DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

VIA CERTIFIED MAIL

March 6, 2018

Timmy Rogers, Director
1806 Jeffries Cross Road
Burlington, NC 27217

RECEIVED
APR 06 2018
DHSR-MH Licensure Sect

RE: Type A1 Administrative Penalty
Alamance Homes II, 801 N. Mebane Street, Burlington, NC 27217
MHL # 001-237
E-mail Address: tb_rogers@bellsouth.net

Dear Mr. Rodgers:

Based on the findings of this agency from a survey completed on February 15, 2018, we find that Alamance Homes, LLC has operated Alamance Homes II in violation of North Carolina General Statute N.C.G.S. § 122C, Article 3, Clients' Rights for individuals with mental illness, developmental disabilities, or substance abuse issues. After a review of the findings, this agency is taking the following action:

Administrative Penalty – Pursuant to N.C.G.S. § 122C-24.1, the Division of Health Service Regulation, Department of Health and Human Services (DHHS), is hereby assessing a Type A1 administrative penalty of $2,000.00 against Alamance Homes, LLC for violation of 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512). Payment of the penalty is to be made to the Division of Health Service Regulation, and mailed to the Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, North Carolina 27699-2718. If the penalty is not paid within sixty (60) days of this notification, a 10% penalty plus accrued interest will be added to the initial penalty amount as per N.C.G.S. § 147-86.23. In addition, the Department has the right to initiate judicial actions to recover the amount of the administrative penalty. The facts upon which the administrative penalty is based and the statutes and rules which were violated are set out in the attached Statement of Deficiencies which are incorporated by reference as though fully set out herein.

Appeal Notice – You have the right to contest the above action by filing a petition for a contested case hearing with the Office of Administrative Hearings within thirty (30) days of mailing of this letter. *Please write the facility's Mental Health License (MHL) number at the top of your petition.* For complete instructions on the filing of petitions, please contact the Office of Administrative Hearings at (919) 431-3000. The mailing address for the Office of Administrative Hearings is as follows:

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION
WWW.NCDHHS.GOV
TEL 919-855-3795 • FAX 919-715-8078
LOCATION: 1800 UMSTEAD DRIVE • WILLIAMS BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 2718 MAIL SERVICE CENTER • RALEIGH, NC 27699-2718
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6714

North Carolina General Statute § 150B-23 provides that you must also serve a copy of the petition on all other parties, which includes the Department of Health and Human Services. The Department's representative for such actions is Ms. Lisa G. Corbett, General Counsel. This person may receive service of process by mail at the following address:

Ms. Lisa G. Corbett, General Counsel
Department of Health and Human Services
Office of Legal Affairs
Adams Building
2001 Mail Service Center
Raleigh, NC 27699-2001

If you do not file a petition within the thirty (30) day period, you lose your right to appeal and the action explained in this letter will become effective as described above. *Please note that each appealable action has a separate, distinct appeal process and the proper procedures must be completed for each appealable action*

In addition to your right to file a petition for a contested case hearing, N.C.G.S. § 150B-22 encourages the settlement of disputes through informal procedures. The Division of Health Service Regulation is available at the provider's request for discussion or consultation that might resolve this matter. To arrange for an informal meeting, you must contact DHSR at 919-397-6856. Please note that the use of informal procedures does not extend the 30 days allowed to file for a contested case hearing as explained above.

Should you have any questions regarding any aspect of this letter, please do not hesitate to contact us at the Department of Health and Human Services, Division of Health Service Regulation, Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718 or call Michiele Elliott, Eastern Branch Manager at 919-397-6856.

Sincerely,

Stephanie Gilliam

Stephanie Gilliam, Chief
Mental Health Licensure & Certification Section

Cc: DHSRreports@dhhs.nc.gov, DMH/DD/SAS
ncdma.dhsrnotice@lists.ncmail.net, Provider Enrollment DMA
Trey Sutten, Interim Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
Susan Osborne, Director, Alamance County DSS
Pam Pridgen, Administrative Assistant
File

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DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

March 6, 2018

Mr. Timmy Rogers, Director
1806 Jeffries Cross Road
Burlington, NC 27217

Re: Complaint and Follow-Up Survey completed February 15, 2018
Alamance Homes II, 801 N. Mebane St., Burlington, NC 27217
MHL # 001-237
E-mail Address: tb_rogers@bellsouth.net

Dear Mr. & Ms. Rogers:

Thank you for the cooperation and courtesy extended during the Complaint survey completed February 15, 2018. The complaint was substantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Type A1 rule violation is cited for 10A NCAC 27D .0304, Protection From Harm, Abuse, Neglect Or Exploitation, Tag V512
- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Type A1 violations must be ***corrected*** within 23 days from the exit date of the survey, which is March 12, 2018. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against Alamance Homes, LLC for each day the deficiency remains out of compliance.
- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, which is March 19, 2018.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is April 16, 2018.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.

