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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 7/24/24. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
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 obtained.	V 112		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement goals and strategies in the treatment/habilitation plans to meet the individual needs for 3 of 3 clients (#1, #2, and #3). The findings are:

Review on 6/26/24 of the Facility's Behavior Collection Data Forms for Clients #1, #2, and #3 from 1/3/24 to 5/31/24 revealed:
-"Location 1. Home 2. Community 3. Day Support.
-Target Behaviors: 1. Verbal aggression, 2. Yelling, 3. Lying, 4. Physical aggression, 5. Throwing objects, 6. Property Damage, 7. Self-injurious, 8. Pee on floor, 9. Elopement.
-Intervention: 1. Verbal redirection, 2. Multiple Verbal Redirections, 3. Remove from area, 4. Physical Intervention, 5. Sought medical attention, 6. Called 911.
-Please document the location where the behavior occurred, which targeted behavior was exhibited and the intervention applied by staff. If a further description is warranted in order to be clearer about the behavior/incident, please place in space underneath the entry.
-If intervention #4, #5 or #6 is given, an incident report is required immediately."

Review on 6/25/24 of Client #1's record revealed:
-Admitted on 5/18/21.
-Age 17.

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V 112	Continued From page 2 -Diagnoses: Attention Deficit Hyperactivity Disorder, Combined Type; Disruptive Mood Dysregulation Disorder; Autism Spectrum Disorder. -Admission assessment dated 5/18/21 noted "Aggression towards self & others..his mother indicated he engages in risky behaviors, including self-harming behaviors..." -Psychological evaluation dated 2/7/23 noted "...the following recommendations are given...if [Client #1] becomes a danger to himself or toward others, inpatient psychiatric hospitalizations should be sought..." -Clinical Discharge Summary from local hospital, dated 5/17/21, noted "...stabbed his arm and stomach several times with a plastic knife...attempted to drink a bottle of hand sanitizer..." -Behavior Data Collection Forms documented 41 Self-Injurious Behaviors (SIBs) in the facility from 1/3/24 to 5/31/24. -Of the 41 documented incidents of SIBs, there was no detailed explanation of what specific behaviors were displayed. -A treatment plan dated 5/27/24. -No goals and strategies in the treatment plan to address Client #1's SIBs. Interview on 6/25/24 with Client #1 revealed: -Had gotten mad at times and hit himself in the face. -"I hit myself with my hand...it was a closed fist, and I did it because I was stressed out with school stuff..." Review on 6/25/24 of Client #2's record revealed: -Admitted on 1/6/23. -Age 15. -Non-verbal. -Diagnoses: Autism, Severe Intellectual	V 112		

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V 112	Continued From page 3 Disabilities; Generalized Anxiety Disorder; Intermittent Explosive Disorder. -An assessment dated 12/20/23. -A treatment plan dated 1/6/24. -Treatment plan stated, " ...is verbally limited ...will need one on one staff to best support him in all settings ...will require one on one staff to support him best with preventing and managing behaviors when/if they occur ...requires one on one support to assist with de-escalating and learning appropriate behaviors ...can be sneaky with his behaviors and staff need to be aware at all times ...struggles with behaviors that require one on one supports to ensure his and other's safety...does not understand dangers in the community or in his home ...residential and DSI (Day Supports-Individual) services will provide support and supervision for [Client #2] and ensure that his health and safety needs are met in the home and the community ..." -" ...will remain with staff at all times and not wander or run away with 3 verbal prompts (Staff will monitor for support and safety. Will remain within arm's reach of staff) ..." -A crisis plan dated 8/31/23..."known to throw things when upset...and has been reported with some past history of self injurious behaviors...Ensure that [Client #1] does not hurt others or himself when experiencing crisis event..." -Behavior Data Collection Forms documented 17 SIBs in the facility from 1/3/24 to 5/31/24. -Of the 17 documented incidents of SIBs, there was no detailed explanation of what specific behaviors were displayed. -No goals and strategies in the treatment plan to address Client #2's SIBs. Review on 6/25/24 of Client #3's record revealed: -Admitted on 8/31/22.	V 112		

