DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G307	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLEA GROUP HOME	5691 MACK LINEBERRY ROAD CLIMAX, NC 27233

(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) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 06/12/23 for intake #NC00202904 and #NC00202942. Although the complaint was unsubstantiated, additional deficiences were cited.	W 000	W 191 The facility will ensure that all Staff receive training on behavior Support plans to include but not limited to updates in an effort to effectively address members' behavior challenges.	8-12-23
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were adequately trained specific to supervision needs to support client safety for 1 of 6 clients (#2). The finding is: Review of facility documentation during the complaint investigation survey completed on 6/12/23 revealed incident reporting from 4/2022-5/2023. Continued review revealed an incident report dated 4/23/22 which indicated client #1 entered into another client's room, pulled his pants down and sat on the client's bed. The incident report also indicated that the other client remained fully clothed and staff redirected client #1 to pull up his pants and go to his room. Review of the 4/2022 incident report revealed the program director (PM) was immediately called and additional monitoring and oversight processes were implemented to prevent further occurrences and ensure client safety. Review of the facility documentation did not reveal evidence of in-service training on additional interventions that were implemented to ensure client safety. Review of documentation revealed an individual habilitation plan (IHP) dated 10/27/22 which	W 191	For Client #1, the Psychologist has in-service all staff on behavior support plans for other applicable clients in the home effective June 20, 2023. To ensure continued compliance, the Clinical Supervisor and the Program Manager will coordinate monitoring activity in the home two times weekly to ensure appropriate implementation of strategies outlined in the behavior support plans for all clients	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lorianne Jarrell — TITLE: Clinical Supervisor — (X6) DATE: 8-18-23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 191	Continued From page 1 indicated that client #1 should have 1:1 supervision during waking hours. Review of the record for client #1 revealed a behavior support plan (BSP) dated 4/24/22 which indicated the following diagnosis: I/DD mild; attention deficit hyperactivity disorder (ADHD); Bipolar I Disorder; Adjustment Disorder with mixed disturbances of emotions and conduct; Post Traumatic Stress Disorder (PTSD); schizoaffective disorder-bipolar type; history of Alcohol Use Disorder, Cannabis Use Disorder, Tobacco Use Disorder, Major Depressive Disorder and Psychotic Disorder. Continued review of the 4/2022 bsp for client #1 revealed the following target behaviors: inappropriate sexual behavior, suicidal and/or homicidal ideation, inappropriate language, property destruction/misuse, elopement and physical aggression. Continued review of the 4/24/22 bsp for client #1 also included the following interventions: close visual monitoring during waking hours in the home, day program and community is needed to ensure client #1's safety, prevent unsafe or maladaptive behaviors, and to prevent or manage episodes consisting of maladaptive behaviors of concern. The client "also needs visual supervision and monitoring during sleeping hours. If the staff responsible for visually monitoring the client has to leave the area for a legitimate reason, other staff should be asked to assume responsibility for visual monitoring". Review of the 4/24/22 bsp included the following environmental interventions: alarms are to be installed and activated on client #1's bedroom door and on exit doors at the home. "The alarms are needed to alert staff if the client is in his bedroom, attempts to leave or he attempts elopement in the form of walking away from the	W 191		

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W 191	Continued From page 2 home. The bedroom alarm is needed due to recent inappropriate sexual behavior involving touching private body parts of another resident in the room without his consent. Surveillance cameras in the common areas of the home are also recommended to alert staff of unusual movement or activity within the home. Staff have reported that the client has previously crawled on the floor to avoid staff monitoring of his movements. Staff will have a designated chair positioned so that visual monitoring of the client's door can be carried out during sleeping hours". Review of the record did not reveal evidence of in-service training on the updated bsp and interventions. Review of an incident report dated 5/18/23 indicated that client #1 was suspected of sexually assaulting client #2 and wrote a suicide letter. Continued review of the 5/18/23 incident report revealed staff observed client #1 to leave out of client #2's room and run into his room locking the door. Review of the 5/2023 incident also revealed client #1 to slide a suicidal note under the door stating "today I will kill myself. Sorry mom ...". Review of the 4/2022 and 5/2023 bsp updates for client #1 did not reveal telling untruths as a target behavior. Review of an internal investigative summary dated 5/24/23 indicated that on 5/17/23 staff witnessed client #1 to run out of client #2's room, enter his room and close the door. Continued review of the investigative summary indicated that staff did not hear client #1's door chime at that time. Review of the 5/2023 investigative summary also revealed client #1 to lock himself in his room and slide a suicidal note under the door. The investigative summary also revealed client	W 191		

