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
	MHL092-411	A. BUILDING: ______ B. WING ______	R-C **09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS SUPERVISED CARE	**7016 BEAVERWOOD DRIVE RALEIGH, NC 27616**

(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 September 20, 2024. The complaints were unsubstantiated intake (#NC00220212 and #NC00221433). 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 5 and has a current census of 4. The survey sample consisted of audits of 2 current clients and 1 former client.	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		

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

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to implement 1 of 3 current client's treatment plan strategies (#4) and 1 of 1 former client's treatment plan strategies (FC#5). The findings are:

A. Review on 9/12/24 of FC#5's record revealed:
- admitted 5/13/20 & discharged 7/20/24
- diagnoses: Moderate Intellectual Disability, Impulse Control, Hypothyroidism and Thrombocytopenia
- a treatment plan dated 3/1/24:
- "...in January 2020 [FC#5] fell and broke his left arm...has not regained any significant uses of his left arm and is not expected that he will...has resulted in an increase in support needs to complete personal care and daily living task..."
- "... [FC#5]'s increased stability is with 1:1 staffing...continues to exhibit physical and verbal aggression...individual staffing helps to address frustration at the time [FC#5] begins to experience and prevent escalation ...due to decrease in mobility and increase in age... need 1:1 staffing..."
- "...[FC#5's] guardian prefers him to stay in his current placement due to its location...however as [FC#5]'s mobility declines and presence of stairs becomes an issue in the home (facility), the team is actively seeking new placement..."

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V 112	Continued From page 2	V 112		

Observation on 9/12/24 at 11:58am of the facility revealed:
- the facility was split level, it consisted of the following:
- 5 stairs led to the downstairs area which consisted of: FC#5's and client #4's bedroom, a sitting area and bathroom
- 7 stairs led to the upstairs area which consisted of the kitchen area, living room and bedrooms

Review on 9/12/24 of the facility's incident reports for FC#5 revealed:
- "3/28/24 at 4:30pm: staff prepared dinner heard thump in his (FC#5)'s room ...came downstairs, [FC#5] on floor & bleeding in back of his head ...transported to ER (emergency room) ...received 3 sutures..."
- "4/21/24 at 1pm: [FC#5] walked to bathroom without assistance ...staff went downstairs ... [FC#5] on commode with blood running downside of face. Blood came from spot he had sutures ...placed band aid on spot and monitored..."
- "7/14/24 at 2:35pm:...said he fell out of bed and had a scratch on his temple with minimum blood ...staff cleaned spot ...no bruising"
- "7/16/24 - complained of pain in shoulder and pain in his back. [staff #1/Licensee's son] called [Licensee]....[Licensee] looked at residents (FC#5's) arm and decided to transport [FC#5] to [hospital] ....resident arm was fractured..."

Review on 9/13/24 of the local hospital discharge summaries for FC#5 revealed:
- admitted & discharged on 3/28/24 for a "mechanical fall"
- "occipital scalp 1 centimeter laceration...will require closure"
- "chief complaint: ...unsteady and patient

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V 112	Continued From page 3	V 112		

(FC#5) got up without assistance and hit his head against the door frame ...per group home staff...patient stumbled and fell into doorway...no report of loss of conscious ...no pain complaints, shortness of breath..."
- admitted & discharged on 7/16/24:
- "chief complaint in triage ...patient wheeled to triage with complaints of right shoulder pain/injury, patient also has abrasion to right side of cheek, right knee and bruising to right outer ankle...had a fall on Sunday...large bruise noted to right shoulder upper arm ...able to move extremities equally ...patient does not remember ...fall was not witnessed. He managed to get himself up after the fall but staff noted some abrasions to the face and knees and subsequently determined that he had fallen...group home staff looked at his shoulder today (7/16/24) and noticed significant swelling and bruising ...no headaches...show a proximal humerus fracture with no underlying dislocation ...orthopedic advised a sling ..."