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-Age 16.
-Non-verbal.
-Diagnoses: Severe Intellectual Disabilities; Autistic Disorder.
-An assessment dated 4/17/23 noted..."will hit himself when he is upset..."
-A treatment plan dated 7/1/23.
-Treatment plan stated, "Ways to reduce risks: [Client #3] needs 24/7 supervision to ensure his health, well-being and safety" and " will remain with staff at all times ..."
-Crisis plan dated 7/1/23..."what a crisis looks like:...I may bang my head...I may bite my hand..."
-Behavior Data Collection Forms documented 24 SIBs in the facility.
-Of the 24 documented incidents of SIBs, there was no detailed explanation of what specific behaviors were displayed.
-No goals and strategies in the treatment plan to address Client #3's SIBs.

Attempted interviews on 6/24/24 with Client #2 and Client #3 revealed:
-Met with Clients #2 and #3 who were non-verbal and unable to respond to questions asked.

Interview on 6/26/24 with Staff #1 revealed:
-Back up staff for the Alternative Family Living (AFL) Provider.
-Worked with Clients #1, #2, and #3.
-Kept documentation of the SIBs for each client on behavior logs.
-"...he (Client #1) has done it (hitting himself) before...Anything he does that is out of the norm, I document it."
-"It's not uncommon for [Client #1] to take things (objects) to use during a self-injury."
-Noted Client #2 picked at sores and Client #3 bit his hands.
-Did not document specific injuries related to

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V 112	Continued From page 5 SIBs. Interviews on 6/25/24 and 7/2/24 with the AFL Provider revealed: -Kept documentation of the SIBs on behavior logs for Clients #1, #2, and #3. -"...He (Client #1) will take a brush and start hitting his feet, head." -Client #2 "picks at sores...likes to see himself bleed." -Client #3 "bites his hands...body" or "he'll start hitting himself in the top of his head." -The clients' SIBs were "in the old treatment plan...shouldn't have been taken out." -"I run (implement) the goals that are in place, and I just execute them. The Qualified Professional #1 (QP #1) and the guardians do (develop) the treatment plans..." -Did not document specific injuries related to SIBs. Interview on 6/26/24 with the QP #1 revealed: -Clients #1, #2, and #3 have SIBs. -"[Client #2] and [Client #3] are nonverbal." -Reviewed the documentation submitted by AFL provider and Staff #1. -"[The Local Management Entity/Managed Care Organization (LME/MCO)] does their treatment plans..." -"I haven't seen or observed (SIBs)." -Had not discussed clients' SIBs in treatment team meetings. -"...Yes, I do see (the Behavior Form), can't say what he (AFL) observes...We observe (clients) in the office (The Kids Workshop), they're always pretty stable when we see them. I don't know what he's (AFL) dealing with in the home, we don't see. He sees it (behaviors), so he documents."	V 112		

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V 112	Continued From page 6 Interviews on 6/27/24 and 7/3/24 with the Clinical Director/Qualified Professional #2 (CD/QP #2) revealed: -Was aware that Clients #1, #2, and #3 had SIBs. -Reviewed the documentation submitted by AFL provider and Staff #1. -"If it (goals and strategies for SIBs) is not in the plan, then we need to address that. I am shocked. I am just very shocked." -"[QP #1] and the team (care team) discusses behaviors...We (The Kids Workshop) are not responsible for that (adding goals and strategies to the clients' treatment plans). We (The Kids Workshop) go with whatever the team recommends." -Was not sure if the clients' SIBs had been discussed in the treatment team meetings. "I am not sure. I am not a part of the ISP (Individual Support Plan) treatment team meeting. [QP #1] sits in on that (treatment team meeting)."	V 112		
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	V 118		

