STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 01/06/20. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness	V 000		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 118	Continued From page 1 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure one of three audited clients (#3)'s medications were administered on the written authorization of a physician as well as assure medications were administered as prescribed and assure one of three audited client's (#5) medication was available to administer. The findings are: I. Failure to have physician's orders and adhere to physician's orders... Review on 01/03/20 of client #3's record revealed: -Admitted: 09/02/05 -Diagnoses: Schizoaffective Disorder Bipolar Type, Major Depressive Disorder, Intellectual Developmental Disability and Diabetes a. Observation on 01/03/20 of client #3's medications revealed the following: -Simvastatin 20 mg one tablet daily (used to lower bad cholesterol) -Metformin HCL 500 mg one tablet daily (used to treat Diabetes) -Poglitazone HCL 30 mg one tablet at night (used to treat Diabetes) -Cogentin .5 mg one tablet twice a day (used to treat side effects of certain psychiatric medications) -Fluphenazine 10 mg one tablet twice a day (antipsychotic medication used to treat schizophrenia and psychotic symptoms) -Neurotin 300 mg one tablet at night (used to	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 118	Continued From page 2 treat seizures and pain) Review on 01/03/20 of client #3's record revealed no physician's order dated prior to 01/03/20 for Simvastatin, Metformin, Poglitazone, Cogentin, Fluphenazine and Neurotin. During interview on 01/03/20, staff #1 reported: -On 01/03/20 he contacted the physician's office to obtain orders because he could not locate prior documentation b. Observation on 01/03/20 at 1:00 PM of client #3's medications revealed the following: -Neurotin 400 mg one tablet at night, -Fluphenazine 10 mg one tablet twice a day Review on 01/03/20 of client #3's records revealed: -Physician's order obtained from the physician's office on 01/03/20 listed Neurotin 300 mg one tablet at night and Fluphenazine 5 mg one tablet daily and the blood sugar level should be checked twice a day -December 2019-January 2020 MAR listed Neurotin 400 mg one tablet daily, Fluphenazine 10 mg one tablet twice a day and blood sugar level checked once a day During interview on 01/06/20, staff #1 reported: -He was not aware of the discrepancy between the 01/03/20 physician's orders obtained, the December 2019/January 2020 MAR and information on the medications -He had made an appointment to see the physician the week of 01/06/20 to obtain clarification for the physician's orders and how often blood sugar levels should be checked. II. Failure to have medications...	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 118	Continued From page 3 Review on 01/03/20 of client #5's record revealed: -Admitted: 09/07/18 -Diagnoses: Attention Deficit Hyperactivity Disorder, Intermittent Explosive Disorder, Oppositional Defiant Disorder and Anxiety Disorder -07/03/19 Physician's order Cogentin .5 mg one tablet daily -January 2020 MAR listed initials Cogentin administered 1st-2nd Observation on 01/03/20 at 2:30 PM of client #5's medication revealed: -No Cogentin During interviews between 01/03/20 and 01/06/20, staff #1 reported the following about client #5's physician: -Had just returned to the country and an appointment had been scheduled for the week of 01/06/20. -Was not reachable when he was out of the country. The pharmacist needed the physician's approval to authorize the Cogentin to be dispensed. During interview on 01/06/20, the Director of Special Services reported the following: -To address the medication system, he agency had implemented an internal audit system conducted periodically (at least every 2 months) to review medications, physician's orders to assure compliance -At this home, the last audit was conducted in December 2019. She was not sure why the issues identified during this survey was not identified by the internal audit system. -	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 369	G.S. 122C-6 Smoking Prohibited § 122C-6 SMOKING PROHIBITED; PENALTY (a) Smoking is prohibited inside facilities licensed under this Chapter. As used in this section, "smoking" means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, "inside" means a fully enclosed area. (b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall: (1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. (2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product. (3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice. (c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section. A violation of this section constitutes a civil offense only and is not a crime. (d) This section does not apply to State psychiatric hospitals. (2007-459, s. 3.)	V 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 369	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview , the facilty failed to ensure that smoking was prohibited inside the facility. The findings are: Observation and tour on 01/06/20 at 11:00 AM revealed -Client #3's bedroom- ashes on the floor, empty packets of black and mild cigar wrappers on the floor. -Client #2's bedroom- ashes located on the dresser During interview on 01/06/20, staff #1 reported: -Prior to the tour, he was not aware of the ashes noted on the floor. -Client #3 had been exhibited non compliant behaviors as he was soon to be discharged from the facility -Clients were not allowed to smoke in the facility During interview on 01/06/20, client #2's Mentor reported the: -Ashes on the dressers were because the client burned incense -Clients were not allowed to smoke but he was not sure if they were not allowed to burn incense During interview on 01/06/19, the Licensee/Qualified Professional stated: -No staff or clients were allowed to smoke inside the facility. -Client #2 was allowed to burn incense because to reduce the odor in his room caused by his shoes	V 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 536	Continued From page 6	V 536		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served;	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 536	Continued From page 7 (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 536	Continued From page 8 by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 536	Continued From page 9 (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure three of three audited staff (staff #1, staff #2, staff #3) had training in the same alternatives to restrictive interventions prior to providing services. The findings are: a. Review on 01/06/20 of the facility's personnel files revealed the following for staff #2 -Hired: 04/19/19 -Primarily worked the morning shift with staff #1. -MANDT training certificate-03/21/20 date of expiration. b-. Review on 01/06/20 of the facility's personnel files revealed the following for staff #1: -Hired: 04/06/10 -Primarily worked as live in staff the overnight shift and the morning shift with staff #2. -North Carolina Intervention (NCI) Plus	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 536	Continued From page 10 certificate issued on 07/29/19. c. Review on 01/06/20 of the facility's personnel files revealed the following for staff #3: -Hired: 04/23/18 -Primarily worked evening and overnight shift. -Had a Evidence Based Protective Interventions Training certificate issued 03/09/19. During interview on 01/06/20, the Director of Special Services revealed: -Over the past few months, the agency had switched restrictive intervention programs. -Currently, the agency trained staff in NCI plus -She was not aware all staff had to be trained in the same alternative to restrictive intervention curriculum	V 536		
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. This Rule is not met as evidenced by: Based on observation and interview, the governing body failed to maintain the facility in a safe, clean, attractive and orderly manner. The findings are: Observation and tour* on 01/06/20 at 11:00 AM of the home revealed the following:	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 11 -Downstairs Bathroom- floor soft and uneven with strong smell of urine. -Client #3's bedroom (located on lowest level of the group home)-trash on floor, food particles in the bed and clothes laying on the floor -Client #2's bedroom (located near the living room)- "x" markings on wall, dressers, doorways and throughout bedroom -Client #4's bedroom (located upstairs, first bedroom on left)- extremely cluttered with excessive items throughout the room -Emergency exit spindles missing or broken on handrails. Exit ramp dirty. -Trash and debris including a white gate, weight equipment noted in the back yard area -Mattress and other trash noted on the side of the home (*Note: observations was not made of the upstairs bathroom as client was in the shower and client #5's bedroom as he was asleep. This room was located on the upper level, second room on the left) During interview on 01/06/20, staff #1 stated: -Some repairs had been completed at the group home. During interview on 01/06/20, the Director of Special Services reported: -Her mother, who served as the Licensee, visited the group home the weekend of 01/03/20. -The agency was aware of some of the identified violations and would resolve the maintenance concerns This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		