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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-261	A. BUILDING: _____ B. WING _____	R-C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS AVENUE GROUP HOME	4425 REGIS AVENUE DURHAM, NC 27705

(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 May 28, 2024. The complaint was substantiated (intake #NC00217082). 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 has a current census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and	V 118	RECEIVED BY MHL & C 6/27/24 Please see attached.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Scott — TITLE: Executive Director — (X6) DATE: 6/24/24

STATE FORM 6899 5I4D11 If continuation sheet 1 of 14

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V 118	Continued From page 1 (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to keep the MARs current affecting two of three audited clients (#2 and #3). The findings are: Review on 5/21/24 of client #2's record revealed: -Admission date of 12/31/75 -Diagnoses of Mild Intellectual Disability, Hypertension, Congenital Hypothyroidism, Obesity, Osteopenia, Dysthymic Disorder, Chronic Kidney Disease, Edema, Overactive Bladder, Heartburn, Neuropathy in foot and Gout Review on 5/21/24 of client #2's physician's order dated 9/14/23 revealed: -Omeprazole 20 milligrams (mg) (Heartburn), one capsule daily -Aspirin 81 mg (Anti-inflammatory), one tablet daily -Enalapril 10 mg (Hypertension), one tablet daily -Check Blood Pressure daily Review on 5/21/24 of MARs for client #2 revealed: April 2024:	V 118		

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V 118	Continued From page 2 No staff initials as administered or checked for the following: -Omeprazole 20 mg on 4/25 -Aspirin 81 mg on 4/17 -Blood Pressure checks on 4/22, 4/18 and 4/17 March 2024: No staff initials as administered or checked for the following: -Omeprazole 20 mg on 3/7 -Aspirin 81 mg on 3/6 and 3/7 -Enalapril 10 mg on 3/7 -Blood Pressure checks on 3/7 and 3/8 Review on 5/21/24 of client #3's record revealed: -Admission date of 10/2/06 -Diagnoses of Mild Intellectual Disability, Type II Diabetes, High Blood Pressure, Chronic Migraines, Chronic Kidney Disease, Insomnia, Chronic Right Side Heart Failure, Depression and High Cholesterol Review on 5/21/24 of client #3's physician's order dated 8/9/23 revealed: -Torsemide 20 mg (Diuretic), one tablet daily -Paroxetine 20 mg (Depression), one tablet daily -Renewal Cream (Moisturizer), apply to feet, heels and hands twice a day Review on 5/21/24 of MARs for client #3 revealed: April 2024: No staff initials as administered for the following: -Paroxetine 20 mg on 4/14 thru 4/17 -Renewal Cream on 4/17	V 118		

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V 118	Continued From page 3 March 2024: No staff initials as administered for the following: -Torsemide 20 mg on 3/13 Interview on 5/21/24 with the Division Director revealed: -Client #2 went to visit her family in March 2024. -Staff forgot to indicate the home visits on her March 2024 MAR. -Staff administered client #3's medication. -Staff "possibly" forgot to sign off on client #3's MAR. -There were no issues with clients #2 and #3 getting their prescribed medications. -She confirmed the MARs were not kept current for clients #2 and #3. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual	V 512		

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V 512	Continued From page 4 characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews, one of three audited staff (#1) abused and neglected one of three audited clients (#1) and one of three audited staff (The Group Home Manager) failed to protect one of three audited clients (#1) from abuse and neglect. The findings are: Review on 5/21/24 of personnel records for staff revealed: Group Home Manager: -Date of hire was 1/16/23. Staff #1: -Date of hire was 8/9/23 -Hired as a Skills Trainer. Review on 5/21/24 of client #1's record revealed: -Admission date of 12/2/85. -Diagnoses of Mild Intellectual Disability, Major Depressive Disorder, Cognitive Impairment, Dementia, Down's Syndrome, Gastroesophageal Disease, B12 Deficiency, Anxiety Disorder, Plantar Fasciitis and Hearing Loss. Review on 5/21/24 of in-house incident reports for client #1 revealed:	V 512		

