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
	MHL080097	A. BUILDING: _____ B. WING _____	C 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY LANE	208 HICKORY LANE SALISBURY, NC 28146

(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 survey was completed on 10/16/24. One complaint was substantiated (intake #NC222519) and the other one was unsubstantiated (intake #NC222527). 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 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	V 112	RECEIVED NOV 12 2024 DHSR-MH Licensure Sect	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/5/24

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V 112	Continued From page 1 obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement goals and strategies to meet the individual needs of 1 of 3 clients (Client #2). The findings are: Reviews on 10/9/24 and 10/14/24 of Client #2's record revealed: - Admission Date: 2/17/23 - Diagnoses: Moderate Intellectual Disabilities; Obsessive-Compulsive Disorder (D/O); Autistic D/O; Attention Deficit Hyperactivity D/O; PICA (eating non-food items) of infancy and childhood; Sensorineural Hearing Loss, unilateral, with restricted hearing on the contralateral side; Asthma; Congenital Deformities of Hip; and Partial Trisomy - No goals nor strategies to address behaviors of going into other clients' bedrooms and having fights with other clients. Interview on 10/14/24 with staff #5 revealed: - She did not know of any goals nor strategies to address the behaviors of client #2 going into other clients' bedrooms and having fights with other clients. Interview on 10/14/24 with staff #4 revealed: - The only strategy he was aware of to address the behavior of client #2 going into other clients'	V 112	QP will schedule with Behavior Specialist provide training on current behaviors for Client #2. Adminstrator will re-inservice the Direct Support Supervisor (DSS) and Direct Support Professional (DSP) scheduling and appropriate coverage. Adminstrator will review schedule to ensure adequate coverage is provided during waking hours. IDT team will conduct random phone and/or visual checks at least 3 times per week for the next 30days The Nursing Team with Primary Care Provider and/or Psychological Provider to re-evaluate the effective ness of current medications.	

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V 112	Continued From page 2 bedrooms would be the use of medication. Interview on 10/14/24 with staff #3 revealed: - The only goal or strategy she knew to address the fights between client #2 and other clients was to use a "PRN" (as needed medication to calm client). Interview on 10/16/24 with the Administrator/Qualified Professional (QP) revealed: - There were no goals nor strategies in client #2's treatment plan to address his behavior of going into other clients' bedrooms and having fights with other clients. - She had not been made aware if a treatment team had been scheduled to address client #2's behaviors of going into other clients' bedrooms and fights with other clients. - "That is scheduled today to reach out to [client #2's] Behavioral Specialist to schedule a treatment team meeting."	V 112		
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	V 290	RHA Health Services will ensure appropriate DSP staffing is in place at all times at the Hickory Lane facility in order to protect the people supported and other DSP staff members.in the facility.	

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V 290	Continued From page 3 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 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 interviews, record reviews, and observations, the facility failed to ensure staffing to meet the individualized needs of the clients served. The findings are:	V 290	The IDD Administrator will re-inserviced, Direct Support Supervisor and all Direct Support Staff to ensure client #2 has 1:1 staffing during waking hours. The QP and IDD Administrator will developed an emergency back-up plan for DSP staffing issues that arise daily at the facility. The clinical and administrative team members will cover shifts as needed when other DSP staff are unavailable to work. No other client than Client #2, requires a 1:1 staff.	

