STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-751	A. BUILDING: _____ B. WING _____	C 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCESS HEALTH SYSTEM 1	5132 DICE DRIVE RALEIGH, NC 27616

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V 000	INITIAL COMMENTS A complaint survey was completed on 3/17/25. The complaint was substantiated (Intake #NC00227403). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 1 current client.	V 000		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children.	V 115		

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V 115	Continued From page 1	V 115		

This Rule is not met as evidenced by:
Based on observation, record reviews and interviews, the facility failed to provide supervision to ensure the safety and welfare of 1 of 1 audited clients (#1). The findings are:

Review on 2/21/25 of client #1's record revealed:
- Admission date: 2016
- Diagnoses: Schizophrenia, Personality Disorder, Hypertension
- Treatment Plan dated 6/8/24 with the following information:
  - "He (client #1) has a history of incarceration for rape. He is on the sex offender registry."
- Form titled "Level of Supervision needed in the Community" dated 2/10/25 with the following information:
  - "[Client #1] recently went to a neighbors' home at 11:00pm and threw pebbles or other debris at one of the windows. For this reason his unsupervised time is being revoked...."
  - "Moves about the neighborhood or community with continual staff supervision requiring staff to be within audible, visual, and physical proximity of the individual."
  - "[Client #1] had been engaging in unsupervised time in the community for several years. Staff and the administrator report that there had not been any issues of concern over the past few years. However on last night, 2/10/25 he went to a neighbors home and was throwing rocks at the window. Guardian was

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V 115	Continued From page 2 notified and agrees to revoke his time...He is only allowed to sit out on the back porch of the home (facility)." Attempted interview with client #1 on 2/21/25 was unsuccessful due to client #1's refusal to be interviewed. Interviews on 2/21/25 and 2/25/25 client #1's Department of Social Services (DSS) guardian reported: - Following an incident on 2/10/25 of client throwing objects at the neighbor's 15 year old daughter's window, he and the Qualified Professional (QP) met and revoked client #1's unsupervised time - On 2/16/25, he was notified that client #1 had knocked on the same neighbor's door and the police responded - Staff #1 was working on 2/18/25 - He was at the facility on 2/18/25 and saw client #1 in the back yard without a staff present - Staff #1, the Director, the QP, and he all met and discussed client #1's recent behaviors and steps they were taking - Was notified by the QP that client #1 had left the facility without supervision on 2/21/25 and 2/23/25 - The team is actively looking for a new placement for client #1 as well as attempting to involve the sheriff's department Interview on 2/20/25 the neighbor of the facility reported: - Client #1 came to her house on 2/15/25 and was knocking on the door - She attempted to contact the facility administrator before calling the police on 2/15/25 but did not get an answer - Client #1 was walking in the middle of the	V 115		

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V 115	Continued From page 3	V 115		

street and waving a lighter
- When the police arrived, client #1 had already returned to the facility
- She did not see staff come outside of the facility or interact with client #1 on 2/15/25

Interview on 2/21/25 the neighbor of the facility reported:
- She had just seen client #1 at a local grocery store at 2:15pm
- Client #1 was at the local grocery store alone

Interview on 2/24/25 the local police officer reported:
- He responded to a call about a suspicious person from the neighbor of the facility on 2/15/25
- Client #1 had returned to the facility when he arrived at the neighbor's home so he went to the facility to speak to client #1
- Staff #1 stated he "didn't want to get involved and that what [client #1] chose to do on his own unsupervised time was completely up to him"

Observation and interview on 2/21/25 staff #1 reported:
- He had worked at the facility since August of 2024 and he worked 2 weeks on and 2 weeks off
- His 2 week shift started on 2/14/25
- On 2/15/25, a local police officer knocked on the door of the facility around 8:30 pm
- The police officer took a report and spoke with client #1 about being at the neighbor's home
- Client #1 had 5 hours of unsupervised time in the community
- He did not know client #1's unsupervised time had been revoked
- "So they (the QP and client #1's DSS guardian) went through with pulling his (client #1) time?"
- "What do I do if he (client #1) leaves? I can't

