STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 000	INITIAL COMMENTS An Annual, Follow up and Complaint survey was completed on 4/2/19. The complaint was substantiated Intake #NC00142818. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. *notation: this is a family owned business and for better understanding of this report, the staff are as follows: Licensee #1 (mother) Licensee #2 (father) Chief Financial Officer (paternal mother) staff #1 (Licensee #1 & #2's daughter)	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and	V 105		

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V 105	Continued From page 1 (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to implement their own admission's policy & assess whether or not the facility could provide services to meet an individual's needs. The findings are:

A. Review on 3/7/19 of the facility's admission policy revealed: "...if a consumer is expected to receive services for more than 30 days, the assessment will include the following: a social and family history; medical history...will conduct thorough screenings prior to admission of prospective consumers to include all available historical data from at least the past five years or prior two placements..." (a 5 page application for admission was attached to the policy)

Review on 3/6/19 of deceased client #5 (DC#5)'s record revealed:
- admitted on 12/31/18 & deceased on 1/2/19
- diagnoses listed on a January 2019 medication administration record were Hypertension; Deaf; Nonspeaking & Chronic Mastoiditis, unspecified

Review on 3/6/19 of a one page initial assessment for DC#5 revealed:
- completed by Licensee #2
- "presenting problem: mute; needs: stable residential placement; strengths: friendly"
- "diagnoses: Hypertension; nonspeaking"

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V 105	Continued From page 3 - the client's medications were listed - "social history: unknown; Medical History (blank) & Family History: mother & siblings listed" Review on 3/6/19 of an incident report dated 1/1/19 for DC#5 revealed: - "client (DC#5) received on 12/31/18 at approximately 8:00pm. The facility was being closed and had to have all consumers placed by 12/31/18. Consumer1 (DC#5) was deaf and mute but could communicate through her writing. Consumer1 first morning and afternoon in the facility were uneventful. Licensee #1 and #2 visited Consumer1 about 8pm on 1/1/19 and she seemed to be adjusting well to her new home and peers. At 3:30am staff #1 noticed the light on in Consumer1's room and went to see if Consumer1 needed assistance with anything. Consumer1 was up taking the linen off her bed because she had soiled them...staff #1 assisted Consumer1 in making her bed and changing her diaper. After doing so Consumer1 sat on the bed and began fanning herself as if she was hot. Staff #1 went to get Consumer1 some water and when she returned consumer1 was lying down on the bed. When staff #1 placed her hand on her shoulder Consumer1 did not respond and staff#1 noticed Consumer1 did not seem to be breathing. Staff #1 called Licensee #2 and stated that Consumer1 was unresponsive Licensee #2 told staff #1 to call 911 and report the situation." During interview on 3/6/19 & 3/7/19 staff #1 reported: - DC#5 knew sign language but staff were not familiar with sign language - she didn't know anything about DC#5's past history - she questioned why DC#5 was at the facility and not in a nursing home	V 105		

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V 105	Continued From page 4 - DC#5 would breath hard and kept falling During interview on 3/7/19 Licensee #1 reported: - DC#5 resided in an assisted living facility that was in the process of closing...DC#5 needed emergency placement - the assisted living facility was in the same neighborhood as the group home and the provider from the previous placement contacted her - she was informed DC#5 had an enlarged heart; was deaf/mute and had no where to go - she didn't want to admit DC#5 because she was nonverbal...she (Licensee #1) had not worked with a "deaf/mute" client before - DC#5 could write but it was on third or fourth grade level - DC#5 knew sign language however staff was not able to sign - prior to any admissions she normally requested psychological assessments, FL2's & physician notes - most clients admitted are from mental health hospitals - she had a FL2 with DC#5's diagnoses, however she was not able to locate it - due to DC#5 being an emergency placement, they did not have time to get assessments - clients will be better assessed in the future During interview on 3/7/19 Licensee #2 reported: - he & Licensee #1 met DC#5 on two occasions prior to her being admitted to the facility - she was nonverbal but communicated by writing...writing skills were limited - the provider at the previous placement said her only health issues were Hypertension and Vertigo - Licensee #1 requested medical information	V 105		

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V 105	Continued From page 5 from the previous provider but never received it - DC#5 had to be out of the assisted living facility by the 1st of the month (January 2019) due to the facility closing - he did not see a reason not to admit her, she was in good health, she could not speak but could write B. Review on 3/6/19 of client #3's record revealed: - discharged in August 2018 - readmitted to the facility in October 2018 - diagnoses of Schizophrenia, unspecified Intellectual Disability and Anemia - no documentation of an assessment completed prior to readmission During interview on 3/6/19 Licensee #1 reported: - client #3 was discharged and readmitted without completing another admission assessment. [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 and must be corrected within 23 days.]	V 105		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be	V 114		