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- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Mr. Bryson Brown at 919-855-3832.

Sincerely,

Maryland M. Chenier, LCSW, MPH

Maryland M. Chenier, LCSW, MSW, MPH
Facility Survey Consultant I
Mental Health Licensure & Certification Section

Cc: Trey Sutten, Interim Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-237	A. BUILDING: _____ B. WING _____	R-C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOMES II	801 N MEBANE STREET BURLINGTON, NC 27217

(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 February 15, 2018. Deficiencies were cited. The complaint was substantiated. (Complaint ID# NC00134293) This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes;	V 113	RECEIVED APR 0 6 2018 DHSR-MH Licensure Sect	

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V 113	Continued From page 1 (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility management failed to assure all required documentation was available in three of three audited client records (#1, #2 & #3.) The findings are:	V 113		
	Review on 1/31/18 of Client #1's record revealed: - Admission date of 7/30/15 - Diagnoses of Schizoaffective Disorder; Chronic Kidney Disease - Stage 3; Basal Cell Carcinoma; Arthritis; Hypertension; Hypothyroidism; Hyperlipidemia; Gastroesophageal Reflux Disease; Gout; B-12 Deficiency; Vitamin A Deficiency (Diet Related;) Thrombocytopenia; Anemia; Cataracts; Ceremen Impaction; Nicotine Addiction and Allergic Rhinitis - The client is his own guardian. - A treatment plan dated 2/28/17 was in the client's record. However, it was not signed by the client acknowledging his review and agreement with treatment plan goals. - There was no documentation of a signed		-Client was met with by staff and has signed Permission form	3/22

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V 113	Continued From page 2 statement from the client granting permission to provide treatment nor seek emergency care from a hospital or physician. Review on 1/31/18 of Client #2's record revealed: - Admission date of 12/2/15 - Diagnoses of Schizophrenia; Advanced Dementia; Stroke; Traumatic Brain Injury; Epilepsy; Seizures; Atrial Fibrillation; Osteoarthritis; Hypokalemia; Hypertension; Hyperlipidemia and B-12 Deficiency. - The client is his own guardian. - There was no documentation a screening and assessment was completed. - The last treatment plan in the client's record was dated 12/18/16 and was not signed by the client acknowledging his review and agreement with goals in the treatment plan. - There was no emergency information in the client's record. - There was no documentation of a signed statement from the client granting permission to provide treatment nor to seek emergency care from a hospital or physician. Review on 1/31/18 of Client #3's record revealed: - Admission date of 12/31/14 - Diagnoses of Schizophrenia; Bipolar Disorder; Osteoarthritis; Vitamin D Deficiency and Allergic Rhinitis. - The client has a DSS guardian. - English is the client's second language. He is limited English-speaking. - The emergency information in the client's record was incomplete and did not contain physician information or contact information. - The client's DSS guardian had not signed granting permission to seek emergency care from a hospital or physician.	V 113	- Screening and assessment form is placed book. - Client Signed treatment plan agreement and granted permission for emergency care - Clients DSS guardian has signed permission for for emergency care. - Clients physician Contact Information has been placed in his record book.	3/22 3/22 3/22 3/22

Division of Health Service Regulation

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V 113	Continued From page 3 Interview on 2/30/17 with the House Manager confirmed the above findings. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 113	Program Director will assure upon admission each individual client admitted to the facility will have all required forms signed by the client or legally responsible person.	3/22
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (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.	V 118		

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V 118	Continued From page 4 This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility management failed to assure: 1) medication was administered according to the physician's order; 2) physician's orders were available for all medications administered and 3) the MAR was kept current for three of three audited client records (#1, #2 & #3.) The findings are: Review on 1/31/18 of Client #1's record revealed: - Admission date of 7/30/15 - Diagnoses of Schizoaffective Disorder; Chronic Kidney Disease - Stage 3; Basal Cell Carcinoma; Arthritis; Hypertension; Hypothyroidism; Hyperlipidemia; Gastroesophageal Reflux Disease; Gout; B-12 Deficiency; Vitamin A Deficiency (Diet Related;) Thrombocytopenia; Anemia; Cataracts; Ceremen Impaction; Nicotine Addiction and Allergic Rhinitis Review on 2/7/18 of the December 2017 and January 2018 MARs revealed staff documented the client was administered the following medication as ordered from 12/1/17 thru 12/31/17 and 1/1/18 thru 1/3/18: 1. Levothyroxine 50 mcg; 1 tablet every AM 2. Fluoxetine 40mg, 1 capsule every AM 3. Divalproex 500mg, 1 every AM and two every night at bedtime 4. Saphris 5mg sublingual tablets, (Asenapine - antipsychotic tablet/medication used to treat the symptoms of schizophrenia, bipolar disorder and manic depression) 1 tablet every morning 5. Saphris 10mg sublingual tablets, 1 tablet every night at bedtime along with one 5mg tablet	V 118	Physicians orders have been placed in Client record books	3/22