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V 512	Continued From page 5 -5/13/24-Report written by the Group Home Manager-"[Staff #1] came to get [client #1] up and ready this morning. She was able to get her into the bathroom and undressed. That's when we saw that she had a bowl movement on herself and needed a shower. [Client #1] had feces on her from the wrist down and started grabbing it from her private area and smearing it. It was all over her face, hands, and in her hair as well. [Staff #1] called me from the room to come and assist her with the shower. [Client #1] began to get combative and aggressive and kept trying to go into the dining room. We got her back in the bathroom and into the shower, but as soon as the water was turned on she began to scream, grabbed me by my clothes, and got feces all over me as well. The situation was very stressful so we turned off the water and let her out of the shower and she tried again to go into the kitchen, but [Staff #1] stopped her. I stepped away to change my clothes and called via phone, [the Division Director] to come and assist...[Staff #1] had grabbed a chair and sat in front of the door to prevent [client #1] from coming out. This was a one time isolation measure to keep her from coming out in the condition she was in." -5/13/24-Report written by Staff #1-"I came in this morning to get [Client #1] up. When I got her into the bathroom and got her undressed, I saw that she was covered in poop. I knew she needed a shower and from past experiences I knew she wasn't going to let me do it so I called [the Group Home Manager] for assistance. When we got her into the shower she became combative and was hitting at us. [Client #1] got poop on [the Group Home Manager] and was not being cooperative. It was a stressful situation and we needed assistance. We called [the Division Director] by	V 512		

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V 512	Continued From page 6 phone for help. We put a chair in front of the door for the safety of us and [Client #1's] housemates, given she was naked and covered in feces from head to toe and being aggressive trying to leave the bathroom. We made sure to check on her to be sure she was safe also." Client #1 could not be interviewed because she was in the hospital. Interview on 5/22/24 with client #4 revealed: -She saw some of the incident with client #1, staff #1 and the Group Home Manager. -Client #1 was walking around the facility screaming and hollering. -Staff #1 told her to get a chair from the dining room area. -Staff #1 took the chair and put it in front of the bathroom door. -The bathroom door was closed. -Staff #1 sat in the chair while it was in front of the door. Interview on 5/22/24 with staff #1 revealed: -There was an incident with client #1 about a week ago (5/13/24). -She went into client #1's bedroom to get her up. -She could smell "poop" as soon as she walked into her bedroom. -She took client #1 into the bathroom and saw "poop" all over her body. -She took off client #1's clothes. -She called the Group Home Manager into the bathroom because she needed help. -They got client #1 into the shower. -They turned on the water and client #1 became combative. -Client #1 was screaming and hitting them. -Client #1 got "poop" on the Group Home Manager.	V 512		

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V 512	Continued From page 7 -The Group Home Manager stepped out of the bathroom to call the Division Director. -Client #1 tried to leave the bathroom and was told she could not leave the bathroom. -She asked client #4 to bring her a chair. -She set the chair in front of the door for the safety of client #1 and the other clients. -Client #1 was trying to get out of the bathroom and go into the kitchen where the other clients were eating. -Client #1 was also being "combative." -The door to the bathroom was cracked and she was standing outside of the bathroom. -Client #1 remained in the bathroom. -She could see client #1 through the crack of the door in the bathroom. -Client #1 had "poop" all over her hands and she didn't want her to hit or touch the other clients with "poop" on her hands. -The chair was in front of bathroom door for "about" 10 minutes. -The chair was never placed underneath the doorknob to the bathroom door. -She may have closed the door all the way for a minute or two while client #1 was in the bathroom because she had to go into her bedroom and clean up. -She or the Group Home Manager stood outside the door while client #1 was in the bathroom the "majority" of the time. -The Care Coordinator with the Local Management Entity/Managed Care Organization (LME/MCO) was at the facility that morning as well. Interview on 5/22/24 with the Group Home Manager revealed: -There was an incident with client #1 last Monday (5/13/24). -Staff #1 got client #1 out of bed and took her to	V 512		