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V 114	Continued From page 6 repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure drills were completed quarterly and on each shift. The findings are: Review on 3/6/19 of the facility's drills revealed: - the last fire & disaster drills were completed in March 2018 During interview on 3/6/19 client #2 reported: - during fire drills they met at the mailbox - tornado drills are practiced in the hallway...put your head down During interview on 3/6/19 client #4 reported: - drills were practiced at the facility - if it was a fire they met at the mailbox - tornado drills they met in the hallway During interview on 3/6/19 staff #1 reported: - drills were being completed but not documented During interview on 3/11/19 Licensee #1 reported: - she and staff #1 completed drills - she (Licensee #1) has not completed any lately - staff #1 informed her she completed the fire and disaster drills on the same day - she explained to staff #1, if drills were not documented, they were not done - she (Licensee #1) was responsible for	V 114		

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V 114	Continued From page 7 ensuring drills were completed	V 114		
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 8 This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure one of three audited client's (#2) and one of one deceased client (DC#5) medications were administered on the written order of a physician. The findings are: A. Review on 3/6/19 of client #2's record revealed: - admitted to the facility on 7/18/10 - diagnoses of Mild Intellectual Disability; Alcohol Abuse; Mood Disorder; Cocaine & Marijuana Dependence & Depressive Disorder - a FL2 dated 6/24/18 "Metformin 500mg twice a day (can treat type 2 diabetes)...blood sugars to be taken by consumer daily in rotation with meals and bedtime" Observation on 3/6/19 of client #2's glucometer revealed the following: - blood sugars stored with no year...no am/pm - 3/2 (109); 3/3 (91); 3/5 (86); 3/6 (95); 3/7 (91); 3/8 (108) During interview on 3/6/19 client #2 reported: - blood sugars were not documented - the blood sugars are stored in her glucometer - she checked her own blood sugars once a day - she was not sure why the glucometer showed blood sugars past the current date of (3/6/19) During interview on 3/6/19 staff #1 reported: - she does not document client #2's blood sugars - staff do not make sure client #2's blood sugars are checked - if client #2 had signs of dizziness, confusion or shaky hands staff would then check her blood sugars	V 118		

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V 118	Continued From page 9 During interview on 3/11/19 Licensee #1 reported: - there was a physician's order for client #2 to check her blood sugars daily - she would try to locate the physician's order - client #2 was responsible for checking her own blood sugars - staff monitor client #2 when she checked her blood sugars - client #2 documented her own blood sugars on paper - she (Licensee #1) has not checked the blood sugars documentation in a couple of weeks - she was not aware of any issues with client #2's glucometer During continued interview on 3/18/19 Licensee #1 reported: - she planned to purchase client #2 a new glucometer today - client #2 documented her own blood sugars as of 3/11/19 - blood sugars are recorded once a day - a physician's order for once a day was not submitted by the close of survey B. Review on 3/6/19 of DC#5's record revealed: - admitted on 12/31/18 & deceased on 1/2/19 - diagnoses listed on a January 2019 MAR were Hypertension; Deaf; Nonspeaking & Chronic Mastoiditis, unspecified - no physician orders for the medications Observation on 3/6/19 at 12:36pm revealed the following: - DC#5's medications in a grocery store bag - the bag of medications were in a locked medication cabinet Review on 3/6/19 of a January 2019 MAR	V 118		

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V 118	Continued From page 10 revealed the following medications: - Fluticasone spray 50mcg 2 sprays daily (can treat seasonal allergies) - Amlodipine 10mg everyday (can treat high blood pressure) - Loratidine 10mg everyday (can treat allergy symptoms) - Hydrochlorothiazide 12.5mg in the morning (can treat high blood pressure & fluid retention) - Losartan Potassium 100mg everyday (can treat high blood pressure) - Omeprazole 20mg everyday (can treat heartburn) - Escitalopram 10mg everyday (used to treat depression) - Aspirin 81mg everyday (common dose used to treat heart attacks) - Metoprolol 100mg everyday (can treat high blood pressure) - Clonidine .1mg twice a day (can treat high blood pressure) - Oxcarbazepine 300mg twice a day (can treat epileptic seizures) - Olanzapine10mg everyday (can treat mental disorders) - Atorvastatin 10mg bedtime (can treat high cholesterol) - Premarin vaginal cream dispense 1 GM via vagina twice a week (Tuesday & Friday) (used by women to to help reduce symptoms of menopause (such as hot flashes, vaginal dryness) - Meclizine 25mg - Antivert 25mg three times a day PRN (as needed) (can treat motion sickness & vertigo) - Isosorbid 30mg everyday (used for heart related chest pain, heart failure & esophageal spasms) - check blood pressure once daily 1 hour after medication pass (no documentation of blood	V 118		