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V 290	Continued From page 4 Reviews on 10/9/24 and 10/14/24 of Client #2's record revealed: - Admission Date: 2/17/23 - Diagnoses: Moderate Intellectual Disabilities; Obsessive-Compulsive Disorder (D/O); Autistic D/O; Attention Deficit Hyperactivity D/O; PICA (eating non-food items) of infancy and childhood; Sensorineural Hearing Loss, unilateral, with restricted hearing on the contralateral side; Asthma; Congenital Deformities of Hip; and Partial Trisomy - A Behavioral Support Plan dated 6/15/24 included: "1. Taking objects that do not belong to him. 2. Intentionally urinating and defecating in areas other than the toilet. He also urinates in his bed during sleep. 3. Tearing and destroying items that are his or that belong to others. 4. Inappropriate sexual contact with others and /or exposing himself. 5. Picking the skin on his fingers and biting his nails. 6. Self-injurious Behaviors (SIB) such as head banging, hitting his body against items that can cause injury. 7. Biting and chewing non-food items. 8. Making false allegations. Approved Restrictive interventions currently in place per his ISP (Individual Support Plan)... [Client #2's] bedroom door has chimes on it to alert the staff due to the severity of his target behaviors. The RHA (Licensee) team felt it was necessary to know [client #2's] whereabouts day and night in the home. He continues to need 24/7 supervision and structure to keep him safe...Try to primarily verbal redirection...The use of any least restrictive physical intervention should be employed with discretion...and as a last resort...If	V 290		

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V 290	Continued From page 5 it is impossible to help [client #2] de-escalate and he gets aggressive and/or starts walking away, simply wait with him and ask for back up assistance." Review on 10/9/24 of an Internal Incident Report dated 9/17/24 revealed: - Staff making report: staff #4 - Date of Incident: 9/10/24 - Time of Incident: 7:15 pm - "[Client #2] came out of his bedroom and entered into another client's (client #1) bedroom. While in the bedroom a fight ensued. After that fight several more fights ensued. Staff (staff #4) broke up several fights. The fighting lasted on and off until the shift almost ended. (11:00 pm)." Review on 10/9/24 of "Nursing Note" completed by the Registered Nurse (RN) revealed: - Date: 9/11/24 - "This nurse completed a full head to toe assessment on resident (client #2) per administrator's request. During the assessment, Dime size knot noted medial forehead and posterior left head. this nurse noted a bright red scratch to L (left) forehead approximately 1 inch long, 1/2 inch bright red scratch to right corner of forehead. Approximately 1/2 inch bright red scratch on bridge of nose and under right eye. Approximate 2.5 inch scratch traveling from middle of nose to top of mouth, Approximate 1/4 inch bright red mark near right tragus (a small, pointed piece of cartilage on the outside of the ear that covers the ear canal) and upper right cheek, Three healed scratches noted to anterior right upper arm varying in size. Bruise noted to anterior left upper arm approximately 2 inches in length and dime size in diameter. Healed scratch noted to posterior L hand and wrist approximately 1 inch. Bright red scratch ranging from lower right	V 290		

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V 290	Continued From page 6 neck to upper right chest approximate 4 inches long. Various healed scratches noted to right and middle of torso. Various healed scratches along upper back. Two bright red perpendicular scratches noted on medial back approximately 4 inches long. No scratches, wounds or bruising noted on bilateral legs. RTL (Residential Team Lead) (staff #5) present in home during assessment. Administrator notified of findings" - Date: 10/19/24 - "Seen by nursing today. Previous abrasions and cuts noted on consumer (client #2) has healed remarkably. No redness noted previous observed sites. No new marks seen on consumer during full body assessment. Consumer denies any pain at time of assessment. This nurse to follow up as needed." Interviews on 10/10/24, 10/11/24 and 10/16/24 with client #1 revealed: - In August 2024, he and client #2 got into a fight and staff #4 was the only staff working that night. - Client #2 had come into his room and "I pushed him out of my room." - When he pushed client #2, staff #4 told client #2 to go back to his own bedroom. - Staff #4 told him to "stay out of it" (client #2's behavioral issues) "so I won't get in trouble." - Client #2 went back into his own bedroom. Then client #2 "kept coming out of his room and coming into my room." - "[Client #2] came into my room probably like 50 times. It was nighttime before 3rd shift came in and when 2nd shift ends." - Client #3 was asleep in his bedroom during the entire incident. Client #2 tried to go into Client #3's bedroom. "[Staff #4] stopped him (client #2) by locking the door." Staff #4 locked the door from the inside of the bedroom. - "[Staff #4] told me to lock my door so [client #2]	V 290		