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V 118	Continued From page 5 6. Clonazapam 1mg, 1 tablet every night at bed 7. Trazaodone 100mg, 1 every night at bedtime 8. Simvastatin 20mg, 1 every evening at bedtime 9. Vitamin B-6 mg, 2 tablets two times each day Additional review on 2/7/18 of Client #1's records revealed: - No documentation was available for medications administered in November 2017 - Current physician's orders were not available for medications staff documented they administered to the client in December 2017 and January 2018. During interview on 2/1/18, the House Manager said: - Staff did not return Client #1's November 2017 MAR to the facility following hospitalization in November 2017. - He said the client was in the hospital "for a few days" because he had MRSA (Methicillin-resistant Staphylococcus aureus.) However, he was uncertain of how long the client was in the hospital in November 2017 and could not provide documentation of medication administered before or after the hospitalization. Observation on 2/7/18 at 12:00 noon of Client #1's medications-on-hand revealed the following: - All medications were dispensed together in one bubble by date for AM or PM administration. - The following unopened bubbles dated dispensed by the pharmacy as noted were found: 1. All medications identified as AM medications for dates 11/15/17 thru 11/28/17 2. All medications identified as PM medications for dates 11/15/17 thru 11/26/17 3. Saphris 5mg sublingual tablets - a) 8/30/17 - one unopened box with 10 tablets; b) 10/23/17 - one partially used box with 3 tablets; c) 10/23/17 -	V 118	All doctor orders have been placed in Clients records Correct mar will be kept in Client records at all times. All medications will be documented correctly	3/22 3/22

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V 118	Continued From page 6 three unopened boxes with 10 tablets each and 11/27/17 - one unopened box with 10 tablets. 4. Saphris 10mg sublingual tablets - a) 10/23/17 - three unopened boxes with 10 tablets each and 11/27/17 - one unopened box with 10 tablets. Review on 2/8/18 of a hospital record admission record for Client #1 revealed: - The client was admitted to the hospital on 11/6/17 for treatment of cellulitis with sepsis and discharged to the facility on 11/24/17. - The discharge instructions, electronically signed by the client's physician, directed the above medications to be continued as ordered. During interview on 12/7/17, the facility's House Manager said: - He confirmed the above medications identified for Client #1 remained stored in the facility's medication closet. - Staff took Client #1 and his January 2018 medications to a rehabilitation facility on 1/4/18 at the directive of his brother/guardian. However, the client's February 2018 medications were available in the facility. - He said he did not know if the client was going to be discharged from the facility. Due to the following it could not be determined if Client #1 received his medications as ordered by his physician: 1. staff's failure to accurately document medication administration 2. all medications remaining in the client's medications-on-hand identified for administration for dates 11/25/17 thru 11/28/17 3. no documentation of medication administered prior to and after the client's hospitalization. Review on 2/1/18 of Client #2's record revealed:	V 118		

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V 118	Continued From page 7 - Admission date of 12/2/15 - Diagnoses of Schizophrenia; Advanced Dementia; Stroke; Traumatic Brain Injury; Epilepsy; Seizures; Atrial Fibrillation; Osteoarthritis; Hypertension; Hyperlipidemia; Hypokalemia and B-12 Deficiency. - December and January 2017 MARs documenting the client was administered the following medications: 1. Olanzapine (Zyprexa) 10mg, two tablets at bedtime. 2. Atorvastatin 10mg, one tablet once daily 3. Amlodipine 10mg, one tablet once daily 4. Memantine HCL 5mg, one tablet once daily 5. Lamotrigine 150mg, one tablet in the AM and one in the PM 6. MAPAP Arthritis 650mg, one tablet twice daily 7. Vitamin B-12 1000 MCG, one tablet once daily 8. Vitamin D3 1000 IU, one tablet once daily - No current physician's orders were present for the client to be administered the above medications.	V 118	PROGRAM DIRECTOR WILL ASSURE STAFF WILL BE PROPERLY TRAINED ON MEDICATION ADMINISTRATION AND DOCUMENTION. PROGRAM DIRECTOR WILL ASSURE IF A CLIENT GOES TO HOSPITAL STAFF WILL MAKE COPIES TO SEND WITH CLIENT AND ORGINAL WILL BE KEPT IN CLIENTS RECORDS.	3/22
	Interview on 2/1/17 with the House Manager: - Confirmed the above findings for Client #2. - He said he would obtain orders from the Veteran's Administration when the client saw the physician the following week. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.			
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible	V 121		