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V 118	Continued From page 11 pressure checks) - all medications were initialed only on 1/1/19 with the exception of the Fluticasone spray and Premarin vaginal cream - the Meclizine was initialed twice on 1/1/19 with no times documented During interview on 3/6/19 staff #1 reported: - the provider from the previous facility informed her DC#5 no longer needed the Fluticasone spray or the Premarin vaginal cream - she was not sure why - she administered the Meclizine that morning but not that night - Licensee #1 checked DC#5's blood pressure on 12/31/18 but it was not documented - she does not recall the blood pressure reading but it was good. During interview on 3/11/19 Licensee #1 reported: - DC#5's blood pressure was checked by staff #1 but the blood pressures were not documented - she had a FL2 with DC#5's diagnoses, however she was not able to locate it [This deficiency constitutes re-cited deficiency] [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 and must be corrected within 23 days.]	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed	V 119		

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V 119	Continued From page 12 of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to dispose of a medication in a manner that guards against diversion or accidental ingestion for one of three audited clients (#2) and one of one deceased client (DC#5). The findings are: Review on 3/6/19 of the facility's disposal policy revealed: "...noncontrolled substances such as medications must be disposed of by flushing or returned to the pharmacy, there must be a witness...medication for a client who dies must be placed in a sealed bag for a reasonable amount of time and then if no question of reason for	V 119		

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V 119	Continued From page 13	V 119		

death, it is to be destroyed by incineration."

A. Review on 3/6/19 of client #2's record revealed:
- admitted to the facility on 7/18/10
- diagnoses of Mild Intellectual Disability; Alcohol Abuse; Mood Disorder; Cocaine & Marijuana Dependence & Depressive Disorder
- a FL2 dated 6/24/18 "Lantus 100 units inject 20 units at bedtime" (used to treat adults with type 2 diabetes)
- no discontinue order for the Lantus
- a physician's note dated 10/16/18: "past history of syncope (fainting), originally considered to be hypoglycemia...no longer on insulin..."

Observation on 3/6/19 at 1:23pm revealed:
- pharmacy disposal bags in a gray 2 drawer file cabinet in the kitchen area

Observation in the kitchen area on 3/6/19 at 4:52pm revealed:
- a miniature unlocked refrigerator with only a bottle of unopened Lantus insulin in it
- client #2's name was listed on it
- the Lantus was filled 1/26/17...refill after 2/17/17

During interview on 3/6/19 staff #1 reported:
- the miniature refrigerator was for medications only
- she kept the Lantus in case client #2 had to use the medication again

During interview on 3/11/19 Licensee #1 reported:
- the pharmacy did not have a copy of the discontinue order for Lantus
- she was not aware the Lantus was in the refrigerator
- she thought she had disposed of the Lantus

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V 119	Continued From page 14 after it was discontinued - the refrigerator should have been locked if the Lantus was in the refrigerator - the facility no longer used the miniature refrigerator B. Review on 3/6/19 of DC#5's record revealed: - admitted on 12/31/18 & deceased on 1/2/19 - diagnoses listed on a January 2019 medication administration record were Hypertension; Deaf; Nonspeaking & Chronic Mastoiditis, unspecified Observation on 3/6/19 at 12:36pm revealed the following: - one bag of medications in a grocery store bag - in the bag was DC#5's medications and an unknown person's medications - DC#5's medications consisted of the following: Fluticasone spray 50mcg 2 sprays daily (can treat seasonal allergies); Amlodipine 10mg everyday (can treat high blood pressure); Loratidine 10mg everyday (can treat allergy symptoms); Hydrochlorothiazide 12.5mg in the morning (can treat high blood pressure & fluid retention); Losartan Potassium 100mg everyday (can treat high blood pressure); Omeprazole 20mg everyday (can treat heartburn); Escitalopram 10mg everyday (used to treat depression); Aspirin 81mg everyday (common dose used to treat heart attacks); Metoprolol 100mg everyday (can treat high blood pressure); Clonidine .1mg twice a day (can treat high blood pressure; Oxcarbazepine 300mg twice a day (can treat epileptic seizures); Olanzapine10mg everyday (can treat mental disorders); Atorvastatin 10mg bedtime (can treat high cholesterol); Premarin vaginal cream dispense 1 GM via vagina twice a week (Tuesday & Friday)	V 119		

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V 119	Continued From page 15 (used by women to to help reduce symptoms of menopause (such as hot flashes, vaginal dryness); Meclizine 25mg - Antivert 25mg three times a day PRN (as needed) (can treat motion sickness & vertigo) & Isosorbid 30mg everyday (used for heart related chest pain, heart failure & esophageal spasms) - Unknown person's medications (all dispensed 12/19/18) were as follows: Gabapentin 100mg 2 by mouth three times a day (2 pills missing) (can treat seizures & pain caused by shingles); Metformin 500mg twice a day (2 pills missing) (can treat type 2 diabetes); Glipizide 10mg twice a day (2 pills missing) (can treat type 2 diabetes) & Colace 100mg twice a day (3 pills missing) (a stool softener) During interview on 3/6/19 staff #1 reported: - she doesn't know the unknown person - he was not a client at their facility - she did not notice the unknown person's medication in the bag - she kept DC#5's medications because "she did not know what to do with it" - she did not know what the disposal bags sent from the pharmacy was used for - sometimes the pharmacy sent the wrong medicine & she thought the bags were used for that During a later interview on 3/6/19 staff #1 reported: - she recalled the unknown person's medication being in the bag with DC#5's medication - the medications were brought in the grocery bag by the prior facility - she took DC#5's medication out of the bag when she arrived to the facility - the unknown person's medications were left	V 119		