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V 290	Continued From page 7 could not come in." - In the den area, "I restrained [client #2] that night. I got on him (client #2). [Client #2] was on his back on the floor and I was on top of him holding his hands. [Client #2] got up and tried to hit me. [Staff #4] said to me '...let him (client #2) go.' " - Staff #4 got a chair and sat in a chair near the computer area in den (between client #1's bedroom and client #2's bedrooms). "Trying to block [client #2] from going into my room." - Client #2 "tried to get to my room (again) and he pushed [staff #4] when he was sitting in the chair." - When client #2 tried to come into his room again, he scratched client #2's neck, face and back. "I have long nails because I don't like to cut my nails." - When he scratched client #2, "[staff #4] told me to let him go and go to my room...I went to my room." - While in the den area, he hit client #2 with a belt. He hit client #2 on his stomach, his bottom and face. Staff #4 told him to "give me the belt." - Client #2 tried to grab a plastic bottle and he grabbed the bottle first and threw the bottle outside. - At some point in the night he "stomped" on client #2 in the stomach in the den. "[Staff #4] said to 'stop doing that' and I stopped. [Staff #4] told [client #2] to go to his room and he told me to go to my room." - A plastic light switch cover in the den was broken when he pushed client #2 into the light switch. When this occurred staff #4 told them to stop fighting. - A plastic outlet cover was broken when he pushed client #2 into the outlet and his leg hit the outlet. - There had been prior incidents of fights between	V 290		

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V 290	Continued From page 8 him and client #2 when client #2 went into his bedroom or when client #2 "copies me." He was unable to provide dates or how often the previous fights occurred. - He felt staff #4 tried to stop him and client #2 from fighting the night of the incident. - The fights ended that night when he and client #2 stayed in their bedroom. He was in his bedroom when 3rd shift arrived. Interview on 10/10/24 with client #2 revealed: - Denied that he and client #1 had a fight. - On 9/10/24, he did not know why he had marks, bruises, or scratches on himself. - He hurt himself "a little bit." - He felt safe in the facility. - He was not afraid to say anything. Attempted interview on 10/10/24 with client #3: - Unable to interview client #3 as he was nonverbal. Interview on 10/14/24 with client #2's Legal Guardian revealed: - It was reported that her son had been "acting out" on 9/10/24 because he was trying to go into another client's bedroom (unknown which client) and that he had marks on his body. She had not seen him since the incident. - It was also reported to her that there were allegations against a 2nd shift staff who had been suspended pending an investigation. - Her son received one-on-one care "maybe parts of the day where he has someone (staff) dedicated to him but it is not all day." - "He's (client #2) either not going to sleep or getting up during the night and that's when these incidents are happening at 10 or 11 o'clock at night and they are down to one person (staff). There is not sufficient support to handle these	V 290		

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V 290	Continued From page 9 incidents." Interviews on 10/10/24 and 10/14/24 with staff #4 revealed: - On 9/10/24 he worked alone. The incident between client #1 and client #2 started "around 7:00 pm that evening and it went on until 11:00-11:30 pm." - "[Client #2] kept going into [client #1's] room and I would go get him out of [client #1's] room." - Then he locked client #1's bedroom from the inside to prevent client #2 from getting into the bedroom. He told client #1 to ignore client #2. - After he locked client #1's bedroom door, client #1 came out of his bedroom. "Then there was a fight (between client #1 and client #2)." - Client #1 and client #2 started the fight in client #1's bedroom and they came out to the hallway. "They were punching and grabbing each other. I broke it up in the hallway." He then told client #1 to go back into his bedroom and he walked client #2 to his bedroom. - As he walked client #2 to his bedroom, client #2 "yelled something" to client #1 and client #1 ran up the hallway. The clients did not hit each other because he stood between them in the hallway. - Client #1 and client #2 went back to their bedrooms for a short period of time. - Client #1 and client #2 then came back out and that is when he moved a chair to the hallway in between their bedrooms and sat in the chair. - Client #2 ran out on the back porch. He went on the back porch to get client #2. Client #1 walked around him and grabbed client #2 and brought him inside. He told client #2 that he could "not grab anybody." - Once client #1 and client #2 were inside in the den area "they started wrestling. They grabbed each other." He gave the clients "verbals" to stop. Then he pulled them away from each other.	V 290		