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V 118	Continued From page 7 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 (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 review and interviews the facility failed to have a signed physician's order for medications administered to clients, affecting for 3 of 3 clients (#1, #2 and #3). The findings: Review on 6/25/24 of Client #1's record revealed: -An admission date of 5/18/21. -Age 17. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD), Combined Type; Disruptive Mood Dysregulation Disorder (DMDD); Autism Spectrum Disorder. -No documentation of signed physicians' orders. Review on 6/24/24 of' Client #1's MARs from 1/1/24 to 6/23/24 revealed: -Following medications were initialed as administered by staff : Banophen 25 milligrams	V 118		

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(mg), "take 1 tablet by mouth every morning" (sleep)(discontinued per MARs); Trazodone 50mg, "take 1 tablet (50mg) by mouth at bedtime" (sleep); Concerta 54mg, "take 1 tablet by mouth every morning" (ADHD/mood); Divalproex SOD (Superoxide Dismutase) DR (Delayed Release) 500mg, "take 2 tablets (1000mg) by mouth every evening" (sleep/mood); Clonidine ER (Extended Release) 0.1mg, "take 1 tablet by mouth every morning and every evening" (sleep/mood); Latuda 40mg, "take 1 tablet (40mg) by mouth daily with dinner" (sleep/mood).

Review on 6/25/24 of Client #2's record revealed:
-Admitted on 1/6/23.
-Age 15.
-Non-verbal.
-Diagnoses: Autism, Severe Intellectual Disabilities; Generalized Anxiety Disorder; Intermittent Explosive Disorder (IED).
-No documentation of signed physicians' orders.

Review on 6/25/24 of Client #2's MARs from 1/1/24 to 6/23/24 revealed:
-Following medications were initialed as administered by staff : Olanzapine 2.5 mg, "take 1 tablet by mouth every day as needed for agitation" (erratic behavior); Propranolol 20mg, "take 1 tablet by mouth twice daily on an empty stomach" (anxiety/IED); Reguloid 0.52gm (grams), "take 1 capsule (0.52 gram) by mouth at bedtime" (laxative); Lamotrigine 100mg, "take 1 tablet by mouth daily at bedtime" (mood/skin); Lamotrigine 150mg, "take 1 tablet by mouth daily at bedtime" (mood/skin); Children's Chewable Complete Vitamin, OTC (Over The Counter), daily vitamin; Pumpkin Seed Oil 1000mg, "take 1 capsule by mouth daily at bedtime" (dry skin); Whole Food Multivitamins, "take 1 tablet by mouth daily" (daily vitamin supplement);

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V 118	Continued From page 9 Magnesium Glycinate 100mg, "take 1 tablet by mouth daily at bedtime" (nervous system support). Review on 6/25/24 of Client #3's record revealed: -Admitted on 8/31/22. -Age 16. -Non-verbal. -Diagnoses: Severe Intellectual Disabilities; Autistic Disorder. -No documentation of signed physicians' orders. Review on 6/26/24 of Client's #3's MARs from 1/1/24 to 6/23/24 revealed: -Following medications were initialed as administered by staff : "risperidone (risperidone) 0.5mg, 1 tablet oral at bedtime as directed(sleep/anxiety); guanfacine (guanfacine) 1mg, tablet extended release 24 hr, Take 1 tablet oral every evening as directed (sleep/mood stabilizer); Depakote ER (divalproex) 250mg, tablet extended release 24 hr, 1 tablet oral every evening as directed (sleep/anxiety); amitriptyline (amitriptyline) 10mg, tablet, 1 tablet oral at bedtime as directed (mood stabilizer/sleep)." Interviews on 6/24/24 and 7/2/24 with the Alternative Family Living (AFL) Provider revealed: -Explained his repeated attempts to find the physician's orders for the clients medications. -Stated Client #2's mother took him "to all of his doctor appointments. I guess I will have to get in touch with her to get that information. I have already gotten in touch with the other 2 clients' physicians and I will have those ready for you tomorrow (6/27/24)." Further interview on 6/27/24 at 9:18am with the AFL Provider revealed: -"I am going to have to go to each doctor's office	V 118		

