STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL031-076	A. BUILDING: _____ B. WING _____	R 05/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME #10	223 ROBERT F HARGROVE ROAD MOUNT OLIVE, NC 28365

(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 and follow up survey was completed on May 22, 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	DHSR - Mental Health JUN 14 2019 Lic. & Cert. Section	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	Signature page on the Residents PCP has been signed by the guardians and all the parties involved. Paperwork was reviewed in the guardians. QP will be responsible for obtaining signatures from all responsible parties involved in PCP development	6/6/19

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 6/6/19

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop a treatment plan in partnership with the client or legally responsible person or both affecting 2 of 4 audited clients (#3 & #4). The findings are: Review on 5/22/19 of client #3's record revealed: - 59 year old female admitted to the facility in 2016. - Diagnoses included Schizophrenia, Intellectual/Developmental Disability, mild, nicotine dependency, and hypertension. - Local Department of Human Services identified as Guardian on the "Face Sheet" and on correspondence. - "Person Centered Plan" completed 12/10/18, not signed by client #3's legally responsible person or the client. During interview on 5/22/19 client #3 stated her goals included learning how to "keep a house" because she wanted to get her own apartment. Review on 5/22/19 of client #4's record revealed: - 56 year old female admitted to the facility 9/7/17. - Diagnoses included Intellectual/Developmental Disability, moderate, Major Depressive Disorder, moderate, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), Major Neurocognitive Disorder due to HIV/AIDS, without behavioral disturbance, Adams-Stokes Syndrome, Dementia, hypertension, and hyponatremia. - "Letters of Appointment of Guardian of the Person" included "Date of Qualification 9/14/12" with client #4's daughter identified as guardian of the person. - "Person Centered Plan" completed 10/1/18, not	V 112	Monthly review of paperwork will be done by QP or assigned staff to ensure proper documentation and compliance.	ongoing

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V 112	Continued From page 2 signed by client #4's legally responsible person or the client. During interview on 5/22/19 client #4 stated her daughter was her guardian. her goals were to get out on her own and live near her children, get a job at Taco Bell and make her own money. During interview on 5/22/19 the Qualified Professional stated he understood the requirement for the treatment plan to be developed in partnership with the client or legally responsible person or both. He would ensure the legally responsible person signed the treatment plans.	V 112		
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 reviews and interviews the	V 114	Inservice/Training was Conducted by QP with all the staff during our staff monthly meeting held on 5/31/19. Rotating fire drills and real life scenarios were reviewed.	5/31/19 / Ongoing

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V 114	Continued From page 3 facility failed to ensure fire and disaster drills were conducted under conditions that simulated emergencies. The findings are: Review on 5/22/19 of the facility's fire and disaster drill records for April 2018 - May 2019 revealed: - All documented fire drills were conducted between the hours of 7:30 am and 8:30 pm. - All documented disaster drills were conducted between the hours of 7:45 am and 9:25 pm. - No drills conducted during normal sleeping hours. During interview on 5/22/19 client #1 stated they did fire and disaster drills at the facility "mostly during the daytime." During interview on 5/22/19 client #3 stated all fire and disaster drills were done during the day. During interview on 5/22/19 the Supervisor In Charge stated facility staff were "live in" staff and were at the facility for 2 - 3 weeks at a time. Staff had been reminded to conduct drills during overnight hours. She would re-train staff on the need to conduct drills overnight.	V 114	Supervisor in Charge will review monthly documentation to ensure Compliance	
V 511	27D .0303 Client Rights - Informed Consent 10A NCAC 27D .0303 INFORMED CONSENT (a) Each client, or legally responsible person, shall be informed, in a manner that the client or legally responsible person can understand, about: (1) the alleged benefits, potential risks, and possible alternative methods of treatment/habilitation; and (2) the length of time for which the consent	V 511	Review of documentation and paperwork was done by the QP with staff to ensure that documentation was done properly	5/31/19 1 Ongoing

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V 511	Continued From page 4 is valid and the procedures that are to be followed if he chooses to withdraw consent. The length of time for a consent for the planned use of a restrictive intervention shall not exceed six months. (b) A consent required in accordance with G.S. 122C-57(f) or for planned interventions specified by the rules in Subchapter 27E, Section .0100, shall be obtained in writing. Other procedures requiring written consent shall include, but are not limited to, the prescription or administration of the following drugs: (1) Antabuse; and (2) Depo-Provera when used for non-FDA approved uses. (c) Each voluntary client or legally responsible person has the right to consent or refuse treatment/habilitation in accordance with G.S. 122C-57(d). A voluntary client's refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available at the facility. (d) Documentation of informed consent shall be placed in the client's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure documentation of informed consent for 3 of 4 audited clients (#1, #3 and #4). The findings are: Review on 5/22/19 of facility records revealed: - "Resident Contract" included "Admission Policies . . . Grievance Procedures . . . Declaration of Resident's Rights . . . House Rules	V 511	SIC - Supervisor in Charge will check monthly documentation to ensure compliance SIC will ensure that Consents and Resident PCP are updated annually	5/31/19 on-going

