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V 000	INITIAL COMMENTS A complaint survey was completed 2/8/21. The complaint was substantiated (Intake #NC00171982 and NC00172932.) 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 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations;	V 105		

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V 105	Continued From page 1 (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by:	V 105		

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V 105	Continued From page 2 Based on record review and interview the facility failed to implement their policy for admission and discharge for two of two former clients (FC #7 & FC #8). The findings are: Review on 1/5/21 and 1/8/21 there was no evidence of an Admission and Discharge summary for FC #7 and FC #8 ever completed. Review on 1/12/21 of Facility Admission and Discharge policy revealed: -"All admissions to the group home must first go through New Day New Beginning Access Team. The team will compromise the Qualified Professional (QP), Director, Quality Assurance (QA) consultant and direct care staff. After meeting with Access Team and it is determined Residential Services are needed, a thorough assessment is completed by a representative (QP) and filed in a chart. When/if the individual is admitted to the residential facility, then the addendum to the Admission Assessment is completed and filed by the QP. When an individual is admitted to a service/program which is expected to be far for more than 30 days, the admission assessment shall include the following within 30 days of admission: a) social and family history, including socio-cultural and religious preferences b) medical history, to include childhood illness, immunizations, operations, dental status and needs c) When applicable, histories and assessments are as follows: 1-psychiatric/psychological, including previous treatment, testing and placements 2-substance abuse, including previous treatment and placements 3-developmental, including previous services received and previous placements	V 105		

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V 105	Continued From page 3 4-health needs, an individual may have in regard to age appropriate instruction regarding pregnancy prevention, aids prevention, and treatment of sexually transmitted diseases d) educational e) auditory and visual f) nutritional and g) vocational/ work history h) residential placement history with noted outcomes, reasons for placement out of home as appropriate i) aftercare possibilities and plans." -"Screenings will include the following: a) An assessment of the individual's presenting problem or need b) An assessment of whether or not the facility can provide services to address the consumer's needs c) The disposition, including referrals and recommendations d) QP, QA owner and direct care will take part in screening process, QP will draft assessment." -"The transfer of discharge of the consumer from the facilty. If a consumer cannot pay for room and board, New Day New Beginning reserves the right to discharge consumer without notice. New Day New Beginning will give 10 days notice before transfer or discharge of a client. In case of an emergency, the facility shall notify the treatment team of the transfer or discharge of the consumer as soon as the emergency situation has been stabilized. In case of an emergency New Day New Beginning may determine the client needs to be removed from the facility client repeatedly disobeys rules, jeopardizes safety of staff and or others, etc. Department of Social Services (DSS) and treatment team will be contacted.	V 105		

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Notification may be made by telephone. A treatment decision making meeting will be scheduled within 24 hours of an emergency, transfer or discharge. The client can be discharged or transferred within 48 hours."

Below is evidence to show the Licensee did not follow her admission and discharge policy.

During interview on 1/5/21 the Licensee stated:
-FC #7 used to live in the home.
-FC #7 was discharged on 11/3/20 to another group home.
-Knew of FC #8.
- "He has never stayed here before."
-"I knew of him from around town, "I know a lot of the clients around here."
-He used to be at a Day Program her clients attended.
-Police came three times last week and over the weekend with FC #8.
-Police brought FC #8 to the facility because he was looking for FC #8 a place to stay.
-The police and FC #8 came two days before Christmas, then he came two times in one night with an officer and she told them he couldn't stay.
-FC #8 stated he had been living in a shelter in a neighboring town.
-FC #8 told the police he wanted to stay at her group home, "probably because everyone wants to stay here."
-Not sure why people would think FC #8 lived at her group home.
-Police stated FC #8's mother/legal guardian had called in a missing person for him.
-Never served him in any capacity.
-No one has ever called on the phone about him.
-He is telling people he lived there.
-Never spoke to his guardian.
-Called mother/guardian several times using the

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number police provided to let her know he was found.
-She did not answer, so she texted her.
-Did not keep that number.
-Never had a record for FC #8.
-Never had any medications, Medication Administration Record (MAR), assessments or treatment plan for FC #8.
-FC #8 had never stayed at any of her homes.
-During this past year, she and her boyfriend (Licensee's boyfriend/staff #2) were the only two working since March 2020.
-Did not trust other staff that may spread Covid to the clients.

During interview on 1/6/21 of FC #8's mother/legal guardian stated:
-FC #8 lived in the Licensee's home after he was moved from his previous placement a few months ago.
-Had spoke on the phone multiple times to the Licensee and Licensee's boyfriend/staff #2 during his initial admission to the home.
-Did everything over the phone with Licensee because she had to find a place quickly.
-Emailed the Licensee a signed medical release.
-Sent the Licensee the bank card that FC #8's social security check was deposited on.
-The Licensee told her she was not going to apply for Special Assistance for FC #8.
-The Licensee stated to her she would just use his social security money for everything and if he needed other stuff she would take care of it.
-"I thought [Licensee] was a great person for saying she would do these for [FC #8]."
-Had talked to FC #8 on the phone and he said he liked it there.
-Never visited him at the group home because of Covid.
-Talked to the Licensee several times over the