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V 290	Continued From page 10 - After that client #1 and client #2 separated for a while. - Then around 10:00 pm, he sat down in the chair that was in the hallway between client #1's bedroom and client #2's bedroom. He did this "because I knew there was going to be another behavior." - As he sat in the chair client #2 crawled on the floor to get to client #1's bedroom. - "[Client #2] would never go to bed. He might sit a few minutes and then he would be right back. This might have been the worst behavior I had seen with [client #2] that night." - At some point during the fights, client #1 brought a belt out of his bedroom and hit client #2 twice on his back. He took the belt from client #1. - The red marks on client #2's back were from when client #2 wrestled with client #1. - The scratches on client #2 occurred when client #1, who had long nails, scratched client #2. - The outlet cover in the den got broken when client #1 and client #2 wrestled and slid into it. - "I was trying to get in between them (client #1 and client #2). I was trying to break them up when they fell and slid into the wall (and broke the outlet cover)." - "I was alone and I had no help...There was a lot that happened that night." - "Even before this behavior I had asked [former QP (Qualified Professional)] for some help on my shift (3 pm- 11 pm). All [client #2's] behaviors were happening at the same time between 10 pm and 11 pm. At first [former QP] said they were going to get them some help and then later said something about the budget and they could not afford to get help." - "When [client #2] has his big behaviors there is no woman who can handle [client #2]. I can't handle [client #2] at times." - "I am stuck and I need a job."	V 290		

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V 290	Continued From page 11 - Prior to the 9/10/24 incident, client #2 had gone into client #1's bedroom "countless"' times and had "a lot of them (fights)" with client #1. Client #2 had also gone into client #3's bedroom 3-4 times. Client #2 seemed to want to go into client #1's bedroom the most because he knows this "bothers" client #1. Review on 10/15/24 of Internal Incident Report dated 8/6/24 revealed: - Staff making report: staff #4 - "Around 10:30 pm [client #2] told staff he felt like he was sick and that he had to vomit. [Client #2] stuck his hand in his mouth but he was not able to make himself vomit. Shortly after trying to make himself vomit [client #2] went into another client (client #1's) room and laid on the floor. After asking [client #2] to move out of his housemate (client #1's) room for several minutes [client #2] finally left the area. [Client #2] went right back in the other client area and a fight ensued. [Client #2] was scratched on his face and his back. Marks is showing both areas of the body. [Client #2] tried to return to the client area several times. Staff tried to talk to [client #2] several times during the shift..." - Note by former QP: "[Client #2] will be closely monitored with add'l (additional) staff in place. Med (medication) mgmt. (management) will continue. Guardian was notified and continuous follow up..." Interview on 10/10/24 with staff #1 revealed: - She worked as client #2's one-on-one staff Monday-Friday 7:00 am - 3:00 pm. From 3:00 pm until 7:00 am and on the weekends only one staff member worked with the 3 clients in the facility. - When she came to work on 9/10/24, she did not see any marks or bruises on client #1. - "[Client #2] had scratches on his neck and	V 290		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	Continued From page 12 scratches on his upper back. [Client #2] had scratches on one of his upper arms (unsure which arm). His face had a red mark/bruise on his forehead above his eye (unsure which side). He had a scratch on his face." - She asked [client #2] what happened. "He kept saying he didn't know at first and then said, 'me and [client #1] were fighting.' " - She noticed that in the den area the plastic piece around the light switch and outlet cover were "torn up." - Staff #3 and staff #2 told her the light switch and outlet cover had been broken during the 9/10/24 fight between client #1 and client #2. Interview on 10/10/24 with staff #3 revealed: - She worked as client #3's one on one staff Monday-Friday 7:00 am - 3:00 pm. - When she came into work on 9/10/24, she noticed there was a hole near the light fixture in the den. - Client #2 told her that he was pushed into the light fixture by client #1 the night before. - She noticed that client #2's nose was red and one of his eyes was bruised underneath. - "[Client #2] wants to get at someone all the time and if he can't get to [client #3] first he will then start going to [client #1's] room over and over. [Client #1] will ignore it as long as you say ignore. When [client #2] gets in [client #1's] room that's when [client #1] will react and start pushing him out of there. [Client #1] will put his arms around [client #2] and picks him up to get him out of his room." - Prior to the 9/10/24 incident, she had sent a group text to staff #5, the Administrator/QP and the former QP and told them she was not comfortable working alone with client #2. - Client #2 had gone into client #1's bedroom and client #3's bedroom "a lot of times. I can't even	V 290		