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V 121	Continued From page 8 for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility management failed to obtain a six months drug regimen review from a pharmacist or physician for 3 of 3 audited clients (#1, #2 & #3.) The findings are: Review on 1/31/18 of Client #1's record revealed: - Admission date of 7/30/15 - Diagnoses of Schizoaffective Disorder; Chronic Kidney Disease - Stage 3; Basal Cell Carcinoma; Arthritis; Hypertension; Hypothyroidism; Hyperlipidemia; Gastroesophageal Reflux Disease; Gout; B-12 Deficiency; Vitamin A Deficiency (Diet Related;) Thrombocytopenia; Anemia; Cataracts; Ceremen Impaction; Nicotine Addiction and Allergic Rhinitis. - There was no documentation a psychotropic drug regimen review was completed within the required time frame. Review on 1/31/18 of Client #2's record revealed: - Admission date of 12/2/15 - Diagnoses of Schizophrenia; Advanced Dementia; Stroke; Traumatic Brain Injury; Epilepsy; Seizures; Atrial Fibrillation; Osteoarthritis; Hypokalemia; Hypertension;	V 121		

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V 121	Continued From page 9 Hyperlipidemia and B-12 Deficiency. - There was no documentation a psychotropic drug regimen review was completed within the required time frame. Review on 1/31/18 of Client #3's record revealed: - Admission date of 12/31/14 - Diagnoses of Schizophrenia; Bipolar Disorder; Osteoarthritis; Vitamin D Deficiency and Allergic Rhinitis. - There was no documentation a psychotropic drug regimen review was completed within the required time frame. Interview on 2/1/17 with the House Manager: - Confirmed the above findings. - He said the facility recently changed to a different pharmacy and the reviews had not been conducted.	V 121	PROGRAM DIRECTOR WILL ASSURE A DRUG REVIEWS WILL BE DONE EVERY 6 MONTHS BY A PHARMACIST OR PHYSICIAN. PROGRAM DIRECTOR WILL ALSO ASSURE THAT CLIENTS BE PHYSICIANS INFORMED OF THE RESULTS	3/22
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 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	V 132		

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V 132	Continued From page 10 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 management failed to report allegations of abuse by Former Staff #1 against 1 of 3 audited clients (#1.) The findings are: Review on 1/31/18 of Former Staff #1's record revealed: - Hired as Direct Care Staff in June 2017. - No documentation of Health Care Personnel Registry of State and National Criminal Records Check. - Resigned after being transferred and working	V 132	- Staff records were misplaced. Staff is no longer working in facility	Dec. 2017

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V 132	Continued From page 11 two weeks in Licensee's other facility in December 2017. During interview on 2/6/18, Client #1 said: - He was physically assaulted at least two times by Former Staff #1 at the facility. - Former Staff #1 knocked him down when he was in the yard. - He reported the incident to assault to the House Manager who said he would inform the Licensee. - He also told his brother/guardian and his social worker about the assault. - His social worker reported the incident to the police. - The Licensee nor the facility Qualified Professional (QP) talked to him about the incident. During interview on 2/15/18 with the Licensee, he reported: - He was "out of the country" during the alleged incident and was not aware the client made an allegation that staff had neglected his needs and physically assaulted him. - He received a call from the House Manager that police were trying to contact him. - He told the QP to handle it and do a report. - He confirmed he did not complete an incident report and include a report of the allegation against Former Staff #1 in the Health Care Personnel Registry. - He said he "believed" the QP had completed an investigation and "called it in." However, he was unable to provide any documentation the QP completed an incident report or Health Care Personnel Registry report. Interview on 2/15/18 with the QP revealed: - She has been the QP since December 2017. - She said she "I was shocked. I didn't even know	V 132	Better observence and monitoring has been put in place for Client safety. Surveillance Cameras have been placed in both facilities 1 & 2.	Feb. 2018

Division of Health Service Regulation

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V 132	Continued From page 12 there was an investigation going on. I came in on the end of the situation." - She said she talked to police "a couple of weeks ago" in response to their call regarding the investigation, however she did not complete an incident report nor make a report on the allegation against Former Staff #1 to the Health Care Personnel Registry. - She said the Licensee informed her he was transferring Former Staff #1 to the other facility. However she also said "I can't report what I don't know."	V 132	PROGRAM DIRECTOR WILL ASSURE THAT WHEN HIRING NEW STAFF A CRIMINAL BACKGROUND CHECK AND HEALTH CARE PERSONAL REGISTRY IS DONE BEFORE STAFF HIRE DATE	3/22
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	V 290		

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V 290	Continued From page 13 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.	V 290		
	This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility management failed to: a) maintain required staff-client ratio (1 to 6) to enable staff to respond to individualized client needs affecting 1 of 3 audited clients (#2) and b) assure one staff member was present at all times when clients were on the premises who had not been assessed as capable of remaining in the home or community without staff supervision. affecting all clients in the facility. The findings are: Observation on 1/31/18 at 11:45 AM revealed: - Three clients in the facility without staff present. - A staff from the Licensee's facility located immediately next door across the street from the			