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in the bag
- after DC#5 passed away she put her medications back in the grocery bag with the unknown person's medications

During continued interview on 3/7/19 staff #1 reported:
- on the night on 1/1/19 she went to get DC#5 a Meclizine
- the Meclizine was not administered because DC#5's medical status changed before it was administered
- she threw the Meclizine in the trash can.

During interview on 3/6/19 the Chief Financial Officer reported:
- she was responsible for the disposal of the medications
- she was not aware the unknown person's medications were in the grocery bag
- she was not familiar with the unknown person
- she got behind on the disposal of medications but would dispose of the medications today
- the clients' primary physician disposed of their medications
- she was not aware there were pharmacy disposal bags at the facility
- she planned to take the medications to the clients' primary physician to dispose of the medications

During interview on 3/11/19 Licensee #1 & #2 reported:
- a reasonable amount of time to dispose of a medication would be within 3 business days
- for current, discharged or the death of a client

During interview on 3/20/19 Licensee #2 reported:
- there has not been a time when medications

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V 119	Continued From page 17 were disposed of by incineration - medications were disposed of by the clients' physician - he will review the disposal policy for changes [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 and must be corrected within 23 days.]	V 119		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure one of three audited client's (#2) medication was securely	V 120		

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V 120	Continued From page 18 locked in a cabinet. The findings are: A. Review on 3/6/19 of client #2's record revealed: - admitted to the facility on 7/18/10 - diagnoses of Mild Intellectual Disability; Alcohol Abuse; Mood Disorder; Cocaine & Marijuana Dependence & Depressive Disorder - a FL2 dated 6/24/18 "Lantus 100 units inject 20 units at bedtime" (used to treat adults with type 2 diabetes) Observation in the kitchen area on 3/6/19 at 4:52pm revealed: - a miniature unlocked refrigerator with only a bottle of unopened Lantus insulin it - client #2's name was listed on it - the Lantus was filled 1/26/17...refill after 2/17/17 During interview on 3/6/19 staff #1 reported: - the miniature refrigerator was for medications only During interview on 3/11/19 Licensee #1 reported: - she was not aware the Lantus was in the refrigerator - the refrigerator should have been locked if the Lantus was in the refrigerator [This deficiency constitutes re-cited deficiency] [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 and must be corrected within 23 days.]	V 120		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which	V 289		

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provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.
(b) A supervised living facility shall be licensed if the facility serves either:
(1) one or more minor clients; or
(2) two or more adult clients.
Minor and adult clients shall not reside in the same facility.
(c) Each supervised living facility shall be licensed to serve a specific population as designated below:
(1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses;
(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;
(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;
(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;
(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or
(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other

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V 289	Continued From page 20 disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to provide residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, developmental disabilities and substance abuse disorder who require supervision when in the residence for four of four (#1, #2, #3 & #4) clients and one of one deceased client (DC#5). The findings are: A. Cross reference tag (V105). 10A NCAC 27G .0201 GOVERNING BODY POLICIES. Based on record review and interview the facility failed to implement their own admission's policy & assess whether or not the facility could provide services to meet an individual's needs.	V 289		

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V 289	Continued From page 21 B. Cross reference tag (V118). 10A NCAC 27G .0209 MEDICATION REQUIREMENTS. Based on observation, record review and interview the facility failed to ensure one of three audited client's (#2) and one of one deceased client (DC#5) medications were administered on the written order of a physician. C. Cross reference tag (V119). 10A NCAC 27G .0209 MEDICATION REQUIREMENTS. Based on observation, record review and interview the facility failed to dispose of a medication in a manner that guards against diversion or accidental ingestion for one of three audited clients (#2) and one of one deceased client (DC#5). D. Cross reference tag (V120). 10A NCAC 27G .0209 MEDICATION REQUIREMENTS. Based on observation, record review and interview the facility failed to ensure one of three audited client's (#2) medication was securely locked in a cabinet. E. Cross reference tag (V513). 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE. Based on observation and interview the facility failed to promote a respectful and least restrictive environment for four of four clients (#1, #2, #3 & #4). F. Cross reference tag (V736). 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS. Based on observation and interview the facility was not kept in a safe, clean, attractive and orderly manner that was free of an offensive odor. G. Review on 3/6/19 of DC#5's record revealed: - admitted to the facility on 12/31/18 &	V 289		

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deceased on 1/2/19
- diagnoses listed on a January 2019 medication administration record were Hypertension; Deaf; Nonspeaking & Chronic Mastoiditis, unspecified
- no mental health diagnoses documented