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V 511	Continued From page 5 . . . Residents Personal Funds Policies . . . Resident's Personal Funds Agreement . . . Rates, Refund, Discharge/Transfer Policies . . . Rate Agreement . . . Normal Risks of Life . . . Confidentiality . . . Consent for Habilitative Treatment, Services and Supports . . . Acknowledgement of Choice for Pharmacy Services . . . Release of Liability: Transportation . . .Suspension and Expulsion . . . Consent to Manage Personal Funds . . . Consent to Seek Emergency Care . . . Restrictive Intervention Policy . . . Medical Care Decisions and Advance Directives What You Should Know . . . " Review on 5/22/19 of client #1's record revealed: - 47 year old female admitted to the facility 10/19/16. - Diagnoses included Schizophrenia, paranoid, Intellectual/Developmental Disability, Asthma, and Gastroesophageal Reflux Disease. - "Letters of Appointment of Guardian of the Person" included "Date of Qualification 8/2/11, with client #1's sister identified as guardian of the person. - No guardian signature on any element of the "Resident Contract." Review on 5/22/19 of client #3's record revealed: - 59 year old female admitted to the facility in 2016. - Diagnoses included Schizophrenia, Intellectual/Developmental Disability, mild, nicotine dependency, and hypertension. - Local Department of Human Services identified as Guardian on the "Face Sheet" and on correspondence. - No guardian signature on any element of the "Resident Contract." Review on 5/22/19 of client #4's record revealed:	V 511		

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V 511	Continued From page 6 - 56 year old female admitted to the facility 9/7/17. - Diagnoses included Intellectual/Developmental Disability, moderate, Major Depressive Disorder, moderate, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), Major Neurocognitive Disorder due to HIV/AIDS, without behavioral disturbance, Adams-Stokes Syndrome, Dementia, hypertension, and hyponatremia. - "Letters of Appointment of Guardian of the Person" included "Date of Qualification 9/14/12" with client #4's daughter identified as guardian of the person. - No guardian signature on any element of the "Resident Contract." During interview on 5/22/19 client #4 stated her daughter was her guardian. During interview on 5/22/19 the Supervisor in Charge stated client #1, client #3, and client #4 had guardians. Clients #1 and #3 moved to the facility from a sister facility in 2016. The guardians signed the consents and the "Resident Contract" when the clients were admitted into the Licensee's services, but when the clients moved into the facility from another of the Licensee's facilities, the clients signed the contract. The staff person who had the clients sign the contract was no longer employed by the Licensee. During interview 5/22/19 the Qualified Professional stated he understood the requirement for informed consent and for the legally appointed guardians to sign consents.	V 511		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND	V 736		

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V 736	Continued From page 7 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. This Rule is not met as evidenced by: Based on observations and interviews the facility was not maintained in a safe, clean, attractive manner. The findings are: Observation of the facility on 5/22/19 at approximately 3:00 pm revealed: - The surface of the vinyl floor covering in the living room area was scuffed around the dining table behind the sofa. - The floor air vent near the table was bent and rusty. - Pieces of metal threshold stripping nailed to the floors throughout the facility, as if used to repair or patch the floor covering. - The ceiling paint was peeling near the bathtub in both client bathrooms, in the main hallway, and in the side hallway leading to the medication room. - A brown stain, approximately 12 inches around, on the ceiling at the side hallway. - The light bulb in client #1 & #4's ceiling fan was exposed. - The vinyl floor covering in client #2's bedroom was scuffed and the light bulb in the ceiling fan was exposed. - The light bulb in the ceiling fan in client #5's bedroom was exposed and there was a dead insect stuck to the wall. - The counter top beside the stove was burned. - Exposed light bulbs in the overhead fixture and the over the sink fixture in the kitchen.	V 736	• The Vinyl flooring was Strengthened out • The rusted floor Vent was repainted • The metal stripping was properly secured to the floor. • The peeling paints from the bathroom ceiling were removed and repainted • Missing bulbs were replaced. • The facility was deep cleaned.	6/6/19 On - going

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V 736	Continued From page 8 - Two air return grates in the hallway were very rusty. - Only 1 light bulb in a 2 bulb fixture over the sinks in both bathrooms worked; there were no working overhead lights in either bathroom. - 2 holes (approximately 2 inches around and 1 inch around) in the bath tub wall at the built in soap shelf in bathroom #2. During interview on 5/22/19 the Supervisor in Charge stated the Licensee rented the facility. Facility maintenance issues were reported to the property owner. A maintenance man would make superficial repairs. The stain on the hall ceiling was from a leak in the roof. Water never leaked through the damaged ceiling. The light fixture globes were stored in the pantry. She would make the Licensee aware of the issues cited.	V 736	All necessary repairs were made	on-going

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

May 24, 2019

Lillian Okoro-Ezuma, Administrator
Ultimate Family Care, Inc.
817 South Second Street
Smithfield, NC 27577

Re: Annual and Follow Up Survey completed 5/22/19
Ultimate Family Care Home #10, 223 Robert F. Hargrove Road, Mt. Olive NC
MHL # 031-076
E-mail Address: ultimatehealthcare1@gmail.com

Dear Ms. Okoro-Ezuma:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed May 22, 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 o receipt of this letter. Below you will find details of the type of deficiencies found, the time fram s for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Re-cited standard level deficiency.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of th survey, which is June 21, 2019.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is July 21, 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.).
- 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 Wendy Boone, South Coastal Team Leader, at 252-568-2744.

Sincerely,

Connie Anderson
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Latisha Grant
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: qmemail@cardinalinnovations.org
DHSR@Alliancebhc.org
DHSReports@eastpointe.net
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO

ULTIMATE FAMILY CARE HOME INC.
817 SOUTH SECOND STREET
SMITHFIELD, NC 27577
Phone: (919) 880-3144. Fax: (919) 550-2163

June 06, 2019

Re: Plan of Correction - MHL 031- 076

Dear Connie and Latisha,

Please find attached plan of correction on the MHL 031- 076
Annual Survey conducted on May 24, 2019.
For more questions or any clarifications please call 919-880-3144

Sincerely,

Lillian Okoro-Ezuma

Administrator UFCHomes