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V 290	Continued From page 14 facility ran to the facility upon the surveyor's arrival. - House Manager arrived to the facility approximately 45 minutes after the surveyor's arrival. Interview on 1/31/18 with the staff from the Licensee's other facility revealed: - He was preparing lunch for the clients in both facilities. - However, after he prepared lunch for the clients present in this facility he would return to prepare lunch in the facility next door where he was assigned as staff to supervise the six residents. - The House Manager left the facility several hours earlier to take a client to the hospital. He was uncertain of his return time however, expected it to be soon. Interview on 1/31/18 with the House Manager said: - None of the clients have authorization for unsupervised time in the community. - He did not report if any client had been authorized for unsupervised time in the facility. - He was unable to provide an assessment documenting if any client in the facility was determined to be capable of unsupervised time in home or community. However, he said "None of them have caused problems, so I think they could (have unsupervised time.)" Interview on 2/7/18 with the Licensee confirmed: - Clients in the facility had not been assessed for unsupervised time. - Clients may remain in the home without staff supervision when staff transport one of the clients to a doctor's visit. - The one staff in the home next door is available and responsible for monitoring the clients in both	V 290	- Clients are not left unsupervised unless stated in their treatment plan that they are allowed to be unsupervised and is kept in their client record.	3/22

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V 290	Continued From page 15 homes if a staff from either home has to leave the facility.	V 290	Program Director will Assure that Clients will Assessed after 30 days to determine if they are capable of being in the home or community without supervision. Unsupervised plans will be added to clients Treatment plan and kept in client files.	3/22
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	V 367		

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V 367	Continued From page 16 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 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	V 367		

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V 367	Continued From page 17 (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 management failed to report all level II that occurred while the client was on the provider's premises within 72 hours of becoming aware of the incident affecting 1 of 3 audited clients (#1.) The findings are: Review on 1/31/18 of Former Staff #1's record revealed: - Hired as Direct Care Staff in June 2017. - No documentation of Health Care Personnel Registry of State and National Criminal Records Check. - Resigned after being transferred and working two weeks in Licensee's other facility in December 2017. During interview on 2/6/18, Client #1 said: - He was physically assaulted at least two times by Former Staff #1 at the facility. - He also alleged staff neglected to give him with his proper medication, sheets for his bed and assist him with getting underwear. He said Client #2 was his roommate and when Client #2 was in the hospital, staff directed him to wear the roommate's underwear. - He reported the House Manager pushed him when he refused to take a bath when directed. - He also said Former Staff #1 knocked him down	V 367	- All staff Health Care registry and Criminal records are present in their record books.	3/22

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V 367	Continued From page 18 when he was in the yard. - He reported the incident to assault to the House Manager who said he would inform the Licensee. - He also told his brother/guardian and his social worker about the assault. - His social worker reported the incident to the police. - The Licensee nor the facility Qualified Professional (QP) talked to him about the incident. During interview on 2/15/18 with the Licensee, he reported: - He was "out of the country" during the alleged incident and was not aware the client made an allegation that staff had neglected his needs and physically assaulted him. - He received a call from the House Manager that police were trying to contact him. - He told the QP to handle it and do a report. - He confirmed he did not complete an incident report. - He did not report the allegation against Former Staff #1 to the Health Care Personnel Registry as required. - He said he "believed" the QP had completed an investigation and "called it in." However, he was unable to provide an incident report or any documentation the QP had talked to the client about the incident. Interview on 2/15/18 with the QP revealed: - She has been the QP since December 2017. She said "I should know everything that's going on." - She spent most of her time with Client #1 and said "I had a really good rapport with him." - She said she "I was shocked. I didn't even know there was an investigation going on. I came in on the end of the situation."	V 367		

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V 367	Continued From page 19 - She said she talked to police "a couple of weeks ago" in response to their call regarding the investigation, however she did not complete an incident report or conduct an internal investigation. - She said "I can't report what I don't know."	V 367	Program Director will assure that all Level II incidents be Reported within 72 hrs to the proper Authorities and Responsible parties for each client. Program Director will Assure the Health Care Registry and Criminal Records Check is done before Hire Date for staff. Program Director will Assure All clients At protected from any harm, Abuse or Neglect by any staff that is hired, staff will be immediately fired for any harm caused by staff	3/22
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility management failed to protect 1 of 2 clients (#1) from harm and abuse by one of one former	V 512		