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V 118	Continued From page 10 to get the physician's orders because the email they (the doctor's office) sent me don't have the physician's signature on it." -He had the printouts from the physician, but not signed orders. -Was unable to produce the signed physician orders for Clients #1, #2 and #3. Interview on 6/26/24 with the Qualified Professional #1 (QP #1) revealed: -Was not aware the AFL Provider did not have physician's signatures documented for clients' medications. Interview on 6/27/24 with the Clinical Director/Qualified Professional #2 (CD/QP #2) revealed: -The AFL was responsible for keeping MARs updated and having physician orders in clients' files. -"...the AFL does (keeps physicians' orders). They are not kept here (The Kids Workshop)..." -The QP that performed the reviews of the MARs was out on leave. "We have another QP that will do that (check MARs for accuracy), but she is going through the medication training first."	V 118		
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	V 132		

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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.
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 ensure all allegations or acts of abuse, neglect or exploitation, including injuries of an unknown source were investigated, failed to make every effort to protect clients from harm while an investigation was in progress, and failed to ensure the results of all investigations were reported to the HCPR within five working days from the initial notification to the Department.
The findings are:

Interview on 6/25/24 with the Alternative Family Living (AFL) Provider revealed:
-"I am not sure of the exact date, but about 5 months ago, around January or February (2024),

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[Client #1] was at school and had a mark on his eye, the school reported it (to Child Protective Services (CPS)), and CPS did an investigation."
-"[Client #1] told his teacher that he had been hit by his 'father.'"

Review on 6/26/24 of the Facility's Incident Reports revealed:
-No incident report documented regarding Client #1's eye injury which resulted in a referral to CPS on 2/14/24.
-No documentation the HCPR was notified of the unexplained injury.

Interview on 6/25/24 with Client #1 revealed:
-"...not being abused or harmed" in the facility."
-Remembered the incident when he had a mark under his eye.
-"...it was a little black and blue. [AFL Provider] saw it."
-"I got mad and hit myself with a closed fist...I did that (hit myself) because I was stressed out with school stuff..."
-"My teacher, [Teacher] took pictures (of the eye injury), I talked to the man (Social Worker) who interviewed me."

Further interview on 6/25/24 with the AFL Provider revealed:
-"CPS showed up at my door (at the AFL home) asking for [Client #1]'s father. I told them [Client #1]'s father didn't live here, and I explained it was an AFL home. They (CPS) said I was the next adult and thought I was his father...[Client #1] calls me 'father.' CPS interviewed me, school (Client #1's), people at [Licensee] and tried to talk to [Client #2] and [Client #3] and nothing was found."

Interview on 6/26/24 with the Qualified

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TAYLOR MADE HOME	11209 POINTER RIDGE DRIVE CHARLOTTE, NC 28214

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V 132	Continued From page 13 Professional #1 (QP #1) revealed: -Accusations (allegation of unexplained injury to Client #1's eye) occurred near the beginning of the year. -"I think it was February (2024). I do not recall the date. I did my care coordination log to show who I talked to and what we talked about. That's how I do my investigations." -"I was not interviewed by CPS. I did not know it (the allegation) was that serious (for CPS to be called)." -"I do not know what the accusations are. The teacher called in (to CPS) and made a complaint about how [Client #1] was being treated at home (AFL facility)." Interview on 6/27/24 with the Clinical Director/Qualified Professional #2 (CD/QP #2) revealed: -Responsible for incident reports and doing internal investigations. -"I conduct that myself. Now, the QPs can do the investigations depending on the severity, but 9 times out of 10, I investigate. I investigate all parties involved." -"No, we did not report the AFL Provider to the HCPR." -"We just thought it was a misunderstanding (the allegation related to Client #1's unexplained eye injury and whether Client #1 was referring to the AFL Provider or Client #1's biological father)." -"If there is an allegation, I call DSS (the Department of Social Services), I do an IRIS (Incident Response Improvement System) incident report, a HCPR and I submit that." -Failed to ensure that the Department was notified of allegation against health care personnel, including injury of an unknown source. -Failed to provide evidence that the unexplained eye injury was investigated.	V 132		