During interview on 9/12/24 client #2 reported:
- he recalled the 7/14/24 incident
- he and staff #5 were upstairs and heard a thump downstairs
- they went downstairs and found FC#5 beside his bed
- FC#5 said he fell and did not say anything else
- did not see 1:1 staff with FC#5
- if staff #1/Licensee's son was 1:1 staff, he would leave work "right" at 12pm

During interview on 9/18/24 staff #5 reported:
- worked the weekend shift from Friday 8pm - Sunday 8pm
- no 1:1 staff on the weekends
- worked with all the clients

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V 112	Continued From page 4 - recalled 1 time in 2024 FC#5 fell in the bathroom - he was upstairs and heard a fall downstairs - FC#5 had fallen in the bathroom - a little blood dripped down FC#5's face and he applied first aid - he was upstairs during the 7/14/24 incident - FC#5 came upstairs and said he fell and bumped his head - he saw a little blood on his head, and applied first aid - FC#5 went on an outing and had no further complaints on 7/14/24 - he assisted FC#5 that night (7/14/24) with his pajamas and there were no bruises or complaints from FC#5 - he made staff #3 aware of the fall and requested staff #3 monitor FC#5 During interview on 9/18/24 staff #3 reported: - on 7/14/24, he worked 8pm - 8am the next day (7/15/24) - FC#5 was in the bed when he arrived on 7/14/24 - no complaints from FC#5 on his shift During interview on 9/16/24 staff #1/Licensee's son reported: - worked 8am - 12pm Monday - Friday, no weekends - he became FC#5's 1:1 in February 2024 or March 2024 - from 12pm - 3pm he was the 1:1 for FC#5 - no incidents of falls when FC#5 was in his care - FC#5 had a walker to use in the facility and in the community - he came to work on 7/15/24 and FC#5 complained of some shoulder pain - on 7/16/24 FC#5 had "low energy" and when	V 112		

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V 112	Continued From page 5 he touched his shoulder to assist him upstairs for breakfast, he complained of shoulder pain. He called the Licensee - the Licensee transported FC#5 to the emergency room During interview on 9/18/24 FC#5's Care Manager with the Local Management Entity/Managed Care Organization (LME/MCO) reported: - was FC#5's Care Manager since October 2023 - FC#5 was supposed to have 1:1 staff during awake hours Monday - Sunday - staff #1/Licensee's son was FC#5's 1:1 staff - he (Care Manager) made announced visits to the facility and staff #1/Licensee's son was present with FC#5 and at times, other clients were present with only staff #1/Licensee - was not aware FC#5 did not have 1:1 staff on the weekends - "that doesn't make sense not to have a 1:1 on the weekends" - FC#5 needed assistance daily due to limitations with his left arm and limited mobility During interview on 9/20/24 the Licensee reported: - FC#5 had 1:1 staff from 8am - 8pm Monday - Friday by his son (staff #1/Licensee's son) - no 1:1 weekend staff for FC#5 - the LME/MCO cut funding for the weekend staff - he could not recall when the funds were cut but planned to reach out to his case management office to find out - had informed the Care Manager during each monthly visit, FC#5 needed a higher level of care due to the decline in his mobility	V 112		

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V 112	Continued From page 6	V 112		

B. Review on 9/12/24 of client #4's record revealed:
- admitted June 2020
- diagnosis: Autism
- treatment plan dated 3/1/24:

"...nonverbal...requires 1:1 staff during all awake hours...he can go from agitation to aggression quickly and will do the following: charge staff, make loud noises, bang on mirrors, jump up and down, break personal items, push against staff and scream..."

Observation on 9/12/24 of client #4 revealed no 1:1 staff present at the following times:
- 11:42am: staff #1/Licensee's son present with client #2 & client #4
- 11:58am: client #4 sat on his bed and listened to his iPad
- 12:25pm: staff #4 arrived and staff #1/Licensee's son left
- 3:02pm: client #4 came out his bedroom and charged at client #2. Client #2 held his fist out and bumped fist client #4. Client #4 fist bumped fist client #2 and returned to his bedroom. Client #4 laughed loudly in his bedroom

Observation on 9/16/24 of client #4 revealed no 1:1 staff present at the following times:
- 12pm - 2:28pm - client #4 remained in his bedroom and his iPad played loudly
- 12:07pm - staff #1/Licensee's son left and staff #2 arrived at the facility and was present with client #2 & #4
- 2:02pm: staff #2 walked in client #4's bedroom briefly and left out
- 3:15pm: client #4 made loud noises in his bedroom
- 3:22pm - client #4 left out of the bathroom and clapped his hands loudly as he returned to his bedroom

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During interview on 9/16/24 staff #2 reported:
- worked Monday - Friday with times varying from either 9am - 3pm or 12pm - 4pm
- he was the 1:1 for client #4 however there were times "I worked alone with [clients #1 - #2] & [FC#5]"