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	MHL080097	A. BUILDING: _____ B. WING _____	C 10/16/2024

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V 290	Continued From page 13 keep count." - Prior to the 9/10/24 incident there had been "little scuffles" between client #1 and client #2 when client #2 went into client #1's bedroom. Interviews on 10/10/24 and 10/11/24 with staff #5 revealed: - She worked as the Direct Support Supervisor. - On 9/10/24 staff #4 had called her late in the afternoon and said that client #2 had behaviors but did not go into details. She asked staff #4 if he needed anything and he said "no." She told staff #4 to call her if he needed anything and he never called back. - She went into work on 9/10/24 around 10:00 pm-11:00 pm. - When she came into the facility, client #2 stood outside of his bedroom and the facility was dark. She asked client #2 how he was doing and he said he was fine and was going to bed. - She noticed when she went into the den area the light switch cover was broken and there was a hole in the wall above the light switch cover. - Staff #4 told her that client #2 hit his head on the light switch and outlet on the wall. - The next morning, she saw scratches on client #2's neck and a red spot on his left forehead and a red mark coming down the side of his head. She also saw scratches on his upper back. She called the former QP who told her to bring client #2 to the day program so that he could be seen by a nurse. - When she asked client #2 what happened he told her he did not know. - When she brought client #2 back to the facility on 9/11/24, she talked to client #2's one-on-one staff (staff #1). - Staff #1 told her that client #1 said he threw a cup at client #2. Client #1 had told staff #1 he had to help staff #4 'get [client #2]' the night	V 290		

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V 290	Continued From page 14 before. - She felt the fight between client #1 and client #2 on 9/10/24 caused the marks, bruises, and scratches to client #2. - All 3 clients had one on one services during the weekdays from 7:00 am - 3:00 pm. At all other times, including the weekends only one staff worked. - Staff #3 and former staff #7 told her they were "afraid" to work alone with client #2. - She felt more staff working on 2nd and 3rd shift during the weekdays and weekends would help a lot. - Prior to 9/10/24 client #2 had gone into the other clients' bedrooms and had fights with client #1. Attempted interview on 10/11/24 with the former QP: - Unsuccessful as the phone number no longer worked. Interview on 10/14/24 with staff #6 revealed: - She worked as client #1's one on one staff for 2 weeks. - She had not witnessed any fights between client #1 and client #2. - She had witnessed client #2 going to client #1's bedroom door and client #3's bedroom door "about every day." Interviews on 10/11/24 and 10/16/24 with the Administrator/QP revealed: - She had become the acting QP when the former QP gave immediate notice and left on 9/21/24. - During an internal investigation about the 9/10/24 incident, "[client #1] admitted to hitting [client #2] with a belt. He admitted to hitting or pushing [client #2] into the wall and the scratches on [client #2] were caused by [client #1's] fingernails."	V 290		