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V 512	Continued From page 20 staff (FS #1) and failed to protect 2 of 2 clients from neglect (#1 & #2) by the House Manager. The findings are: 1). Review on 1/31/18 of Client #1's record revealed: - Admission date of 7/30/15 - Diagnoses of Schizoaffective Disorder; Chronic Kidney Disease - Stage 3; Basal Cell Carcinoma; Arthritis; Hypertension; Hypothyroidism; Hyperlipidemia; Gastroesophageal Reflux Disease; Gout; B-12 Deficiency; Vitamin A Deficiency (Diet Related;) Thrombocytopenia; Anemia; Cataracts; Ceremen Impaction; Nicotine Addiction and Allergic Rhinitis Interview on 2/6/18 with Client #1 revealed: - He was physically assaulted two times by staff at the facility. - He said the first time was around his birthday. He said "[House Manager] pushed me. He told me 'Get your bath right now!' I got so rattled I threw my glasses in the toilet." - He said the second time he was in the yard of the facility. "[Former Staff] knocked me down. He half-sucker punched me." - He said the House Manager was not present when the incident occurred, however he reported the assault to him. - The House Manager told him he would inform the Licensee. - He also told his brother/guardian and called his social worker to report the assault. During further interview on 2/6/18, Client #1 said: - "About Halloween all my (medical) problems started." - "I had blood in my urine. They got mad at me 'cause I couldn't make it to the bathroom." - "I had the sore on my foot about the size of a	V 512		

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V 512	Continued From page 21 silver dollar. I didn't tell anybody 'cause I didn't think they'd get me any antibiotics." - He said the House Manager thought it was a spider bite. "He took him to some religious women who vulcanized my foot." - "It got worse and [House Manager] took me to the hospital. I had MRSA (Methicillin-resistant Staphylococcus aureus.)" Review on 2/7/18 of the hospital report revealed: - "Date of Service -11/6/17, 7:31 PM; Chief Complaint: Left Leg pain and redness." - " [Client #1] presenting to the ED (emergency department) with a chief complaint of significant worsening of left lower extremity pain, redness and swelling which started with a small blister on the left foot. Denies any insect bites. Denies similar complains in the past. DVT (deep vein thrombosis) ruled out in the emergency department." "Patient has a large swollen fluid filled area to the top pf his left foot. Patient denies pain to foot at this time but group home staff states he was complaining of pain earlier." - "History of Present Illness: [Client #1] presents with significant left lower extremity redness and swelling with a large blister on the anterior surface of his left foot. According to the group home staff they did not see any redness or swelling the evening before when they got the patient dressed. Patient had complained of some pain earlier per the staff when asked when they noticed the swelling and redness. Patient described diffuse pain across his lower extremity and has a history of Schizoaffective disease and psychotic disorder along with a history of anemia and thrombocytopenia." Review on 2/7/18 of police reports from the facility from November 2017 through January 2018 revealed:	V 512		

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V 512	Continued From page 22 - On 12/13/17, local police responded to a report of "elder abuse/neglect" which was alleged to have occurred on 12/6/17. - Police report documented the client's allegations included: 1. staff at the facility had been abusive to him "verbally and physically" 2. staff pushed him down at least twice 3. staff did not provide him with sheets or proper medication. - Police spoke to the facility's Qualified Professional (QP.) The Licensee was not available and the House Manager was identified as one of the possible perpetrators. During interview on 2/7/18, Client #2 reported: - He and Client #1 used to be roommates. - He was outside and saw the former staff hit Client #1. - Client #1 fell on the ground after the staff hit him.	V 512		
	During interview on 2/7/18 with the House Manager he stated: - He had never been physically or verbally aggressive with any of the clients in the facility. - He denied he was ever informed Client #1 was assaulted by facility staff and/or alleged he was assaulted by staff. He said "I've never known no staff to hit him." - He reported Client #1 was "real bad and evil" and "hard to get along with" and made "multiple calls to police and crisis." During interview on 2/15/18 with the Licensee, he reported: - He was "out of the country" when he received a call from the House Manager regarding a police investigation. - He told the QP to handle it. She talked to the			

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V 512	Continued From page 23 police. - Police did "a full investigation" and determined the complaint was not valid. - He spoke to the former staff by phone to question him about the incident. "He said he didn't do it." - The former staff said "He wanted to take himself off the schedule for a while." - The former staff worked at the Licensee's other facility then "resigned." - He said he believed the QP had talked to clients and staff in the facility and "called it in" - However, he was unable to provide an incident report or any documentation about the incident. Interview on 2/15/18 with the QP revealed: - She has been the QP since December 2017 and was in the facility "every week." She said "I should know everything that's going on." - She spent most of her time with Client #1 and said "I had a really good rapport with him." - "He was very open with me. He never mentioned he was assaulted by staff." - The Licensee called her and said he was out of the country. He told her to "call the police and find out why they were trying to reach him." - She said she talked to police "a couple of weeks ago" in response to their call regarding the investigation. - She reported the Licensee said he was going to move the former staff (that was part of the police investigation) to the other house. - She did not talk to Client #1 nor to any of the other clients or staff about the incident to conduct an internal investigation. - She said "I can't report what I don't know." Interview on 2/15/18 with Client #1's brother/guardian revealed: - Client #1 informed him staff "knocked him down	V 512		

