middle seat.</li> <li>-Client #2 never got into the driver's seat of the van and/or tried to put the key in the ignition.</li> </ul> <p>Interview on 3/21/24 with staff #3 revealed:</p> <ul style="list-style-type: none"> <li>-She worked 2nd shift on 3/18/24.</li> <li>-Client #2 was complaining about her stomach hurting.</li> <li>-She called the Residential Team Leader (RTL) because client #2 said she wanted to go to the hospital.</li> <li>-The RTL and Nurse said if client #2 wasn't having any symptoms she didn't need to go to the hospital.</li> <li>-When staff #2 came in for her shift she told her about client #2 complaining about her stomach.</li> </ul>	V 110		

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V 110	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>-Staff #2 called her after she left the facility a little later and said client #2 locked herself in the van.</li> <li>-The key to the van was normally kept in the computer drawer.</li> <li>-The key to the van was supposed to be in the locked box.</li> <li>-They "always" keep that key in the computer drawer and the clients never "mess" with the van key.</li> <li>-She had not used that van, she "rarely" uses the facility van.</li> </ul> <p>Interview on 3/21/24 with the RTL revealed:</p> <ul style="list-style-type: none"> <li>-Client #2 took the van keys and locked herself in the van on 3/18/24.</li> <li>-Staff #3 called her prior to the incident to give her heads up that client #2 had been acting up during her shift earlier that day.</li> <li>-Staff #2 was the staff working during that incident when client #2 took the van keys.</li> <li>-The police department was called by staff #2 during that incident.</li> <li>-Police Officers came to the facility and got client #2 out of the van.</li> <li>-Client #2 possibly got the van keys from the file cabinet.</li> <li>-There was a locked box for the van keys.</li> <li>-She wasn't sure who put those keys in the file cabinet.</li> <li>-She talked to staff other times about keeping those van keys in the locked box.</li> </ul> <p>Interview on 3/21/24 with the Qualified Professional revealed:</p> <ul style="list-style-type: none"> <li>-She was aware of incident with client #2 locking herself in van.</li> <li>-Client #2 was complaining about not feeling well.</li> <li>-Client #2 grabbed the van keys and told staff she was going to drive herself to the hospital.</li> <li>-Client #2 locked herself in the van and would not</li> </ul>	V 110		

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V 110	Continued From page 5  get out. -The police department was called for that incident. -Staff #2 said client #2 was never in driver's seat of the van. -Staff #2 didn't say where the keys were or how client #2 got the van keys. -The van keys were supposed to be "kept on the person." -They also had a locked box for the keys. -She thought the keys were not locked due to staff going in out of the facility because staff #2 was a smoker.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan  10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (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	V 112		

Division of Health Service Regulation

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V 112	<p>Continued From page 6</p> <p>obtained.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies to meet the needs of one of two current clients (#2) and one of one former client (FC #3). The findings are:</p> <p>Review on 3/21/24 of client #2's record revealed: -Admission date of 3/24/23. -Diagnoses of Mild Developmental Disability, Unspecified Impulse Control Disorder, intermittent Explosive Disorder, Major Depressive Disorder, Morbid Obesity, Constipation, Osteoarthritis, Gingivitis and Vitamin D Deficiency. -Client #2's Individualized Support Plan (ISP) dated 9/1/23 had no strategies to address walking away from the facility.</p> <p>Review of the North Carolina Incident Response Improvement System (IRIS) on 3/20/24 revealed:</p> <p>-(1)-"On Tuesday February 6, 2024 [client #2] from Coggins Group Home (GH) went Absent without leave (AWOL) at approximately 7pm. The [The Residential Team Leader] started searching all the normal locations for [client #2] as soon as she was called ... The police brought [client #2] home at 11:15pm from [name of store] because</p>	V 112		