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V 132	Continued From page 14 -No documentation that measures were put in place to protect clients pending the completion of an internal investigation. -Failed to report the AFL Provider to the HCPR.	V 132		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if	V 290		

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V 290	Continued From page 15 specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the staff-client ratios to allow staff to respond to the individualized needs as specified in treatment plans for 2 of 3 clients (Client #2 and #3). The findings are: Observation and review on 6/25/24, at 9:12am, of the Client and Staff Identifier (CSI) Form revealed: -The Alternative Family Living (AFL) Provider filled out the CSI Form. -Listed Staff #1 as the backup staff for the facility. Reviews on 6/24/24 and 7/2/24 of Client #2's record revealed: -Refer to V112 for specific information on Client #2's treatment plan. -An admission date of 1/6/23. -Diagnoses: Autism; Severe Intellectual Disabilities; Generalized Anxiety Disorder; Intermittent Explosive Disorder (IED).	V 290		

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V 290	Continued From page 16 -Age 15. Review on 6/25/24 of Client #3's record revealed: -Refer to V112 for specific information on Client #3's treatment plan. -An admission date of 1/6/23. -Diagnoses of Severe Intellectual Disabilities; Autistic Disorder. -Age 16. Review on 7/1/24 of Client # 3's progress note dated 6/25/24 revealed: -Provided by the Advance Practice Nurse-Psychiatric Mental Health Nurse Practitioner's (APN-PMHNP). -" ...[Client #3] continues to need one on one supervision to ensure his ADL (Activities of Daily Living) needs ..." Interview on 7/1/24 the APN-PMHNP revealed: -Provided telehealth (therapy/psychiatry) and medication management for Client #3. -Last appointment with Client #3 was 6/25/24. -"You are aware that [Client #3] is autistic?...that he is on the IDD (Intellectual Disabilities Disorder) track? His behaviors are spontaneous and unpredictable." Further observations on 7/1/24 from 7:14pm to 8:35pm revealed: -The AFL Provider was outside and threw away an adult incontinence diaper -Staff #1 was cooking dinner downstairs in the kitchen -Clients #1, #2 and #3 were upstairs alone and unsupervised. -The AFL Provider went upstairs to where the clients' bedrooms were located and then came back downstairs and assisted Client #2 to the sofa in the living room.	V 290		

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V 290	Continued From page 17 -Staff #1 continued cooking dinner. -Staff #1 and the AFL Provider were not at arm's length of Client #2 -Client #3 remained upstairs alone and without supervision -The AFL Provider went back upstairs and returned downstairs with a small plastic bag and walked outside. -The AFL Provider came back into the facility and stayed at the bottom of the steps. -Client #3 came halfway down the stairs to where the AFL Provider stood and then returned upstairs unsupervised. -The AFL Provider went upstairs and assisted Client #3 with changing his adult incontinence diaper. -The AFL Provider instructed Client #3 to "go wash your hands." -Client #3 went upstairs to the bathroom, alone and unsupervised. -It could not be determined if Client #3 turned on the water alone and washed his hands as no running water was heard, and the facility staff remained downstairs. -Client #3 then came back down the stairs alone and sat on the sofa next to Client #2. -Client #2 was not at arm's length of staff #1 or the AFL Provider -Client #2 went upstairs alone and was not at arm's length. -AFL stood at the bottom of the stairs and Staff #1 sat in the living room. -Client #1 and #3 were upstairs alone and Client #2 sat on the sofa. Interview on 6/26/24 with Staff #1 revealed: -"I fill in when he (the AFL Provider) needs a break, or I fill in (at the facility) as needed because 3 (clients) is a lot. I do that (fill in) about maybe once or twice a month or every other	V 290		