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V 512	Continued From page 24 on the ground." - Client #1 can be a "handful" - confrontational, easily agitated and used offensive language. - The client threw his glasses in the toilet a few months ago because he became agitated by staff's verbal interactions with him. - The brother/guardian said his expectation was that staff would know how to avoid situations and de-escalate his brother. "You can't be confrontational with people with mental illness." - He said "[Client #1] may exaggerate but he wouldn't lie." - He reported his brother had cellulitis which turned into sepsis. He said "It shouldn't have gotten as bad as it was without notice." - The House Manager told him he had to have a doctor's order to transfer his brother to another facility. He informed staff to move his brother to a rehabilitation facility in January 2018. 2). Review on 1/31/18 of Client #2's record revealed: - Admission date of 12/2/15 - Diagnoses of Schizophrenia; Advanced Dementia; Stroke; Traumatic Brain Injury (TBI;) Epilepsy; Seizures; Atrial Fibrillation; Osteoarthritis; Hypokalemia; Hypertension; Hyperlipidemia and B-12 Deficiency. - Assessment included in treatment plan that documented the client is frequently disoriented, has "limitations" with his vision and requires 24 hour staff supervision. During interview on 2/7/18, Client #2 revealed: - He was recently hospitalized after losing consciousness outside of the facility. - He said "They found me on the sidewalk with nothing on but my drawers!" - He was uncertain how or why he went outside of the facility.	V 512		

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V 512	Continued From page 25 - He did not know where staff was when the incident occurred. - He said the doctor said he probably had a seizure. During interview on 2/7/18, the House Manager: - Reported Client #2 was hospitalized for "about 2 hours a few weeks ago." The client "woke up tired and wouldn't eat." He called the Licensee who told him to transport the client to the hospital. - Confirmed staff found Client #2 outside of the facility in an unconscious state. - He was unable to say how the client left the facility without staff supervision and without proper clothing since he was not assessed to be capable of unsupervised time . - He could not say how long the client was outside the facility. - Staff called Emergency Services (EMS) to transport the client to the hospital since they could not arouse him. - He was not able to provide information about the client's hospitalization and did not have any documentation or discharge information from the doctor related to the reason for emergency care. - He confirmed he was aware Client #2 was diagnosed with conditions that placed him at high risk of loss of consciousness. Review on 2/8/18 of reports of EMS calls to the facility revealed: - EMS responded to a call from the Licensee on 1/12/18 at 7:32 AM for medical assistance. - The report documented the caller (Licensee) was not present at the facility and was unable to provide more details regarding Client #1's status, however he reported the client was "not responding well." - Client #2 was found "unconscious or fainting" on the sidewalk outside of the facility.	V 512		

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V 512	Continued From page 26 - EMS transported the client to the hospital"unconscious" with a possible "seizure." A Plan of Protection was requested during additional interview with the Licensee on 2/15/18. The Licensee said he would contact the facility's QP and fax the completed Plan of Protection to the surveyor by the end of the day. During follow-up phone contact with the QP, she stated she would try to assist the Licensee in completing the requested information. However, she also said she did not know there was an investigation being conducted and was informed at the "end of the situation." She said "I can't report what I don't know." Despite multiple attempts to obtain a Plan of Protection, a Plan of Protection was not received by the completion of this report. Client #1 was physically and verbally assaulted on two occasions by Former Staff #1(FS #1) and the facility's House Manager. During one of the assaults by FS #1, Client #1 was punched in the face and knocked down to the ground. The incident was witnessed by another client in the facility. In another of the abusive situations, he was pushed to the bathroom by the House Manager when he refused to bathe. The incident involving the physical assault by FS #1 was reported to the House Manager as well as to Adult Protective Services and the local police department. The facility management did not do internal investigations for these incidents and did not report the allegations/incidents to the Health Care Personnel Registry. The Licensee reported he was not aware Client #1 alleged staff physically assaulted him. However, he moved FS #1 to work with clients in his other facility located directly across the street. As staff in the Licensee's other facility, he was required to also	V 512		

Division of Health Service Regulation

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V 512	Continued From page 27 monitor clients in the facility where Client #1 was a resident if another staff was not present. However, FS #1 resigned approximately two weeks after the incident. There were no other efforts to assure clients were protected and staff were trained to properly meet the physical and medical needs of clients in the facility. Additionally, the House Manager neglected Client #1 when he did not recognize the need to seek appropriate and timely medical treatment for Client #1's foot infection, resulting in the client becoming septic and consequently hospitalized for more than two weeks. The House Manager thought Client #1 had a "spider bite" and initially took him to a non-medical source for treatment. Client #2 was found unconscious on the sidewalk outside of the facility without clothing. The House Manager was unaware Client #2 had left the facility. Client #2 has a diagnoses of Advanced Dementia; Epilepsy; Seizures; TBI and stroke. EMS was called and Client #2 was transported to the hospital and was believed to have had a seizure. This constitutes a Type A1 rule violation for serious abuse, harm and neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512	Program Director will assure that all incidents will be reported to any proper authorities within 72 hours. Program Director will assure that no abuse, harm or neglect will be done by any staff. Immediate termination will be given if any rights of clients are in violation Program Director will assure if the client has any medical issues arise staff will recognize and seek medical treatment immediately	3/22
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be	V 736		