Division of Health Service Regulation

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V 112	<p>Continued From page 7</p> <p>they were called for a possible shoplifting incident. [Client #2] was not charged with shoplifting. The police report she had been at the store for a long period of time, but they were not able to give us the length of time."</p> <p>(2)"On Sunday January 28, 2024 [client #2] displayed her behavior of verbal and physical aggression by threatening to fight the third shift staff. One of her peers heard her and [client #2] and her peer got into a physical altercation. [Client #2] went next door and asked the neighbor to call 911. [Name of local Police Department] attempted to speak with her, and [client #2] refused to talk with them. After the police left [client #2] went AWOL to a staff's house."</p> <p>Review on 3/21/24 of in-house incident reports for client #2 revealed:</p> <p>-2/26/24-"[Client #2] was upset because staff got on her, for not helping her peer. [Client #2] took her medications (meds) and walked out the front door and took off down the road."</p> <p>-2/10/24-At 9:14 pm "[Client #2] was upset about incident with bathroom so AWOL. Returned back took meds then chilled in living room. Moments after asked staff about time then said she was walking to [Name of store]."</p> <p>-2/10/24-At 6:38 pm-"[Client #2] came out her room and said that she was leaving. Walked out the front door and walked off."</p> <p>-2/10/24-At 5:20 pm-"[Client #2] came out her room and said that she was going walk. Left out the house and walked off."</p> <p>Interview on 3/21/24 with client #2 revealed: -She had walked away from the facility a few times. -She walked to a restaurant in the area because</p>	V 112		



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V 112	<p>Continued From page 8</p> <p>she needed some time to herself. -Police Officers picked her up and returned her to the facility a few times. -Staff also picked her up and took her back to the facility.</p> <p>Interview on 3/21/24 with staff #1 revealed: -Client #2 had walked to restaurant in the area "about" 3 times. -She thought she last walked away from the facility in January 2024 during her shift. -The police department was called whenever client #2 walked away from the facility. -Staff also picked up client #2 when she walked away from the facility.</p> <p>Interview on 3/21/24 with staff #3 revealed: -Client #2 had walked off a few times during her shift. -She never had to call the police department whenever client #2 walked away from the facility. -She followed client #2 in the van. -Client #2 would normally walk to mini golf place or a store in the area.</p> <p>Interview on 3/21/24 with the Residential Team Leader revealed: -Staff contacted her "several" times about client #2 walking away from the facility. -Client #2 had walked away "about" 6 times since living at the facility. -Staff called the police department whenever client #2 walked away from the facility. -Client #2 last walked away from the facility in February or March 2024.</p> <p>Interview on 3/21/24 with the Qualified Professional (QP) revealed: -Client #2 had walked away from the facility. -Client #2 walked away from the facility "about"</p>	V 112		

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V 112	<p>Continued From page 9</p> <p>12 times.</p> <ul style="list-style-type: none"> <li>-The last time was in February 2024 when she upset and scared because of an incident with FC #3.</li> <li>-They were in the process of getting a behavior plan for client #2.</li> <li>-The behavior plan for client #2 was never put in place.</li> <li>-She confirmed client #2's plan had no strategies to address walking away from the facility.</li> </ul> <p>Review on 3/21/24 of FC #3's record revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 5/5/22.</li> <li>-Diagnoses of Mild Intellectual Disability, Autistic Disorder, Oppositional Defiant Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Hypothyroidism, Vitamin D3 Deficiency and Osteopathy.</li> <li>-Discharge date on 3/7/24.</li> <li>-FC #3's ISP dated 2/1/24 had no strategies to address walking away from the facility and physical aggression towards others.</li> </ul> <p>Review of the NC IRIS on 3/20/24 revealed:</p> <ul style="list-style-type: none"> <li>-(1)-"On Sunday February 11, 2024 at approximately 10:17 am [FC #3] displayed physical aggression towards her peer. Staff were able to assist with removing [FC #3] off of [client #1] and redirected [FC #3] to her room. [Name of local Police Department] arrived about 1 hour later with an involuntary commitment (IVC) order and took [FC #3] to [Name of hospital] to be evaluated."</li> <li>-(2)-"On Sunday January 28, [FC #3] displayed her behavior of physical aggression when she became upset with a peer for threatening staff. There was a physical altercation between the 2</li> </ul>	V 112		