During interview on 3/11/19 Licensee #1 reported:
- she had a FL2 with DC#5's diagnoses, however she was not able to locate it

Review on 3/20/19 of a Plan of Protection dated 3/20/19 written by Licensee #2 revealed "BTWs admission policy will be followed for all future admissions with no exceptions. Doctors orders will be obtained and maintained for all medications. Medications for prior clients or discontinued orders will be disposed of within 3 business days. Medications will be stored in a locked location at all times when not in immediate use. Locks will be removed from the facility refrigerator. The neighborhood cat will be taken to the vet to receive shots and any other medical needs that may arise. The records will be kept at the facility. The facility will be kept clean and free of clutter and offensive odors. The Chief Executive Officer will ensure that the following actions take place."

The facility failed to provide required residential services to all four clients and one deceased client. DC#5 was an emergency admission to the facility on 12/31/18 at 8:00pm. She passed away on 1/2/19. She had diagnoses of Hypertension; Deaf; Nonspeaking & Chronic Mestoiditis. She was admitted with a one page incomplete assessment completed by Licensee #2, without determining whether or not the facility could meet her needs. None of the staff knew sign language. The medical history was left blank even though

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V 289	Continued From page 23 DC #5 was apparently taking at least 16 different medications, including 5 for blood pressure and one for epileptic seizures. There were no physician orders for any of DC#5's medications. The medications were still at the facility over 2 months after her death in a bag which also included medication from an individual not associated with this facility. Client #2 had insulin dated 1/17/17 in an unlocked refrigerator at the facility. Staff #1 had not disposed of the insulin even though there was a physician note dated 10/16/18 that client #2 no longer used insulin due to past history of syncope (fainting) Due to the failure to accurately document medication administration it could not be determined if any of the clients received their medications as ordered by the physician. There was a locked refrigerator for staff that contained a variety of foods and an unlocked refrigerator for clients that contained a bottle of water. Clients needed to asked staff if they wanted anything from the locked refrigerator. Upon entrance to the facility on 3/6/19 the facility smelled of smoke. The kitchen floor had dried mud stains, spots, and dried blood stains in the staff's refrigerator, a big hole in a hallway wall that had been there approximately 3 months and a cat litter box with feces in it. The neighborhood cat was allowed to enter and exit the facility. The clients loved to hug and play with the cat, however, there were no vaccination records for the cat. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000 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 289		

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V 512	Continued From page 24	V 512		
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 review and interview one of two staff (#1) failed to protect one of one deceased client (DC#5) from neglect. The findings are: Review on 3/7/19 of the facility's Medical Emergency Policy revealed: "a medical emergency is any situation involving a consumer which is thought to require more than routine first aid on an immediate basis...(1) assess the situation and provide cardiopulmonary resuscitation (CPR) as needed (2) determine	V 512		

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severity of illness and (3) call ambulance if needed..."

Review on 3/7/19 of staff #1's personnel record revealed:
- she was hired in July 2014
- first aid/CPR was renewed 2/1/19

Review on 3/6/19 of DC#5's record revealed:
- admitted on 12/31/18 & deceased on 1/2/19
- diagnoses listed on a January 2019 medication administration record were Hypertension; Deaf; Nonspeaking & Chronic Mastoiditis, unspecified

Review on 3/6/19 of an incident report dated 1/1/19 for DC#5 revealed:
- "client (DC#5) received on 12/31/18 at approximately 8:00pm. The facility was being closed and had to have all consumers placed by 12/31/18. Consumer1 (DC#5) was deaf and mute but could communicate through her writing. Consumer1 first morning and afternoon in the facility were uneventful. Licensee #1 and #2 visited Consumer1 about 8pm on 1/1/19 and she seemed to be adjusting well to her new home and peers. At 3:30am staff #1 noticed the light on in Consumer1's room and went to see if Consumer1 needed assistance with anything. Consumer1 was up taking the linen off her bed because she had soiled them...staff #1 assisted Consumer 1 in making her bed and changing her diaper. After doing so Consumer1 sat on the bed and began fanning herself as if she were hot. Staff #1 went to get Consumer1 some water and when she returned consumer1 was lying down on the bed. When staff #1 placed her hand on her shoulder Consumer1 did not respond and staff#1 noticed Consumer1 did not seem to be breathing. Staff #1 called Licensee #2 and stated that Consumer1

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was unresponsive Licensee #2 told staff #1 to call 911 and report the situation. Licensee #2 arrived at the facility in less than 2 minutes. Staff #1 was on the phone with 911 when Licensee #2 arrived. The emergency operator instructed staff #1 to lay Consumer1 on the floor and begin chest compressions. Licensee #2 followed the operator's instructions. Licensee #2 continued chest compressions for approximately four minutes until emergency services (EMS) took over. EMS tried to revive Consumer1 for approximately twenty minutes before pronouncing her dead from a heart attack...Consumer1's death was from natural causes the paramedics did not take Consumer1 to the hospital for an autopsy. The funeral home removed Consumer1 from the facility..."

