


PRINTED: 05/01/2019
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-232	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/25/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CHANGING LIVES FAMILY CARE HOME, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 207 AARONS WAY 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	V 000		
<p>An annual and follow-up survey was completed on April 25, 2019. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p>				
V 114	27G .0207 Emergency Plans and Supplies	V 114	<p>Staff would be re-trained regarding all emergency plans and safety procedures. # Protocol for fire drills with Changing Lives Family Care Home include two fire drills per month with at least (1) drill being during 3rd shift basis per quarter.</p>	<p>B-1 5/15/19</p>
<p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(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.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to conduct fire drills under conditions that simulate emergencies. The findings are:</p> <p>Review on 4/25/19 of the facility's fire drill log revealed the following: -2/25/19- 2nd shift -2/4/19- 2nd shift. -1/28/19- 2nd shift. -1/10/19- 1st shift.</p>				

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Justa Leticia BSQP</i>	OWNER	5/10/19

PRINTED: 05/01/2019
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-232	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/25/2019
NAME OF PROVIDER OR SUPPLIER CHANGING LIVES FAMILY CARE HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 207 AARONS WAY 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 114	Continued From page 1 -12/15/18- 1st shift. -12/3/18- 3rd shift. -11/20/18- 1st shift. -11/7/18- 2nd shift. -10/20/18- 3rd shift. -10/3/18- 2nd shift. -9/17/18- Blank. -9/5/18- Blank. -8/28/18- Blank. -8/4/18- Blank. -7/14/18- Blank. -7/1/18- Blank. -6/28/18- Blank. -6/12/18- Blank. -5/16/18- Blank. -5/3/18- Blank. -4/25/18- Blank. -There were no fire drills conducted on third shift for the first quarter of 2019. -During the second and third quarter of 2018, it was unable to be determined which shift the drills were conducted from 4/25/18 through 9/17/18 as "time/shift" on the fire drill log were left blank. Interviews with client #1 and client #2 on 4/25/19 revealed: -Drills were being conducted at the group home. Interview on 4/25/19 with the Executive Director revealed: -Staff that worked at the home from April through September of 2018 was no longer employed. -New staff started working in September at the group home. -He was unaware the fire drill log was missing which shift drills had been conducted from 4/5/18 through 9/17/18. -Staff would be re-trained on completing fire drill log correctly to include a drill per shift per quarter. -He confirmed fire drills shifts for the second and	V 114	Staff are to rotate drills so they are being performed during the week and also on weekends.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-232	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/26/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHANGING LIVES FAMILY CARE HOME, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 207 AARONS WAY 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 114	Continued From page 2 third quarter of 2018 were unable to be determined.	V 114		
V 121	<p>27G .0209 (F) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible 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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to obtain drug reviews every six months for one of three clients (Client #2) who received psychotropic drugs. The findings are:</p> <p>Review on 4/25/19 of Client #2's record revealed: -Admission date of 1/18/17. -Diagnoses of Schizophrenia; Mental Retardation. -Physician's order dated 11/19/18 for Benzotropine Mesylate 0.5 mg, 1 tablet twice a day. -Physician's order dated 3/7/19 for Trazodone 100 mg, 2 1/2 tablets every night. -Physician's order dated 1/15/19 for Clozapine 200 mg, 2 tablets every night. -The February, March and April MAR revealed</p>	V 121	<p>Drug reviews by the pharmacist would be performed every (6) months with results being provided to the client's medication prescriber</p>	<p>1st review by 4/1/19</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED R 04/25/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING LIVES FAMILY CARE HOME, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 207 AARONS WAY 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 121	<p>Continued From page 3</p> <p>Client #2 was administered the above medications daily. -There was no evidence of a six months psychotropic drug review for Client #2.</p> <p>Interview on 4/25/19 of Client #2's pharmacist revealed: -Drug reviews had never been performed for the client. -Group home owner had never requested from the pharmacist a drug review of psychotropic medications to the clients served at the home. -Pharmacy would conduct drug reviews of Client #2's psychotropic medications if group home owner/director would order them.</p> <p>Interview on 4/25/19 with the Director revealed: -He was not aware that a drug review of psychotropic medications had to be conducted to the clients by a pharmacist or physician every six months. -He would have pharmacist review Client #2's psychotropic medications. -He confirmed the six months psychotropic drug review for Client #2 was not completed.</p>	V 121		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>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.</p> <p>This Rule is not met as evidenced by:</p>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/25/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHANGING LIVES FAMILY CARE HOME, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 207 AARONS WAY 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 736	<p>Continued From page 4</p> <p>Based on observation and interview, the facility failed to ensure facility grounds were maintained in a clean, safe and attractive manner. The findings are:</p> <p>Observation on 4/25/19 at 12:15 PM of the kitchen area revealed: -Linoleum flooring was peeling off next to the fridge.</p> <p>Observation on 4/25/19 at 12:20 PM of the living area revealed: -Paint was peeling off from the green wall. -Alarm system was hanging off by its cables and not secured to the wall.</p> <p>Observation on 4/25/19 at 12:22 PM of the bedroom next to the kitchen revealed: -Carpet next to the bed had a stain about 12 inches in diameter. -Bottom drawer from the dresser was missing the front side. -Closet doors were dirty and stained. -Inside of room's entrance door was stained and dirty.</p> <p>Observation on 4/25/19 at 12:27 PM of bedroom on the right side of the hall revealed: -Dresser drawers were all out of track.</p> <p>Observation on 4/25/19 at 12:30 PM of bedroom on the left side of the hall revealed: -Carpet had several stains.</p> <p>Observation on 4/25/19 at 12:35 PM of the facility's outside revealed: -The back side of back door was dirty and stained.</p> <p>Interview on 4/25/19 with the Director revealed:</p>	V 736	<p>Executive Director will do a thorough walk-through of the facility. All repairs of the home and cleaning will be conducted.</p> <p>* Changing Lives Family Care Home protocol. The facility is cleaned (each room) on a weekly basis including cleaning during the weekend. The first week of each month, the facility is to have a 'deep' clean during the week and repairs are to be reported to the Director. During the third week of each month, weekend staff is to provide a deep clean of the facility and report any repairs of the facility to the Director.</p>	5/1/19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-232	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CHANGING LIVES FAMILY CARE HOME, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 207 AARONS WAY 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 736	Continued From page 5 -Agency was responsible for doing maintenance for the home -He confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner.	V 736		
-------	--	-------	--	--

**CHANGING LIVES FAMILY CARE
HOME, LLC**

From: 207 AARONS WAY
BURLINGTON NC 27217

Fax: 336-229-5108

Phone: 336-229-5108

FAX
TRANSMISSION

To: Mental Health Licensure & Certification Section

Fax: 919-715-8078

Phone: 336-516-7296

Pages: 7

Re: _____

CONFIDENTIAL HEALTH INFORMATION ENCLOSED

ADDITIONAL COMMENTS:

*Any Questions or concerns please contact Quentin Williams
@ 336-516-7296*

STATEMENT OF CONFIDENTIALITY: The information contained in this facsimile message is a client privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message IS NOT the intended recipient, you are hereby notified that any dissemination distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone and return the original message to us at the above address via the US Postal Service. Thank you.