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V 112	<p>Continued From page 10</p> <p>and her peer asked her neighbor to call 911. [Name of police department] arrived and spoke with staff and then left."</p> <p>Review on 3/21/24 of in-house incident reports for FC #3 revealed:</p> <p>-2/2/24-[FC #3] gotten upset because her vape had stop working and ask staff to buy her one and she got told no and she gotten upset and went AWOL and said she's not coming back until next shift arrive."</p> <p>-1/7/24-"[FC #3] went AWOL because she kept nick picking with her peer and had gotten her peer upset and walked off and walked down the road."</p> <p>Interview on 3/21/24 with staff #1 revealed:</p> <p>-FC #3 had walked away from the facility.</p> <p>-She had walked away from the facility "several" times.</p> <p>-She was normally working alone and couldn't always leave the facility to look for FC #3.</p> <p>-She called the police department most of the time whenever FC #3 walked away from the facility.</p> <p>-FC #3 would sometimes try to attack client #3 during her shift.</p> <p>-There was an incident in January 2024 with FC #3 and client #2.</p> <p>-Client #2 was upset and looked as if she was going to hit her.</p> <p>-FC #3 grabbed client #2 by her hair and pushed her down to the ground.</p> <p>-There was another incident with FC #3 and another former client at the store in Novemeber 2023.</p> <p>-FC #3 got mad and told that other former client she was going to "f**k him up."</p> <p>-FC #3 bit the other former client's finger and a</p>	V 112		

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V 112	<p>Continued From page 11</p> <p>police officer came over and intervened because he was present at the store. -FC #3 had also thrown water at her. -FC #3 was upset because she told another staff that she saw FC #3 walking down the road unsupervised the day before.</p> <p>Interview on 3/21/24 with staff #3 revealed: -FC #3 walked away from the facility once during her shift "about" a month or two ago. -The police department was called when FC #3 walked away from the facility.</p> <p>Interview on 3/21/24 with the Residential Team Leader revealed: -FC #3 walked away from the facility "about" 10 times since the December 2023 survey. -"Sometimes she is just walking out to get air, it wasn't always related to behaviors." -The police department was called whenever FC #3 walked away from the facility. -FC #3 could also be aggressive towards staff and/or clients. -FC #3 had "at least" 10 incidents of aggression towards staff and/or clients.</p> <p>Interview on 3/21/24 with the Qualified Professional (QP) revealed: -FC #3 had walked away from the facility a "few" times. -Staff called the police department most of the time whenever FC #3 walked away from the facility. -FC #3 continued to have incidents of aggression. -FC #3 got into a fight at the Day Program with another client. -FC #3 also hit client #2 during another incident on 2/11/24. -Client #2 was scared and went "AWOL" during that incident.</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL084-093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 03/22/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COGGINS GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>235 COGGINS AVENUE ALBEMARLE, NC 28001</b>
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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 112	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>-The police involuntarily committed FC #3 during that incident on 2/11/24.</li> <li>-"We felt [FC #3] was not suitable for this agency."</li> <li>-The Local Management Entity/Managed Care Organization for FC #3 was given a discharge notice.</li> <li>-They were in the process of updating FC #3's plan to address the "AWOL" and aggressive behaviors.</li> <li>-FC #3 was involuntarily committed to the hospital on 2/11/24 and never returned to the facility.</li> <li>-She actually wrote up the goals to address those issues, but the plan for FC #3 was never implemented.</li> <li>-She confirmed FC #3's plan had no strategies to address walking away from the facility and physical aggression towards others.</li> </ul> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 112		