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V 290	Continued From page 18 month." Interviews on 6/25/24 with The AFL Provider revealed: -Staff #1 does not live at the residence. -"[Staff #1] is the backup...she is in the facility; I'd say between three to four times a week." Further interview on 7/2/24 with the AFL Provider revealed: -Client #1 was in his room, Client #2 and Client #3 had just had baths. -"I got one in the bathroom naked." -"If [Client #1] elopes, I put the other 2 clients in the truck, and we follow him." -"[Client #2] don't have to be (within arm's length), he (Client #2) just is. [Client #2] won't go too far from me. Anytime somebody opens or closes a door (in the home) it chimes. I try to respect their boundaries but still being in a safe manner." -"...With [Client #3] (need for one-on-one supervision), I give him a little bit more freedom. When he's (Client #3) in his room with the door closed, there's nothing in there, but there is a chime that goes off if he goes out of his room, (like to the bathroom). When he (Client #3) opens or shuts his door I'll hear the chime." -"....at bath time, we have 2 (Clients #2 and #3) that require hand over hand assistance." -"With [Client #2], I will point to where he needs to wash. [Client #3] is very stubborn and requires hand over hand assistance with bathing." -If there was a behavior during bath time with another of the clients, "I will just get [Client #3] out of the tub to dry off while I deal with the other client's behavior. Then I come back to continue with the bathing. [Client #3] will sit down while I deal with the other client's behaviors, and he won't move. [Client #1] will remain in his room during this time."	V 290		

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V 290	Continued From page 19 Interview on 7/3/24 at 9:30pm with the Qualified Professional (QP) #1 revealed: -"Arm's length is making sure you are 4 feet from the individual you are processing with. For [Client #2] you can't get too close to him without him flinching ...he's gotten a lot better than when we first got him." -"[Staff #1] is the back up. She is there (in AFL facility) quite often ...I would say 4-5 days a week. She picks them up from school, drops them off (#2 and #3) and picks them up from AFL provider when he has to work." -"I wouldn't say they (Clients #2 and #3) need 1:1 with ADLs from a residential standpoint. If going off the paperwork, then yes, but if going off clinical, then in my observations, I beg to differ." -"Hand over hand for [Client #3] I would suppose (that hand over hand is needed for ADLs)." -AFL provider has 3 consumers, 2 of which need 1:1 for ADLs ..."it's been working. Hypothetically, there's always room for incidences. You run the risk at all times (of an incident occurring), hypothetically speaking." -"ADL is the day-to-day skills. I didn't correlate that to be from a residential standpoint (didn't correlate need for 1:1 supervision with ADLs in the AFL facility) ...From clinical observation, if it was a red flag (if there was an incident or threat of an incident), we needed to change that (need for 1:1 ADL in residential setting, not just 1:1 in the community)." Interview on 6/27/24 at 9:27am with the Clinical Director/QP #2 (CD/QP #2) revealed: -Was not sure how the AFL Provider kept the clients at arm's length in the home. -Regarding arm's length of Client #2 and 1:1 supervision with Client #3 ..."That's a good question. They all have 1:1s (community support	V 290		

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V 290	Continued From page 20 workers), but [the AFL Provider] is in the home and they (the clients) are all in his care. I think he 'gauges' it (the clients' behaviors). He takes them out to eat all the time. I don't know (how he handles a behavior with a client while maintaining supervision of other 2 clients)." -"Sometimes [Client #1] will be the one to have a tantrum. He may not have had that (negative behaviors in the community) happen. But what if? What if (negative behaviors)? That's a good question. That's a great question. You are absolutely right! He is not the only AFL provider with 3 clients in the home. And the AFL Provider has no one else that lives with him. That's a good question. I wonder if he (AFL) gets [Staff #1] to help him out? I will have to ask because I want to know too. That's a great question ..." Further interview on 7/2/24 with CD/QP #2 revealed: -"I want to say [Client #3] needs 1:1 ...don't know that it is written anywhere. They all have one on one care (in the community)..."	V 290		
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;	V 366		

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V 366	Continued From page 21 (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 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	V 366		

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V 366	Continued From page 22 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 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	V 366		