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V 290	Continued From page 15 - Staff #4 had worked 2nd shift alone since she had been the Administrator (November-December 2023). - The 3 clients in the facility had one on one services during the weekdays from 7:00 am-3:00 pm because that was all their plans authorized. Client #2 received one on one services because he did not like being part of a group. - She knew that client #2 had a history of going into client #1's bedroom but did not know how many times this had occurred. She had always "heard" it was client #1's bedroom that client #2 would try to go into. She had not heard that client #2 had gone into client #3's bedroom. - "I heard they (client #1 and client #2) were arguing prior to 9/10/24 and [client #2] would go after [client #1]." She did not know how many times this had occurred. - "What we are going to do (from here on out) is put another staff in the home on 2nd shift to have the extra supervision. [Client #2's] meds are being re-evaluated again today because he is tired and irritable all day due to staying up at night." Review on 10/15/24 of the Plan of Protection dated 10/15/24 written by the Administrator/QP revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. The RHA (Licensee) Administrator will re-Inservice the Direct Support Supervisor and all Direct Support Professional at Hickory Lane to ensure supervision is adequate, there will be additional staff during waking hours. 2. The RHA Clinical Team (Administrator, QP, Nursing Staff, Hab (Habilitation) Spec (Specialist), Administrative Staff, etc.) will do a random phone and/or visual checks at least 3 times per week with the Hickory Lane DSP	V 290		

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V 290	Continued From page 16 (Direct Support Professional) Team to ensure appropriate staffing is in place at the home for the next 30 days. 3. The Nursing Team will discuss with Primary Care Provider and/or Psychological Provider to re-evaluate the effectiveness of current medications. Describe your plans to make sure the above happens. 1. The Direct Support Supervisor will ensure appropriate staffing for [client #2] is in place or come in and ensure coverage is appropriate for the Hickory Lane location. 2. The QP will develop a back-up emergency plan to address staffing ratio and ensure the residents are protected. 3. Clinical and Management Team may cover shifts when other Direct Support Professionals are not available." The facility served clients with diagnoses of Moderate Intellectual Disabilities; Obsessive-Compulsive D/O; Autistic D/O; Attention Deficit Hyperactivity D/O; PICA of infancy and childhood; Sensorineural Hearing Loss, unilateral, with restricted hearing on the contralateral side; Asthma; Congenital Deformities of Hip; and Partial Trisomy. On 9/10/24 staff #4 worked alone when several fights occurred over a 4-hour period between client #2 and client #1. The fights occurred after client #2 repeatedly went into client #1's bedroom and the one staff working had to repeatedly break up the fights. The staff reported they cannot handle client #2 alone and need additional help. The staff also reported being afraid to work alone with client #2. During the week the facility had one staff member who worked from 3:00 pm until 7:00 am and one staff who worked on every shift on the weekends.	V 290		

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V 290	Continued From page 17 This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 290		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on interviews, the facility failed to report all allegations against health care personnel within 24 hours of the health care facility becoming aware of the allegation. The findings are: Review on 10/9/24 of the North Carolina Incident Response Improvement System (IRIS) revealed: - Date of Incident: 9/10/24 - Submitted by: the Former Qualified Professional (QP)	V 318	QP will re- inservice staff on report ing incidents immediately as they occur. QP will submit IRIS reports within 24hrs of incidents.	

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V 318	Continued From page 18 - "An investigation was initiated on 09/12/2024 to look into an allegation of abuse while in the home. SU (supported user) (client #1) informed administrator that [staff #4] grabbed [client #2] at the back of his neck to remove him from hitting another SU." Review on 10/14/24 of reports made by the facility against health care personnel revealed: - "Date submitted 9/19/24" - "Incident date: 9/10/24" - "Accused Individual Information: [staff #4]" Interview on 10/16/24 with the Administrator/QP revealed: - She did not report within 24 hours of learning about the abuse allegations because she thought she was supposed to fax over the report to health care personnel after the internal investigation was completed.	V 318	Type text here The Adminstrator/ QP will ensure that all allegations will be reported in a 24 hr turn around time. QP will retain proof of submission.	
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; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;	V 366		

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V 366	Continued From page 19 (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 review team shall complete all of the activities as follows: (A) review the copy of the client record to	V 366		