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V 115	Continued From page 4 stop him." - At 11:45am, he did not know if client #1 was in the facility and had to go downstairs to see if he was there Interview on 2/24/25 staff #1 reported: - The police officer that came to the facility on 2/15/25 asked if client #1 had been outside and if he had seen anything - He told the officer that client #1 had been in the front yard alone but he did not know client #1 had gone to the neighbor's home - "I walked by the front window and saw him (client #1) standing in the front yard. This was before the unsupervised time was revoked" - He was notified client #1's unsupervised time was revoked on 2/16/25 following the incident with police involvement - The QP, client #1's DSS guardian and the Director were at the facility on 2/16/25 and notified him that the unsupervised time was revoked - Client #1 left the facility without supervision on 2/21/25 and he did not know until the neighbor called - On 2/23/25, client #1 left the facility again and he immediately notified the QP - He knew now what he was supposed to do if client #1 left the facility without staff - If client #1 left the facility without supervision, he would notify the police Interviews on 2/21/25, 2/24/25 and 2/25/25 the QP reported: - Client #1's unsupervised time was revoked on 2/10/25 with permission from client #1's guardian - Staff #2 was on shift and notified of the revoked unsupervised time, along with client #1 - Staff #1's shift started on 2/14/25 and he was	V 115		

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V 115	Continued From page 5 notified by her and the Director of client #1's recent behaviors and the revocation of the unsupervised time at the start of his shift - Staff #1 reported to her that he did not know client #1 had left the facility on 2/15/25 until the police arrived at the facility door - Client #1 continued to leave the facility without staff supervision - She was not aware that client #1 had left the facility on 2/21/25 until the neighbor called - She again reviewed the steps staff #1 should take if client #1 eloped "really really well" on 2/24/25 - "I told him (staff #1) to call me or [the Director] to staff it with us. Maybe one of us will be in the area and can find him (client #1). We don't want the police to do our jobs for us. We need to alert the police, but alert me first." - She is currently looking at other facilities that may be more appropriate for client #1 - The facility cannot meet his needs at this time and they have a responsibility to the community Interview on 2/24/25 the Director reported: - Client #1's unsupervised time was revoked on 2/10/25 following the incident with throwing pebbles at the neighbor's 15 year old daughter's window - When staff #1 came on shift on 2/14/25, "he got reports on everything that happened with [client #1] and was notified that the unsupervised time was revoked" - The facility was looking for alternate placements for client #1 due to the neighbors not feeling safe - She had spoken with client #1 therapist and psychiatrist regarding needed medication and treatment changes	V 115		

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V 367	Continued From page 6	V 367		
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 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	V 367		

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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 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

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V 367	Continued From page 8 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 interviews, the facility failed to report a Level III incident to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours. The findings are: Review on 2/21/25 of client #1's record revealed: - Admission date: 2016 - Diagnoses: Schizophrenia, Personality Disorder, Hypertension - Treatment Plan dated 6/8/24 with the following information: - "He (client #1) has a history of incarceration for rape. He is on the sex offender registry." Review on 2/21/25 of the Incident Response Improvement System (IRIS) revealed: - No reports for the facility for February 2025 Attempted review on 2/21/25 of the facility's incident reports for February 2025 was unsuccessful as no reports were provided. Review on 2/25/25 of the IRIS revealed: - A level III incident report submitted for client #1 by the Qualified Professional (QP) on 2/23/25 with the following information:	V 367		

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- "On the morning of 2/12/25 a neighbor in the community came to the group home (facility) to inform the staff (#2) that the client (#1) had been at her window at approximately 11:00 pm.
- "...On 2/15/25 the [local police department] came to the group home (facility) and advised that the client (#1) had gone to the same neighbor's home and went up to the door. The police advised the client (#1) to stay away from the neighbors property and according to the staff (#1) the police indicated that the sheriff's dept (department) would follow up...
- "...On 2/18/25, [the Director], staff (#2), guardian (client #1's DSS guardian) and QP arrived at the home (facility) to meet with the client (#1). He became very agitated and disruptive. The guardian went to the Magistrate's Office to file a petition for an emergency evaluation for involuntary commitment. The police came to the home (facility) and the client was not there. Staff (#1) called the police the next morning and client (#1) was subsequently transported to [local hospital] for an emergency evaluation. He was assessed by [doctor at the local hospital] and determined that he was not appropriate for an involuntary admission."