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V 512	Continued From page 8 the bathroom. -Staff #1 discovered client #1 had feces on her. -Staff #1 took client #1 into the bathroom and called for assistance. -Client #1 was "combative and aggressive" while they tried to get her undressed. -They got client #1 undressed and got her in the shower. -Client #1 then started yelling, screaming and kicking. -"[Client #1] grabbed me and got feces all over me." -Client #1 kept fighting and they turned the water off and let her out of the shower. -Client #1 "took off" and tried to leave the bathroom. -Staff #1 "blocked" the doorway to keep client #1 from leaving the bathroom. -Client #1 "got mad, started kicking, screaming, and tried to fight her way out of the bathroom." -She told staff #1 she needed to call the Division Director because "the situation had gotten out of control." -She stepped out of bathroom. -She also needed to change her clothes. -She went back to bathroom and the door was cracked slightly with a chair in front of the door. -The chair was not underneath the bathroom doorknob. -She told staff #1 the Division Director was on her way. -Client #1 was still in the bathroom. -Staff #1 was standing outside of the bathroom looking at client #1 through the crack of the door. -Staff #1 said "I'm not fighting with her anymore, I'm going to leave the chair here until [the Division Director] comes." -Staff #1 had to help one of the other clients and she also stood in front of the door and monitored client #1 while she was in the bathroom.	V 512		

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V 512	Continued From page 9 -She didn't go back into the bathroom either because she was assisting the other clients as well with medication. -She "thought" the chair was in front of door for "about" 15 minutes. -Staff #1 moved the chair from in front of door prior to the Division Director arriving. Interview on 5/22/24 with the Care Coordinator with the LME/MCO revealed: -She was at the facility on 5/13/24 when she witnessed an incident. -She was the Care Coordinator for two of the other clients residing in that facility. -She was sitting at the table in the kitchen area and doing a monitoring visit with client #6. -The Group Home Manager and staff #1 were also at the facility. -They were all in the kitchen area. -She saw a chair pushed up against the bathroom door. -The chair was pushed underneath the doorknob. -"I thought maybe staff were cleaning the facility." -She had been sitting in the kitchen area for about 20 minutes or longer with the Group Home Manager and staff #1. -She saw one of the staff go to the bathroom, move the chair and open the door and started talking to someone. -She heard that staff say client #1's name. -She asked the staff if she was talking to client #1 and staff replied "yes." -She had no idea client #1 was in that bathroom while the chair was pushed up against the knob. -She told staff they could not do that. -She told staff they were not allowed to "confine" a client in the bathroom. -She never saw staff go to the bathroom prior to that to check on client #1. -Staff said client #1 had behaviors and was being	V 512		

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V 512	Continued From page 10 "combative." -She talked with the Division Director about the incident. -She told the Division Director what she witnessed while she was at the facility. -She (the Care Coordinator) used to work for that agency and was the Former Division Director for that facility. -"I know the clients well at that facility." Interview on 5/21/24 with the Division Director revealed: -On 5/13/24 the Care Coordinator with the LME/MCO reported staff confined client #1 in the bathroom with a chair in front of the door. -The Care Coordinator with the LME/MCO was at the facility earlier that morning visiting a client. -She was not working during that incident. -The Group Home Manager and staff #1 were the two staff working during that incident. -Both staff assisted client #1 when the incident occurred. -She was told by staff client #1 was covered from head to toe in "poop." -Staff also said client #1 had some "combative" behaviors during that incident. -Staff #1 placed the chair in front of the bathroom door. -She was told the chair was not underneath the door handle. -Staff #1 said she put the chair near the bathroom door and left the door cracked. -Staff #1 said the chair was there to keep client #1 safe. -She was told the Group Home Manager had to step away and clean up because she had feces on her. -She was told the other clients were in the kitchen area eating breakfast. -Staff #1 said she didn't want client #1 to come	V 512		

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V 512	Continued From page 11 out of the bathroom and spread feces. Interview on 5/21/24 with the Assistant Director revealed: -She was aware of the incident on 5/13/24 with client #1, staff #1 and the Group Home Manager. -The Care Coordinator with the LME/MCO for other consumers was at the facility. -The Care Coordinator with the LME/MCO called the Department of Social Services because she had some concerns. -It was "alleged" staff locked client #1 in the bathroom. -She was told staff #1 put a chair in front of the bathroom door. -She was also told staff #1 never put the chair underneath the knob to the bathroom door. Interview on 5/23/24 with the Executive Director revealed: -She was aware of the incident on 5/13/24 with client #1, staff #1 and the Group Home Manager. -The Assistant Director talked with her about the incident. -She did not talk with staff about that incident because she was on vacation when that incident occurred. -The Assistant Director addressed that incident with staff. Review on 5/23/24 of a Plan of Protection written by the Executive Director dated 5/23/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? I will immediately put the two staff involved on administrative leave pending conclusion of this investigation. Based on all findings from the current investigations, we will make the decision to either terminate staff or discipline and retrain staff on Clients Rights, Abuse and Neglect, and	V 512		