Division of Health Service Regulation

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V 736	Continued From page 28 maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on record reviews, interviews and observation, the facility management failed to assure its grounds were maintained in a safe, clean, attractive and orderly manner. The findings are: Review on 1/31/18 of client records revealed the facility has six clients currently identified as residents in the facility. One client is currently hospitalized and may not return to the facility. Observation on 1/31/18 at 3:30 PM of the facility revealed: Client bedrooms: - Mattresses on beds in several of the client rooms were worn and dirty, sheets did not fit the bed mattress and were not clean. Client bathrooms: 1. Bathroom one - bathroom near the client living room/common area: - The entrance to the bathroom had a sudden drop down on the floor upon opening the door and entering the bathroom. - The drop-off at the door/entrance into the bathroom was approximately four inches. - The was no warning/notification of the step down/drop down in the floor levels from living room to bathroom thus creating the risk of stumbling and/or falling when stepping into the bathroom. - The toilet seat was too small and did not properly fit the toilet. Facility kitchen:	V 736	Progam Director will Assure facility will be safe and clean bed mattress will be replaced and clean sheet will be placed on beds. A warning sign will be placed at Door entrance to Avoid a fall. A new toilet seat will be replaced to properly fit toilet. Progam Director will replace linoleum on the kitchen floor refrigerator will no longer have a chain and padlock giving clients right to food and water if needed	3/22

Division of Health Service Regulation

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V 736	Continued From page 29 - The linoleum on the kitchen floor was cracked and broken. - The refrigerator door was locked with a chain and padlock. Interview on 2/1/18 with the House Manager confirmed the above findings. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736	All repairs, Cleaning and refrigerator incident have been Corrected.	3/22

Plan of Corrections Continued

Alamance Homes

March 28, 2018

V 113- Client Records	Pgs 1-4	Program director will ensure upon admission that each individual client admitted to the facility will have all required forms and a completed admission packet. All forms in the admission packet will be filled out completely and will be signed by the client and the legal responsible person. Forms will be updated as needed.
V 118- Medication Requirements	Pgs 4-8	Program director will ensure that all staff is properly trained on medication administration and documentation of medication. Program director will also ensure that if a client goes into the hospital that the staff will make copies of MAR and needed documents to send with the client. All original documentation will be kept in the client file.
V 121- Medication Requirements	Pgs 8-10	Program director will ensure that a drug review will be done according to policy by a pharmacist or physician. Program director will also ensure that clients are informed of all results
V 132- HCPR Notifications, Allegation & Protection	Pgs 10-13	Program director will ensure that a new staff's criminal background check and healthcare registry is done prior to staff hire date. Program director will also ensure that staff documents all allegation and immediately reports the finds to the appropriate personal. Program director will ensure that the QP is informed of all allegation immediately and together they will develop a corrective action plan.
V 290- Supervised Living Staff	Pgs 13-16	Program director will ensure that all clients are assessed after 30days for to determine if they are suitable for unsupervised time, which includes being in the community without supervision. Unsupervised plans will be added to clients' treatment plan and kept in the clients' file.
V 367 Incident Reporting Requirements	Pgs 16-20	Program director will ensure that all level II incidents are reported within 72hrs to the proper authority and responsible parties for each client. Program director will ensure that any report of abuse will be reported to the health care registry. Program director will ensure that all staff is trained on reporting and documenting abuse. Program director will ensure that all clients are protected from any harm, abuse or neglect by staff and if a situation occurs it will be reported immediately, and the staff will be terminated from their duties immediately.
V 512 Clients Rights,- Harm, Abuse, Neglect	Pgs 20-28	Program director will ensure that all incidents will be reported to the proper authorities within 72hrs. Program director will ensure that no abuse, harm, or neglect will be done by any staff, immediate termination will be given if any findings occur and the staff member will be reported

		to the healthcare registry. Program director that if client has any medical issues client will receive medical attention immediately.
V 736 Facility Grounds and Maintenance	Pgs 28-30	Program director will ensure that the facility is safe and clean. All mattress are in good condition with clean sheets will be on beds. A warning sign will be placed at door entrance to avoid a fall. A new toilet seat will be replaced to properly fit the toilet; program director will fix linoleum on the kitchen floor; refrigerator will no longer have a chain pad lock giving clients a right to food and water if needed;