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V 366	Continued From page 23 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 written policies governing their response to the incidents as required. The findings are: Review on 6/24/24 of the Incident Response Improvement System (IRIS) from 1/1/24 to 6/24/24 revealed: -No level III incident report regarding unknown injury to Client #1 dated 2/14/24. -No documentation the LME/MCO were notified. Review on 6/24/24 of the Facility's internal investigation revealed: -No documentation of an internal investigation in response to an alleged incident which involved the Alternative Facility Living (AFL) Provider and an unknown injury to Client # 1 on 2/14/24. -No documentation of facility's response to Child Protective Services (CPS) allegation and investigation of the incident dated 2/14/24. -Clinical Director/Qualified Professional #2 (CD/QP #2) made aware of incident with Child Protection Services (CPS) investigation "after the fact." Interview on 6/26/24 with the Qualified Professional #1 (QP #1) revealed: -"I did my care coordination log to show who I talked to and what we talked about. That's how I	V 366		

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V 366	Continued From page 24 do my investigations." -"I did not hear about marks when I spoke with [Client #1]." -"I did not follow up with CPS. I did not do a level III incident report. [Clinical Director/Qualified Profession QP #2 (CD/QP#2)] was responsible for submitting incident reports." Interview on 6/27/24 with the CD/QP #2 revealed: -"I was made aware (of the allegation) after the fact. [AFL Provider] bought up in the meeting as a case of concern..." -"With the hustle and bustle of everything, I did not think to ask the AFL Provider for a copy of the CPS letter." -"The case was unsubstantiated. I didn't think any more about it and no one has ever called or notified me of anything." Further interview on 6/27/24 with the CD/QP #2 revealed: -Was responsible for ensuring investigations and incident reports were completed. -Failed to attend to the health and safety needs of the client involved in the incident. -Failed to determine the cause of the incident. -Failed to develop and implement corrective measures. -Failed to develop and implement measures to prevent similar incidents from occurring. -Failed to assign person(s) to be responsible for implementation of the corrections and preventive measures.	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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V 367	Continued From page 25 (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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601374	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR MADE HOME	11209 POINTER RIDGE DRIVE CHARLOTTE, NC 28214

(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 367	Continued From page 26 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.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TAYLOR MADE HOME	11209 POINTER RIDGE DRIVE CHARLOTTE, NC 28214

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V 367	Continued From page 27 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to submit Level III incident reports to the LME/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are: Review on 6/24/24 of the Incident Response Improvement System (IRIS) Report from 1/1/24 to 6/24/24 revealed: -No level III incident report regarding the unknown injury to Client #1. Review on 6/26/24 of Client #1's Coordination of Care Log, dated 2/15/24 at 2:30pm with the AFL Provider revealed: -"Communicated Via: direct." -"Area/Problem Discussed:[The AFL Provider] processed with the QP to let him express his feelings towards the accusations (related to unexplained injury to Client #1's eye). He was a little confused and worried that bigger action would need to take place. I asked if this would affect him and [Client #1]'s therapeutic relationship and he agreed that it would not. Will follow up with him." -"Comments/Concerns: Only concerns are the accusation. QP will follow up with [Client #1] as well." Interview on 6/26/24 with the Qualified Professional #1 (QP #1) revealed: -"I did my care coordination log to show who I talked to and what we talked about. That's how I do my investigations."	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 28 -"I did not hear about marks when I spoke with [Client #1]." -"I did not follow up with CPS. I did not do a level III incident report. [Clinical Director/Qualified Profession QP #2 (CD/QP#2)] was responsible for submitting incident reports." Interview on 6/27/24 with the CD/QP #2 revealed: -"I was made aware (of the allegation) after the fact. [AFL Provider] bought up in the meeting as a case of concern..." -"With the hustle and bustle of everything, I did not think to ask the AFL Provider for a copy of the CPS letter." -"The case was unsubstantiated. I didn't think any more about it and no one has ever called or notified me of anything." -Was responsible for ensuring investigations and incident reports were completed. -Failed to submit a level III incident report for Client #1's unexplained eye injury.	V 367		