During interview on 9/16/24 the Licensee reported:
- was aware client #4 did not have 1:1 staff at times
- was in the process of hiring additional staff to meet client #4's needs

Review on 9/20/24 of the Plan of Protection dated 9/20/24 written by the Licensee revealed:
- "What immediate action will the facility take to ensure the safety of the consumers in your care? All consumers who are in need of one on one staff will from this day Sept. (September) 20, 2024 will receive one on one staffing. Presently there are one on one staff available to provide this service. Will go through all updated plans to make sure all residents needs or goals are being met for there safety and progress."
- "Describe your plans to maker sure the above happens. I will be on duty as a one on one staff until interviews are finished for hired staff. Staff will be hired on or before next week and start on 9/30/24. There will be 2 staff on at all times to cover the one on one."

This deficiency constitutes a re-cited deficiency.

Clients were admitted to the facility with diagnoses of Moderate Intellectual Disability, Impulse Control and Autism. Client #4 and FC#5's treatment plans documented they needed 1:1 staff daily to meet behavioral needs and

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V 112	Continued From page 8 FC#5's mobility issues. The 1:1 staff assigned to client #4 and FC#5 worked alone with 4 other clients in the facility. There were no 1:1 staff for client #4 and FC#5 on the weekends. FC#5 fell on 2 different occasions during weekend shifts. On March 28, 2024, the staff was upstairs, and FC#5 fell downstairs hitting his head which resulted in 3 sutures. On July 14, 2024, the staff was upstairs, and FC#5 fell downstairs resulting in a humerus fracture to the right arm. On 9/12/24 and 9/16/24, client #4 was observed at least 9 times without a 1:1 staff an attempted on one occasion to charge at client #2. The Licensee was aware at times client #4 and FC#5 did not have 1:1 staffing. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 112		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which	V 289		

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V 289	Continued From page 9 serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).	V 289		

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V 289	Continued From page 10 This Rule is not met as evidenced by: Based on observation and interview the facility failed to provide residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have developmental disabilities for 4 of 4 current clients and 1 of 1 discharge client (FC#4). The findings are: Observation on 9/12/24 at 11:58pm of the facility revealed: - the staff bedroom had clothes on the bed and miscellaneous items on dresser During interview on 9/16/24 the Licensee reported: - the facility was his personal resident - he received mail at the facility - he lived at the facility	V 289		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (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	V 367		

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V 367	Continued From page 11 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 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	V 367		

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V 367	Continued From page 12 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. This Rule is not met as evidenced by: Based on record review and interview the facility	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-411	A. BUILDING: ______ B. WING ______	R-C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS SUPERVISED CARE	7016 BEAVERWOOD DRIVE RALEIGH, NC 27616

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V 367	Continued From page 13 failed to ensure a Level II incident reported was submitted to the Local Management Entity/Managed Care Organization. The findings are: Review on 9/12/24 of the Incident Response Improvement System (IRIS) revealed: - no documentation of a 3/28/24 incident Review on 9/12/24 of a facility's level one incident report dated 3/28/24 revealed: - "...staff was upstairs preparing dinner when staff heard a loud thump. The consumer was in his room when staff was upstairs preparing dinner. staff came downstairs to find consumer (FC#5) sitting on the floor with the back of his head bleeding. Staff applied first aid to stop bleeding and bandaged his wound...took consumer to the emergency room...staples (3) in his head..." During interview on 9/12/24 the Licensee reported: - his case management office was supposed to submit the incident reports	V 367		
V 784	27G .0304(d)(12) Therapeutic and Habilitative Areas 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (12) The area in which therapeutic and	V 784		

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 784	Continued From page 14 habilitative activities are routinely conducted shall be separate from sleeping area(s). This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure therapeutic and habilitative activities were routinely conducted and were separate from sleeping areas. The findings are: Observation on 9/12/24 at 11:58pm of the facility revealed: - downstairs area had a sitting area with recliners and a couch During interview on 9/18/24 staff #5 reported: - he was the weekend staff - came in on Fridays and left on Sundays - he slept on the couch in the downstairs area - he could better monitor client #4 and FC#5 when he slept downstairs During interview on 9/20/24 the Licensee reported: - was aware staff #5 slept on the couch downstairs - he planned to make the staff's office into a bedroom	V 784		