PRINTED: 03/05/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R MHL084-078 B. WING 02/26/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2215 WAVERLY STREET WAVERLY GROUP HOME ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on 2/26/20. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. V 108 27G .0202 (F-I) Personnel Requirements V 108 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and DHSR-Mental Health bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff MAR 2 5 2020 member shall be available in the facility at all times when a client is present. That staff Lic. & Cert. Section member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their

Division of Health Service Regulation

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

equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and

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If continuation sheet 1 of 6

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R MHL084-078 B. WING 02/26/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2215 WAVERLY STREET **WAVERLY GROUP HOME** ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 108 Continued From page 1 V 108 The group home manager/QP clients. has been registered for the next CPR/First Aid training as the lost certificate has not been located. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were currently trained in cardiopulmonary resuscitation (CPR) and first aid techniques provided by the Red Cross, the American Heart Association, or their equivalence for 1 of 1 Qualified Professional (QP). The findings are: Review on 2/25/20 of the QP's personnel record revealed: -Hire date of 4/17/14; -CPR and First Aid training documentation could not be located in the personnel file. Interview on 2/26/20 with the QP revealed: -the Human Resources Department could not locate a copy of her current CPR and First Aid certification; -had taken CPR and First Aid but could not recall when she had taken the class: -her jobs duties required her to work alone with the individuals in the group home and during medical appointments;

possible.

was out of the office:

- had reached out the CPR/First Aid Instructor

- would get her training updated as soon as

for a copy of her certification but the instructor

V 114 27G .0207 Emergency Plans and Supplies

V 114

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R MHL084-078 B. WING 02/26/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

2215 WAVERLY STREET

WAVERLY	GROUP HOME	AVERLY STREET ARLE, NC 28001		
(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
	Continued From page 2 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.	V 114	Fire drills, disaster drills will be completed and documented as required by regulation as well as Easterseals UCP policy. Drill data for all of our licensed facilities is collected by the QM department for data analysis.	
	This Rule is not met as evidenced by: Based on interview and record review, the facility failed to complete fire and disaster drills at least quarterly and repeated for each shift. The findings are:			
- i 2 1 - (Review on 2/26/20 of the facility's Fire and Disaster Drill Logs from February 2019 to January 2020 revealed: - the home operates with 3 shifts which were dentified as 1st shift: 6:00am-2:00pm, 2nd shift: 2:00pm-10:00pm, and 3rd shift/overnight shift: 10:00pm-6:00am; - no 3rd shift Fire Drill completed for 2nd quarter April - June) 2019; no 3rd shift Disaster Drill completed for 2nd quarter (April - June) 2019.			
-	nterview on 2/26/20 with Client #1 revealed: had lived at the facility for 7 years; the facility had fire and disaster drills but was not			

Division of Health Service Regulation

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
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			ERLY STREE	STATE, ZIP CODE		
WAVERL	Y GROUP HOME		LE, NC 280			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
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V 114	Continued From page	3	V 114			
	sure how often the dril	lls were conducted.				
	Disaster Drills monthly conducted as schedule	ty for 8 years; ired to conduct Fire and " and the drills were ed.				
	Interview on 2/26/20 w - Fire and Disaster Dril month; - Drills are conducted to duty for the shift and/or (QP).	Is are conducted once				
	Interview on 2/26/20 w - employed for 6 month - Fire and Disaster Drill rotating shifts each monument - the drills are primarily	ns; ls are conducted monthly, nth;				
	both the QP and/or the that shift is responsible"not sure how we miss	aled: s are held once monthly; e staff member on duty for for conducting the drills; sed the one in June." e Fire and Disaster Drills				
	10A NCAC 27G .0303 L EXTERIOR REQUIREM (c) Each facility and its	MENTS grounds shall be ean, attractive and orderly	V 736			

Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES	(VA) PROMERENCE INC.				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 22 22	PLE CONSTRUCTION	(X3) DATE SURVEY	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
WAVERIN	Y GROUP HOME	2215 WA	VERLY STREE	:T		
WAVEKE	OKOOF HOME	ALBEMA	RLE, NC 280	01		
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				DEFICIENCY)		
V 736	Continued From page	4	V 736			_
	,		100 1000.0			
				All residents will be remine	ما ما	
					10-70070	
				of the no smoking policy w	ithin the	
	This Rule is not met a	s evidenced by:		home, and reminded of		
		and interviews, the facility				
	was not maintained in	a safe, clean, attractive,		designated smoking areas	outside	
	and orderly manner. T	he findings are:		of the home.		
	and arony marrior.	The midnigs are.		Bathrooms will be monitore	ad	
	Observation on 2/26/2	0 at 10:47am of the facility		A COLUMN TO A COLU		
	revealed:	and the same of the facility		daily by staff on duty to as:	sure	1
				that they are clean and in		-
	- Facility's bathroom, u	sed by all clients:		working condition. The sho		1
	- bathtub with approxim	nately 5-6 inches of				1
	standing water in the b	ottom of the tub;		curtain was replaced by 3/	10/20.	١
	- the plug was positioned	ed correctly for draining;		The plumber was schedule		1
	 Staff #1 moved the dr 	ain plug up and down and		3/11/20	,4 101	1
	the water did not drain;			3/11/20		1
	- the shower curtain line	er had several large, light				1
	grayish/black spots on	the inside of the liner.				١
	0					ı
	Client #4's bedroom:					ı
	- strong smell of cigaret	ttes in the room;				ı
	- approximately 15-20 (already smoked) cigarette				ı
	butts lying in a pile on the	ne top of the dresser;				١
	- no cigarette ashes we	re found in the bedroom.				ı
	Intension on 2/26/20	No Chaff HA				ı
	Interview on 2/26/20 with					
	- was unaware of the wa bottom of the tub:	ater standing in the				
	- "no one told me about	the water in the fall.				
	- was linaware of the	lready smoked) cigarette				
	outts located in Client #	d's bodroom:				
	the cigarette butts "we					
	he had to have done it	today "				
	no nau to nave done it	louay.				
1	nterview on 2/26/20 wit	h the Qualified				
	Professional (QP) revea					
	was unaware of the wa					
	oottom of the tub:	acc. standing in the				

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER					2/26/2020	
NAME OF F	ROVIDER OR SUPPLIER			STATE, ZIP CODE			
WAVERLY	Y GROUP HOME		ERLY STREE				
			LE, NC 280	01			
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 736	Continued From page	5	V 736				
V 736	- was unaware of the (already smoked) cigarette the dresser in Client #4's	V 736				

Division of Health Service Regulation