

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL095-049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2019
NAME OF PROVIDER OR SUPPLIER RAY HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 6837 OLD US HIGHWAY 421 DEEP GAP, NC 28618		
(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 An annual survey was completed on May 20, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000	<p style="text-align: center;">DHSR - Mental Health</p> <p style="text-align: center;">JUN 10 2019</p> <p style="text-align: center;">Lic. & Cert. Section</p>	
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 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 fire and disaster drills were repeated for each shift on a quarterly basis. The findings are: Review on 5/17/19 of the fire and disaster drill log revealed: -There was no documentation of a fire drill and a disaster drill conducted on 2nd shift for the 2nd quarter of 2018 or 2nd quarter of 2019	V 114	<p>V114</p> <p>The QP, Safety Chairperson, and Home Manager will meet to discuss the fire drill schedule. The Home Manager will be in-serviced on the monthly required fire and disaster drills including a complete list of the required drills being posted in the office. The QP will monitor monthly each fire and disaster drill for the appropriate shift, timing, and staffing. In the future, the QP will ensure that the required quarterly fire and disaster drills are completed for each shift by receiving a copy of the fire and disaster drill monthly.</p> <p>Correction will be completed by 07/19/19</p>	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Luray Rominger

TITLE

Regional Administrator 6/5/19

(X6) DATE

STATE FORM

6899

IXKY11

If continuation sheet 1 of 4

Division of Health Service Regulation

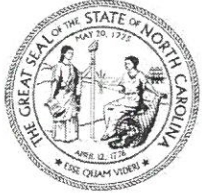
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL095-049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2019
NAME OF PROVIDER OR SUPPLIER RAY HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 6837 OLD US HIGHWAY 421 DEEP GAP, NC 28618		
(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	<p>Continued From page 1 (April-June).</p> <p>Interview on 5/16/19 with Client #1 revealed: -Fire drills were practiced every month and usually at night; -The meeting place was on the front porch "months ago" but now they all met in the front yard and away from the house; -Disaster drills such as tornado drills were practiced every month.</p> <p>Interview on 5/16/19 with Client #2 revealed: -Fire drills were run "once in a while" and the meeting place was outside and on the porch; -When they ran tornado drills, they "ran and hid;"</p> <p>Interview on 5/16/19 with Client #4 revealed: -They had fire drills, but he did not know when they were done; -He initially stated the meeting place was on the porch and then stated the front yard, but he did not know.</p> <p>Interview on 5/16/19 with Staff #1 revealed: -He started work at the facility approximately 4 months ago; -Fire drills were practiced monthly and he understood they were to be done on every shift; -The meeting place for clients and staff during fire drills was in the front yard near the large tree; -He had not conducted any disaster drills yet but understood they were to be practiced on every shift.</p> <p>Interviews on 5/16/19 and 5/20/19 with the Group Home Manager revealed: 5/16/19-Fire and disaster drills were conducted at least once a quarter and on every shift; -There were 3 shifts at the facility which were: -1st shift from 7:00 am to 3:00 pm;</p>	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL095-049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2019
NAME OF PROVIDER OR SUPPLIER RAY HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 6837 OLD US HIGHWAY 421 DEEP GAP, NC 28618		
(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 -2nd shift from 3:00 pm- 11:00 pm; -3rd shift from 11:00 pm to 7:00 am; -She did not know why Clients #1, #2 and #4 would have said the meeting place for the fire drill was the porch because that was too close to the home; -The meeting place was in the front yard; 5/20/19-She was surprised there was not a 2nd shift fire and disaster drill completed for the 2nd quarter; -She stated the drill documentation may have been misfiled.	V 114		
V 753	27G .0304(b)(5) Indoor Lighting 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (5) All indoor areas to which clients have routine access shall be well-lighted. Lighting shall be adequate to permit occupants to comfortably engage in normal and appropriate daily activities such as reading, writing, working, sewing and grooming. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the dining room where clients ate their meals was well-lit. The findings are: Observations made on 5/16/19 at approximately 10:45 am and on 5/17/19 at 4:30 pm revealed: -The lighting over the dining room table was	V 753	V753 The lighting in the dining room was replaced on 5/21/19 by maintenance. The lighting in the dining room will be monitored by monthly environmental assessments completed by the clinical team. In the future the Home Manager will ensure all areas of the home have adequate lighting.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL095-049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2019
NAME OF PROVIDER OR SUPPLIER RAY HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 6837 OLD US HIGHWAY 421 DEEP GAP, NC 28618		
(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 753	<p>Continued From page 3</p> <p>significantly dim with low visibility; -On 5/17/19, Client #1 checked the light bulbs and found one light bulb out of 6-7 bulbs not lit as he began to sit at the table to eat his snack.</p> <p>Interviews on 5/16/19 with the Qualified Professional (QP) and Group Home Manager (GHM) revealed: -They both acknowledged the low lighting of the dining room light fixture despite each of their attempts to turn the light up from a dimmer switch; -Clients #1-#4 ate their meals at the dining table.</p> <p>Interview on 5/20/19 with the Human Resources Coordinator (HRC), QP and GHM revealed: -The HRC stated he facility's maintenance staff was available and could correct the dining room lighting so this area was well-lit.</p>	V 753		



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

May 29, 2019

Luray Rominger, Administrator
RHA Health Services NC, LLC
176 Wildcat Road
Deep Gap, NC 28618

DHSR - Mental Health

JUN 10 2019

Lic. & Cert. Section

Re: Annual Survey completed May 20, 2019
Ray House, 6837 Old US Highway 421, Deep Gap, NC 28618
MHL # 095-049
E-mail Address: lrominger@rhanet.org

Dear Ms. Rominger:

Thank you for the cooperation and courtesy extended during the annual survey completed May 20, 2019.

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

Standard level deficiencies are cited for:

- 10A NCAC 27G .0207 Emergency Plans and Supplies (V114);
- 10A NCAC 27G .0304 Facility Design and Equipment (V753).

Time Frames for Compliance

Standard level deficiencies must be **corrected** within 60 days from the exit of the survey, which is July 19, 2019.

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.).

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603

MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718

www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

May 29, 2019
Luray Rominger, Administrator
RHA Health Services NC, LLC

- 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.
- 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 Sonia Eldridge, Mountains Team Leader, at (828) 665-9911.

Sincerely,

Rebecca Hensley

Rebecca Hensley
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: dhhs@vayahealth.com
File