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V 512	Continued From page 12 Incident Reporting, and any other areas needed to make sure that they are fully competent. In addition, we will continue to work with the residents to understand fully their rights, and that they should report any time that they feel abuse or neglect may be taking place. Describe your plans to make sure the above happens. I have already contacted the two staff involved to inform them that they are on administrative leave immediately pending conclusion of the investigations. I have let them know that we will be making a determination with our administrative staff as to the actions that need to be taken when all that information is compiled. At that time, they will face disciplinary action up to and including termination of their employment. We train all staff on client rights, abuse and neglect and incident reporting annually as needed. The pieces for making sure consumers are advised of their rights are in place, but we will go over these again, and going forward. Client rights and reporting numbers are already posted in the house, and we will make sure that all consumers are familiar with the locations and understand the purpose." Client #1's diagnoses included Mild Intellectual Disability, Major Depressive Disorder, Cognitive Impairment, Dementia, Down's Syndrome, Anxiety Disorder and a Hearing Loss. On 5/13/24 the Group Home Manager and Staff #1 took client #1 into the bathroom at attempt to assist with bathing her as client #1 was covered in feces. Client #1 became combative with staff and got feces on the Group Home Manager. The Group Home Manager left the bathroom, called the Division Director and changed her clothes. Staff #1 left client #1 in the bathroom alone and unsupervised. Staff #1 put a chair underneath the doorknob to the bathroom which prevented client	V 512		

PRINTED: 06/06/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-261	A. BUILDING: _____ B. WING _____	R-C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS AVENUE GROUP HOME	4425 REGIS AVENUE DURHAM, NC 27705

(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 512	Continued From page 13 #1 from leaving the bathroom for at least 20 minutes. This deficiency constitutes a Type A1 rule violation for serious abuse and neglect and must be corrected within 23 days.	V 512		

Durham County Community Living Programs, Inc.

Post Office Box 51159
Durham, N.C. 27717-1159
(919) 489-0682

Regis Avenue Group Home
MHL # 032-264
Plan of Correction to Survey Completed May 28, 2024

V118 27G .0209 (C) Medication Requirements

To correct the deficiency: The Division Director and Assistant Director reviewed all medications to make sure that all medications were in place and being documented correctly on the MAR since the monitoring. There will be medication administration retraining for staff with an RN as soon as possible to review the relevant areas. Annual training for Managers, who are the primary people who give medication, was held on April 26, 2024. The RN has been unavailable due to illness to reschedule the refresher course to date.

To Prevent the Deficiency from Occurring Again: The Division Director and the staff working in the home at the time of the deficiency will be required to attend additional Medication Administration as soon as it can be scheduled. We will continue to hold annual Medication Administration training to make sure all staff are up-to-date and refreshed on the policies and procedures. The incidents will be documented in their personnel record. We reviewed the signing of the MAR with all managers at our monthly staff meeting on Wednesday, June 26, 2027. The documentation errors were made by substitute managers working in the home, and not by the assigned manager to that home. I reminded all staff that they must be particularly careful when subbing, because you are less familiar with the medication, and documentation is a critical piece of administration. We take medication administration seriously, and mistakes such as this will not be tolerated.

Who will Monitor: The Division Director will review all MAR's, at the end of each month to assure all medication labels and Doctor's orders match the information on the MAR, and to assure that they are correct going into the next month, as well as reviewing to makes sure the documentation is correct. The Division Director is responsible for spot checks throughout the month as she visits the home to make sure the staff are correctly documenting administration. The Assistant Director will spot check over the next few months on a periodic, unannounced basis throughout the month to verify that medication administration records are signed each time they are administered. An RN will review the medications and MARs quarterly, completing a pharmaceutical care review identifying any issues.