Review on 3/7/19 of an EMS report dated 1/2/19 for DC#5 revealed:
- assessment time: 3:42am
- "fire department crew was doing CPR upon arrival...[staff #1] stated she found [DC#5] standing in her room with the lights on flashing her clothes like she was hot...patient unable to hear or speech...patient was transferred to this group home about 9pm...patient seemed to be not happy (anxiety issue)...she went to get patient some water to take an anxiety pill when she return back, she found patient unresponsive, not breathing...she called 911 advised patient not breathing...EMS give advance life support...after 20 minutes of advance life support care no change in patient status...police on scene...no signs of foul play...called [hospital] morgue to receive the body...gave permission to release body to funeral home...cardiac arrest"

Review on 3/7/19 of the local police narrative dated 1/2/19 for DC#5 revealed:

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V 512	Continued From page 27 - "...[staff #1] advised me that [DC#5] was complaining of chest pains and she called EMS to respond to the scene...[EMS] advised me that [DC#5] had swelling to her lower legs which is commonly found in his training and experience with cardiac patients...]" Review on 3/7/19 per Google map revealed the distance between the two sister facilities are 3 minutes apart During interview on 3/6/19 client #4 reported: - DC#5 was her roommate. A lady brought DC#5 to the facility. She laughed with the clients. She was able to get her to come outside with the clients for a little awhile earlier that day. She ate dinner. She noticed throughout the day DC#5 would pat the side of her neck...like she couldn't breathe. She (client #4) did not know what that meant. She (client #4) went to bed around 9pm after taking her medication. DC#5 came to bed about 10:30pm. DC#5 sat up in her bed and watched television however she noticed DC#5 breathing hard. She (client #4) got up and turned the light on. DC#5 was breathing hard so she turned the light off and went back to bed. The way she was breathing scared her. When she got back in bed she heard a fall. She went to look and saw DC#5 was on the floor. She looked as if she tried to walk to the closet because she had urinated on herself. She (DC#5) motioned her finger for her (client #4) to come here. DC#5 could not talk and she could not understand what she was trying to say. She asked DC#5 to write it down but she wouldn't write it down. She was breathing hard. She went to get staff #1 who was asleep on a couch in the living room. Staff #1 came in the room and helped her (DC#5) change out of her clothes and put on a pull up. Staff #1 asked DC#5 if she wanted some water and she	V 512		

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said "yes." Staff #1 went to get her some water. DC#5 drank a little water however wet her chest with most of the water. DC#5 then laid back on the bed and was breathing hard. She (client #4) went to walk out of the bedroom but looked back and saw DC#5 with a blank stare. She starred straight up at the wall and her breathing stopped. DC#5 looked like she had stopped breathing for about 3 minutes. Client #1 & client #2 came into the room at the end. Somebody asked if she was dead. DC#5's stomach had stopped moving. DC#5's eyes began to get smaller. I said "she must be dead." Staff #1 checked her pulse. Staff #1 called her dad (Licensee #2). She (client #4) started to cry. Licensee #2 arrived about 5 minutes later. Licensee #2 started CPR. Staff #1 told her dad to call 911 and he requested staff #1 to call 911. DC#5 had stopped breathing before Licensee #2 started CPR. EMS arrived and said she was dead.

During interview on 3/6/19 staff #1 reported:
- DC#5 came to the facility on 12/31/18. She was not sure what time it was but knew it was dark when she arrived. The previous provider with the assisted living program dropped DC#5 off at the facility. DC#5 staggered when she arrived to the facility and fell several times on her butt. Licensee #1 called the previous provider and she said DC#5 had vertigo. The previous provider requested Licensee #1 to check her blood pressure. Licensee #1 checked her blood pressure but did not document it. She does not recall the blood pressure reading but it was good. The next day (1/1/19) DC#5 fell about 12pm and about 3pm at least 3 times. Staff didn't know much about DC#5. Staff was told she had vertigo. The night of DC#5's death she was outside smoking a cigarette at about 3am. When she walked back in the facility DC#5 had walked to

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the living room because she had soiled herself. She helped DC#5 change her clothing in her bedroom. DC#5 waved her hand like she was hot. She told client #2 to fan her. She got DC#5 a glass of water and a Meclizine for vertigo. She (staff #1) thought DC#5 felt dizzy. DC#5 was sitting up in the bed when she went to get the water. When she came back DC#5 had laid back in the bed. She was breathing hard. She thought DC#5 had fallen asleep. She had not monitored DC#5 while she slept before. Some people breathe hard while they sleep. She didn't know anything about her past. DC#5 could write but she could not get DC#5 to write anything down. She checked her pulse on her arm and neck. She was not good at checking pulse. She did not feel anything but DC#5 was still breathing. It was hard breaths like she was struggling to breathe. She had not been in a situation like that before. She was scared. It did not cross her mind to do CPR. She called Licensee #2. Licensee #2 came to the facility and began CPR while she called 911. When EMS arrived they pronounced her dead.