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W 191	Continued From page 3 #1 was transported to the local ED for a psychiatric evaluation on 5/18/23 and released. Further review of the investigative summary revealed client #1 was sent home with his family on 5/19/23 on therapeutic leave until an alternative, appropriate placement could be found. Additional review of the investigative summary dated 5/24/23 revealed staff completed a body check on client #2 and found no redness, swelling or injury and the client's adult brief was still intact. Continued review of the investigative summary revealed client #2 was transported to the emergency department (ED) on 5/18/23, provided a forensic examination and rape kit and returned to the facility. Further review of the investigative summary concluded the bsp for client #1 was not followed appropriately and there was no evidence of inservice training on interventions. Review of facility incident reporting policy and reporting suspected or actual abuse, neglect, or exploitation policy on 6/12/23 revealed the following parties should be contacted immediately: PM, Nurse, local department of social services (DSS), healthcare personnel registry (HCPR) and monitoring LME/MCO. Review of facility documentation did not verify if the LME/MCO was contacted relative to the incident that occurred on 5/17/23. Continued review of facility documentation on 6/12/23 did not reveal in-service training between 4/23/22 and 5/19/23 in the following areas: updated BSP for client #1, 1:1 interventions for client #1 to keep himself safe and protect the clients in the facility, incident reporting protocol and abuse/neglect/exploitation reporting.	W 191		

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W 191	Continued From page 4 Interview with staff A on 6/12/23 revealed that on 5/19/23 client #1 approached her at the day program and stated that he "raped and masturbated in front of" client #2. Continued interview with staff A revealed that she reported the information to management. Interview with staff A also revealed on 5/19/23 that client #2 was not himself throughout the day. Staff A also revealed client #2 was withdrawn, restless and not being able to sit still. Further interview with staff A did not reveal any intervention changes for both clients #1 and #2 after the 5/17/23 incident. Interview with staff B on 6/12/23 revealed he was made aware of the incident by the PM on 5/19/23. Continued interview with staff B revealed he was not instructed to implement additional interventions or precautions after the 5/17/23 incident. Staff B further revealed client #1 went home with family on therapeutic leave on the afternoon of 5/19/23. Interview with the PM on 6/12/23 revealed that when client #1 was involved in a sexually inappropriate incident on 4/23/22, a decision was made by the team and human rights committee to implement the following interventions: place a door chime on the client's door, increase supervision to "close supervision on 1st shift only" and install surveillance cameras in common areas. Continued interview with the PM also revealed that client #1's BSP was updated to include increased monitoring and surveillance cameras, however, the surveillance cameras in the common area were never installed. Subsequent interview with the PM verified the facility employed six new staff over the past twelve months. Continued interview with the PM revealed that revealed that staff were given	W 191		

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W 191	Continued From page 5 updates on client #1's BSP in staff meetings, communication logs and phone calls after the 5/17/23 incident. Further interview with the PM revealed she could not locate the staff meeting minutes or in-service forms as well as dates to confirm formal training of client #1 behaviors and interventions were provided to staff. Interview with the qualified intellectual disabilities professional (QIDP) on 6/12/23 revealed that on 5/18/23 the interdisciplinary team met to discuss client #1's behaviors. Continued interview with the QIDP also revealed that the facility was no longer able to meet client #1's needs and the client was sent on therapeutic leave on 5/19/23 until an appropriate placement was available to meet the client's 1:1 needs. Further interview with the QIDP could not confirm dates or evidence of in-service training relative to incident reporting protocol, abuse/neglect/exploitation (ANE) reporting, bsp updates and intervention changes to ensure the clients safety in the home between the incidents that occurred on 4/23/22 and 5/17/23. Additional interview with the QIDP revealed that HCPR was not made aware of the alleged incidents. Subsequent interview with the PM and QIDP also revealed that evidence of in-service trainings and staff meeting minutes should have been completed and readily available during the complaint investigation survey.	W 191		