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V 366	Continued From page 20 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 applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 21 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement written policies governing their response to level II incidents as required. The findings are: Review on 10/9/24 of Internal Incident Report dated 9/17/24 revealed: - Staff making report: staff #4 - Date of Incident: 9/10/24 - Time of Incident: 7:15 pm - "[Client #2] came out of his bedroom and entered into another client's (client #1) bedroom. While in the bedroom a fight ensued. After that fight several more fights ensued. Staff broke up several fights. The fighting lasted on and off until the shift almost ended." Review on 10/15/24 of Internal Incident Report dated 8/6/24 revealed: - Staff making report: staff #4 - "Around 10:30 pm [client #2] told staff he felt like he was sick and that he had to vomit. [Client #2] stuck his hand in his mouth but he was not able to make himself vomit. Shortly after trying to make himself vomit [client #2] went into another client (client #1's) room and laid on the floor. After asking [client #2] to move out of his housemate (client #1's) room for several minutes [client #2] finally left the area. [Client #2] went right back in the other client area and a fight ensued. [Client #2] was scratched on his face and his back. Marks is showing both areas of the body. [Client #2] tried to return to the client area several times.	V 366	QP will collaborate with Behavior Specialist regarding interventions to address behaviors and preventative measures. The nursing team with the Primary Care /Pychological Provider will meet to disc uss the effectiveness of current medica tions.	

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V 366	Continued From page 22 Staff tried to talk to [client #2] several times during the shift..." Review on 10/10/24 of the Incident Response Improvement System (IRIS) revealed: - No risk/cause analysis was submitted into IRIS for the incidents which occurred on 8/6/24 and 9/10/24. Interview on 10/16/24 with the Administrator/QP revealed: - She did not determine the cause of the incident. - She did not develop and implement corrective measures - She did not develop and implement measures to prevent similar incidents - She did not assign staff members to be responsible for implementation of the corrections and preventative measures.	V 366	Type text here	
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 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	V 367		

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V 367	Continued From page 23 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 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	V 367		

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V 367	Continued From page 24 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 reviews and interviews, the facility failed to report all Level III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are:	V 367	QP will re-service the Direct Support Supervisor and Direct Support Staff on incident reporting what defines an IRIS report. QP will report Level II and Level III into the IRIS reporting system.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 25 Review on 10/9/24 of Internal Incident Report dated 9/17/24 revealed: - Staff making report: staff #4 - Date of Incident: 9/10/24 - Time of Incident: 7:15 pm - "[Client #2] came out of his bedroom and entered into another client's (client #1) bedroom. While in the bedroom a fight ensued. After that fight several more fights ensued. Staff broke up several fights. The fighting lasted on and off until the shift almost ended." Review on 10/15/24 of Internal Incident Report dated 8/6/24 revealed: - Staff making report: staff #4 - "Around 10:30 pm [client #2] told staff he felt like he was sick and that he had to vomit. [Client #2] stuck his hand in his mouth but he was not able to make himself vomit. Shortly after trying to make himself vomit [client #2] went into another client (client #1's) room and laid on the floor. After asking [client #2] to move out of his housemate (client #1's) room for several minutes [client #2] finally left the area. [Client #2] went right back in the other client area and a fight ensued. [Client #2] was scratched on his face and his back. Marks is showing both areas of the body. [Client #2] tried to return to the client area several times. Staff tried to talk to [client #2] several times during the shift..." Review on 10/10/24 of the North Carolina Incident Response Improvement System (IRIS) revealed: - No IRIS report was submitted regarding the 9/10/24 and 8/6/24 incident. Interview on 10/16/24 with the Administrator/QP revealed: - Level II incident reports had not been completed on 9/10/24 and 8/6/24 because "If this was peer	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080097	A. BUILDING: _____ B. WING _____	C 10/16/2024

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V 367	Continued From page 26 on peer (physical fighting) we always do it as a Level 1."	V 367		