During continued interview on 3/7/19 staff #1 reported:
- She noticed DC#5 was breathing hard when she was admitted. The previous provider said "that's how she breaths." DC#5 was mobile however she was unsteady when she walked. She and her mom (Licensee #1) assisted her to a chair to sit down. She (staff #1) wondered why she was breathing hard and why she was unsteady. DC#5 never fell because staff assisted her around the facility. She did not have a walker or gait belt. That night the Meclizine was not administered but the next morning (1/1/19) it was administered. DC#5 seemed fine after the Meclizine was administered but she was still breathing hard. DC#5 was off balance and fell

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that morning. She questioned herself why DC#5 was at the facility and not in a nursing home. DC#5 later ate dinner and took her medications.
- if she could do anything different in regards to the 1/2/19 incident..."would immediately call 911 and began CPR"

During interview on 3/7/19 Licensee #2 reported:
- he came over the night DC#5 was admitted (12/31/18). There were no breathing issues. She seemed to get along with the clients. One of the clients did her hair. He came back over on 1/1/19 around 6pm or 7pm. She was breathing normal. She was in the den area. He didn't observe her fall on any day he came. Neither Licensee #1 or staff #1 made him aware DC#5 staggered or fell since admitted to the facility. About 3am he received a telephone call from staff #1 that she could not tell if DC#5 was breathing. He was at a sister facility. He immediately came over and staff #1 was on the phone with 911. The 911 representative instructed him to place DC#5 on the floor and start chest compressions. EMS arrived and they took over. EMS pronounced DC#5 dead of cardiac arrest.

During interview on 3/7/19 Licensee #1 reported:
- the previous provider's daughter dropped DC#5 off at the facility about 7pm. When she (Licensee #1) came over DC#5 was sitting in a chair. DC#5 started twirling her finger like she maybe felt dizzy. She called the previous provider and was informed DC#5 had vertigo. DC#5 knew sign language however staff did not. DC#5 could read lips. She did not witness DC#5 stagger or fall while at the facility. She (Licensee #1) stayed until 9pm and DC#5 sat in a chair smiling
- she did notice short breaths from DC#5 prior to admission but the previous provider said the short breaths were normal

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V 512	Continued From page 31 - she (Licensee #1) did not come to the facility on 1/1/19 and no calls were received from staff #1 - she received a telephone call on 1/2/19 around 3am from staff #1 in regards to DC#5 - took her (Licensee #1) about 15 minutes to get to the facility - EMS was present when she arrived and DC#5 had been pronounced dead Review on 3/7/19 of a Plan of Protection written by Licensee #2 revealed: Licensee #1 and Chief Financial Officer will staff the facility until staff #1 takes further training and demonstrates mastery of the current medical emergency plan. This plan will be in force immediately. Licensee #1 and Chief Financial Officer will ensure that all shifts will be handled by Licensees' until staff is competent to follow policy and procedure. DC #5 was admitted to the facility on 12/31/18 at 8:00pm with diagnoses of hypertension, deafness, nonspeaking & chronic mastoiditis. She died at the facility on 1/2/19. When DC #5 was admitted to the facility, she exhibited difficulty breathing, was unsteady with walking and fell several times. No safety measures or strategies were put in place to address these health concerns. Though accounts of the evening events and timeline from staff #1 varied, it is apparent that DC #5 was having medical symptoms which required emergency care. Client #4 heard DC #5 fall on the floor of their bedroom. Client #4 woke Staff #1 who was asleep on the couch in the living room. Staff #1 went to DC #5's bedroom and found her to be breathing hard and fanning herself as if she were hot. Staff #1 told Client #2 to fan DC #5 while staff #1 left to get water for her. In one account staff #1 reports upon her return DC #5 was laid back in bed, did	V 512		

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V 512	Continued From page 32 not have a pulse and was struggling to breathe. In another account to the police, staff #1 stated DC #5 had complained of chest pains. Staff #1 did not start CPR or call 911, but instead called Licensee #2, her father, who was working 0.6 miles away at another group home. According to staff #1, Licensee #2 started CPR upon his arrival while she called 911. However, the recording of the 911 call revealed that CPR was not started until over 5 ½ minutes into the 911 call and then only under the direction of the 911 operator. EMS arrived on the scene at 3:42am and attempted advanced life support for 20 minutes, after which DC #5 was pronounced deceased. Due to staff #1's delay in contacting emergency medical help DC #5 was denied the opportunity to survive the fatal reported cardiac emergency. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $10,000 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		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities	V 513		