Interview on 2/20/25 the neighbor of the facility reported:
- On 2/10/25, client #1 was throwing objects at her 15 year old daughter's window around 1:00 am
- Notified the facility of client #1's action and someone from management contacted her about the incident on 2/10/25
- She knew client #1 was a sex offender because she looked up the facility address on the public registry website and he was registered at that address
- On 2/15/25, client #1 returned to her home

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V 367	Continued From page 10 and was knocking on her door around 8:00 pm - She contacted the police on 2/15/25 and client #1 returned to the facility - She had not seen client #1 since 2/15/25 Interview on 2/24/25 the local police officer reported: - He responded to a call about a suspicious person from the neighbor of the facility on 2/15/25 - When he arrived, client #1 had returned to the facility - He spoke with staff #1 and client #1 at the facility Interviews on 2/21/25 and 2/25/25 client #1's Department of Social Services (DSS) guardian reported: - He was notified on 2/10/25 that client #1 had been at a neighbor's window at 1:00 am on 2/10/25 - On 2/16/25, he was notified that client #1 had knocked on the same neighbor's door and the police responded - He filed a petition for involuntary committment (IVC) for client #1 - Client #1 was transported to the local hospital by the local police department on 2/19/25 - Client #1 had left the facility again on 2/21/25 without supervision and the police were contacted Interviews on 2/21/25 and 2/24/25 the QP reported: - She submitted incident reports for the facility - She was informed of client #1 going to the neighbor's window on 2/10/25 - The neighbor contacted the police on 2/15/25 because client #1 was knocking on her door - She should have submitted the incident report for the police involvment to IRIS on 2/18/25 and she did not	V 367		

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V 367	Continued From page 11 - Client #1's DSS guardian filed an IVC petition on 2/18/25 due to client #1's behaviors and the local police transported him to a local hospital on 2/19/25 - She submitted one report on 2/23/25 with the information for all the incidents included - She thought she included the information about the police contact on 2/21/25 for unplanned absence for client #1 Interview on 2/24/25 the Director reported: - The QP submitted incident reports for the facility - She did not "have any information different from what [the QP]" reported	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 habilitative activities are routinely conducted shall be separate from sleeping area(s). This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure the area in which therapeutic and habilitative activities were routinely conducted was separate from sleeping areas. The findings are:	V 784		

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V 784	Continued From page 12 Observation on 2/21/25 at 11:23 am revealed: - Staff #1 and staff #2 were inside the facility Interviews on 2/21/25 and 2/24/25 staff #1 reported: - He had worked at the facility since August of 2024 - He worked at the facility for 2 weeks and was then off for 2 weeks - There was not typically 2 staff working at the facility - His 2 week shift started on 2/14/25 - Staff #2 did not have transportation to leave the facility on 2/14/25 at the end of her 2 week shift and was unable to leave later in the week due to inclement weather - With both staff present at the facility, staff #2 had slept in the staff bedroom and staff #1 had slept on the couch Interview on 2/21/25 at 12:16 pm staff #2 reported: - She had worked at the facility for 10 years - There was not typically 2 staff working at the facility - She worked at the facility for 2 weeks and was then off for 2 weeks - She was leaving the facility today - She was "off duty and not allowed to be there (the facility)" Interview on 2/24/25 the Qualified Professional reported: - She was informed on 2/21/25 that staff #2 was still at the facility after her 2 week shift ended on 2/14/25 - When she was informed, she immediately notified the Director - Staff #1 and staff #2 did not notify anyone	V 784		

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that staff #2 was still present at the facility
- She had been at the facility on 2/18/25 for a meeting and did not see staff #2
- Staff #2 reported that she had stayed in the staff bedroom while the meeting was being conducted
- Staff #2 typically left immediately following the end of her 2 week shift
- Staff #2 informed her that she remained at the facility because she did not have transportation due to the inclement weather
- Staff #1 slept on the couch and staff #2 slept in the staff bedroom while both staff were at the facility overnight
- Staff #2 left the facility on 2/21/25

Interview on 2/24/25 the Director reported:
- The facility normally only had 1 staff working
- Staff #2 normally left the facility as soon as she was "off duty"
- Staff #2 was there past her typical 2 week shift because she was unable to secure transportation due to the inclement weather
- She was not sure where both staff had slept during the nights they were both at the facility