How Often the Monitoring will Take Place: The Division Director will review all MAR's, at the end of each month to assure that medications are signed off as required at each administration, as well as completing periodic checks throughout the month. The Assistant Director will spot check on a periodic, unannounced basis to make sure the MAR's are documented correctly over the next few months. An RN will review the medications and MAR quarterly, completing a pharmaceutical care review identifying any issues.

V512 27D NCAC 27D .0304 Client Rights

To correct the deficiency: The rule was reviewed as not met by DHSR, stating that one staff abused and neglected one of three audited clients, and one of three staff failed to protect one of three audited clients from abuse and neglect. To correct this deficiency, staff were put on administrative leave pending investigation. One staff was then put on unpaid leave for an additional two weeks to assess her role in this incident and to consider all factors related to her handling of the incident and her future interest in this field. Both staff were then disciplined through write-up, put on probationary status, and retrained in client rights, with a focus on this particular situation and issues similar to this that could arise in this field, as well as a professional ethics review, and a training focused on OSHA standards related to wearing appropriate PPE that may be needed in a given situation. On the day of the incident, staff were reminded that the consumer's plan is to step away if she becomes agitated, monitor her, and then to return and "try another way" in a few minutes as the situation calms down. They were also reminded that the Assistant Director and Director (who was out of town at the time of this incident) live minutes from the home, and could have been a quicker resource in this situation than the home supervisor.

In addition, we have been requesting that this client be moved to a higher level of care for two years, with a concerted push in the last year. We have repeatedly contacted her psychiatrist, Primary Care doctor, Alliance Care Coordinator and guardian seeking help to get her transitioned to a more appropriate level to meet her needs. Her psychiatrist has put in writing to the Care Coordinator that this consumer needs a higher level of care multiple times, and she has been on waiting lists throughout the State. Due to an injury that occurred days after this incident when the consumer moved furniture in her room in the night, the consumer was admitted to the hospital. DHRS investigated this second incident as well while she was on-site. The consumer is moving on June 27th to an ICF-IDD level home in Person County. Due to this move, Staff #1 will not be returning to work at this home at this time, and will instead continue working with two other higher-functioning consumers at other locations.

To Prevent the Deficiency from Occurring Again: Staff #1 met with the Executive Director and Human Resources Director on 6/18/24, following her two week unpaid leave. The situation itself and the disciplinary action were reviewed with her at that time, and training took place by the Executive Director on the topics specified above. The Executive Director and Human Resources Director met with the Manager on 6/19/24 before she returned to work. She took additional time off at her own request following the incident. The incident, disciplinary action, and training all took place on 6/19/24 prior to her returning to work on that day.

We do Client Rights, Abuse and Neglect, and Incident Reporting training with all staff annually to prevent issues such as this from occurring. While all aspects of the topic are covered during training, we intend to "beef up" the training in the future to focus on what to do in a similar situation, as well as all of the options of who to call for help and guidance BEFORE and during an incident to get the maximum assistance. The Executive Director also met with all consumers in the Regis Home to review client rights with them, particularly regarding this situation. They all felt that they were treated respectfully overall, and that staff were trying to protect the consumer and them in this situation. We had a lengthy conversation about rights, and who to call if you have any concerns, etc. We review Client Rights with consumers annually, and focus on a specific right monthly in our weekly house meetings.

Who will Monitor: The Division Directors are responsible for monitoring and supervising their staff. In this case, the Manager will continue to have the same supervising Division Director at

this time. Since the Staff #1 will not be working in that home or with an Innovations consumer, she will have a different Division Director as her supervisor. During their probationary period, the Assistant Director and Executive Director will also provide some supervision and periodic check-in to ensure that they are going forward using the correct procedures and following regulation and policy.

How Often the Monitoring will Take Place: Official supervision will take place as required, with 2 hours per month prorated at 1 FTE. Additional supervision and training will occur on a periodic and as needed basis throughout the probationary period, and ongoing as each individual case warrants.

Note that the IRIS has been updated with our final results of the investigation, so those notes can be reviewed there. Neither DSS nor the HCPR found abuse or neglect in this case.

Respectfully submitted,

Elizabeth Scott

Elizabeth Scott
Executive Director