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V 513	Continued From page 33 meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on observation and interview the facility failed to promote a respectful and least restrictive environment for four of four clients (#1, #2, #3 & #4). The findings are: Observation in the kitchen area on 3/6/19 at 11:30am revealed the following: - one unlocked refrigerator which only had a bottle of water in it - a pad lock on a refrigerator with a variety of food (breakfast items, frozen meats...cooked barbeque chicken, collards & mashed potatoes) - the locked refrigerator was relocked by staff after surveyors observation of the refrigerator During interview on 3/6/19 client #1 reported: - locks are on the refrigerator because clients stole food During interview on 3/6/19 client #2 reported: - the locked refrigerator was staff refrigerator - the clients asked staff if they needed something from the locked refrigerator	V 513		

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V 513	Continued From page 34 - she was fine with staff refrigerator being locked - she wasn't sure why the staff refrigerator was locked During interview on 3/6/19 client #4 reported: - the clients have their own refrigerator and the staff have their refrigerator - the locked refrigerator belonged to staff - staff planned to take the clients shopping for food today - clients normally purchased foods such as: hot dogs & pizza During interview on 3/6/19 staff #1 reported: - clients stole food from the refrigerator - meals are prepared for dinner earlier during the day - clients ate the food prior to dinner During interview on 3/11/19 Licensee #1 reported: - the staff's refrigerator has been locked for the last 2 or 3 years with no issues in the past - meals are prepared for dinner earlier during the day - clients ate the food prior to dinner [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 and must be corrected within 23 days.	V 513		
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 maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736		

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V 736	Continued From page 35	V 736		

This Rule is not met as evidenced by:
Based on observation and interview the facility was not kept in a safe, clean, attractive and orderly manner that was free of an offensive odor. The findings are:

Observation on 3/6/19 from 10:42am - 4:42pm revealed the following:
- a nosmoking sign on the front door
- entered the facility at 10:42am there was a strong odor of cigarette smoke...a pack of cigarettes & lighter on the TV stand
- staff #1 smoked out of the cigarette pack on the TV stand throughout the day
- 2 small trays of animal food on the floor in the living room area
- at 10:59am there was a gray & white cat scratching the back door
- at 11:30am the staff refrigerator had frozen blood stains in the bottom of the freezer portion
- 11:33am a few unclean dishes in the sink...kitchen floor with spots of dried mud stains
- 11:36am a hole in the wall of the hallway the size of a baseball
- at 4:42pm surveyors re-entered the facility and there was fruity deodorizer smell...
- a cat litter box behind the front door with feces in it

During interview on 3/6/19 client #1 reported:
- the cat does not live in the facility
- the cat belonged to her best friend
- everyone cleaned up after the cat

During interview on 3/6/19 client #4 reported:
- all the clients play with the cat inside the

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V 736	Continued From page 36 facility - the cat lives outside - they "love the cat" - staff and clients cleaned up after the cat - her chores were to wash dishes and sweep the floor - when she washed dishes someone would use a dish and not wash the dish afterwards During interview on 3/6/19 staff #1 reported: - nobody smoked in the facility - the cat was a neighborhood cat - client #1 loved to play with the neighborhood cat - the cat was allowed to come in and out of the facility During interview on 3/12/19 client #1's Department of Social Services guardian reported: - she has witnessed the cat at the facility on numerous occasions - "its a big cat" and has crawled on her during the visits to the facility - client #1 will hug and play with the cat...she has not witnessed any scratches on client #1 During interview on 3/11/19 Licensee #1 reported: - she was not aware of anybody that smoked in the facility - she visited the facility 2-3 times a week - she consistently spoke with staff and clients about the cleanliness of the facility - she had an inspection sheet to ensure the cleanliness of the facility (toilet, floors) - the hole in the wall had been there for the last 2 -3 months - client #2 experienced dizzy spells in the past and had fallen into the wall - repairs are being done to all the sister facilities...she was not sure when the repairs	V 736		

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V 736	Continued From page 37 would begin at this facility - she was aware the cat was at the facility - she and staff #1 cleaned up after the cat...the clients also helped - it was a neighborhood cat so there was not a vaccination record - she planned to keep the cat and have the cat vaccinated [This deficiency constitutes re-cited deficiency] [This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 and must be corrected within 23 days.	V 736		
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 & interview the facility failed to ensure areas in which therapeutic and habilitative activities are routinely conducted were separate from sleeping areas. The findings are: Observation on 3/6/19 revealed the following: - arrived at the facility at 10:33am	V 784		

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V 784	Continued From page 38 - staff opened the door at 10:42am - no staff sleeping quarters revealed during the tour of the facility (between 11:17am - 11:42am) During interview on 3/6/19 staff #1 reported she: - apologized for taking so long to open the facility doors - was asleep - was considered the live in staff - was awake staff during the night - slept during the day when the clients were at their programs - did not confirm where she slept at the facility During interview on 3/6/19 Licensee #1 reported: - staff #1 was the live in staff - staff was considered awake staff - she relieved staff #1 if she needed time off - staff #1 left the facility during the day to get some sleep	V 784		