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course of the time he was there and along with a man who stated he was the Licensee's boyfriend.
-The Licensee's boyfriend/staff #2 also sounded like he was over the facility.
-The Licensee's boyfriend/staff #2 was calling it, "his group home."
-"How would I know [the Licensee] phone number and address to the home if [FC #8] had not stayed there."
-Called the Licensee on Christmas day to inquire about taking some presents to him.
-The Licensee stated FC #8 no longer lived in the home.
- The Licensee stated they called the police when he came back to the home.
-They had no business to put him out without calling his guardian first.
-The Licensee knew she was his legal guardian.
-The Licensee explained she didn't know he was not his own guardian.
-Called the local police and made a missing person report.
-Local police acted like they didn't know who FC #8 was.
- They took her info and went looking for him.
-FC #8 was found at a local homeless shelter by local police department.
-After speaking with the officer and FC #8, she felt like he needed to go to the hospital because he was delusional.
-FC #8 stated he had not taken his medications in weeks.
-FC #8 is currently in the hospital now to get stabilized.
-That night (12/31/20) when he was admitted to the hospital his blood sugar was over 500 due to not taking his medications for his diabetes.

During interview on 1/6/21 FC #8's previous provider stated the following:

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-FC #8 used to live in his group home
-"They closed me (the state) and I had to move my clients."
-The Licensee/staff#1 came to his house and picked up FC #7 and FC #8 to move into her home.
-She picked them up around the end of September 2020.
-Local county DSS knew FC #7 and #8 went with the Licensee to her facility.
-She took their records and medications with her.
-Informed the Licensee about FC #8's behaviors.
-FC #8 had a history of walking off many times from his home.
-The county DSS assisted with making these placements.

During interview on 1/6/21 the county DSS worker stated the following,
-FC #7 and FC #8 were moved from a previous provider to the home of Licensee on 9/28/20.
-The previous provider contacted her to let her know of the clients new location.
-The previous provider stated the Licensee had picked up FC #7 and #8 from his home.

During interview on 1/8/21 with Pharmacy who provides medications for the facility stated the following:
-FC #8 was listed under New Day New Beginning and received his medications at their address.
-FC #8's last delivery of medications was on 12/21/20 to the facility address.
-Previous deliveries for FC #8 to the facility was on 10/5/20, 11/3/20, 11/10/20, 11/25/20, 12/1/20.
-The Licensee was the contact person for former client #8's medications.
-Orders for FC #8 had come from a doctor at a medical clinic in the town where the facility is located.

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V 105	Continued From page 8 During interview on 1/8/21 the local police officer stated the following: -FC #8 said he wanted to go home at which time he stated was on Atlantic Ave (facility street). -FC #8 stated he could not remember the address only the street name. -Drove him to Atlantic Ave and shined the lights on houses to see if he could recognize which one. -FC #8 picked 616 Atlantic Ave as the house he used to live in. -FC #8 continued to say this location was where he once lived. -They approached the door and spoke to the lady who was working. -Description of the female staff matched the description of the Licensee. -Asked the Licensee if FC #8 stayed in the home. -The Licensee stated no, he stayed at another home. -She said he had stayed there a day or two before he was moved to another group home because she was over capacity. -The Licensee seemed upset and appeared bothered they were there. -The Licensee had the mother/guardian's number and provided it to him to contact. -The Licensee knew exactly who FC #8 was. -FC #8 seemed "a little let down" when she would not let him in. -FC #8 seemed coherent in what he was talking about. -The police officer stated he had not had contact with FC #8 prior to 12/31/20. -FC #8 stated he was schizophrenic. -After a conversation with him and his mother, she felt he needed medications so he took him to the hospital. -FC #8's mother/legal guardian was concerned	V 105		

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because she was never notified he had been discharged.
-He said he had not had medications in a month.

During interview on 1/12/21 the QP stated:
-Been working as a QP for over a year at the facility.
-Worked as a contract employee.
-Since pandemic, had been doing "video chatting", two to three times a month.
-Had not been to the home in many months.
-Not always see all the clients during video conference because they would refuse to talk to her.
-When the Licensee is admitting a client, she would let her know when the client was coming.
-Would meet with the client and complete their admission assessment and treatment plan.
-When discharging a client, the QP would give thirty day notice to client/guardian.
-Would help find them placement for discharge.
-Provided supervision for the Licensee and Licensee's boyfriend/staff #2 by phone.
-Never heard the names of FC #7 or FC #8.
-Did not have any admission assessment or treatment plan for FC #7 or FC #8.
-"Their names do not ring a bell to me."
-The process is the Licensee contacts her for admissions and discharges.
-If the Licensee is admitting and discharging people without telling her, she had no way of knowing.

Review on 2/4/21 of FC #8 medical records provided by local physician and pharmacy revealed the following:
-FC #8 seen by physician on 10/1/20 and medication orders sent to pharmacy and delivered to the facilty on 10/5/20.
-FC #8 seen by physician on 11/2/20 and

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medication orders sent to pharmacy and delivered to the facilty on 11/3/20.
-FC #8 seen by physician on 11/13/20 and deliveries from the pharmacy to the facility on 11/16/20 and 11/25/20.
-FC #8 was seen by physician on 12/1/20 and refills were delivered to the facility on 12/1/20 and 12/21/20.

During further interview and observation on 2/8/21 at approximately 11:30 am, the Licensee stated:
-Did not remember when FC #7 came to her facility.
-Picked FC #7 up from another provider.
-A treatment plan was not done for FC #7 because he was not in the home long enough.
-The QP did an admission assessment and discharge summary for him.
-The Licensee attempted to locate FC #7's admission assessment and discharge summary.
-The Licensee stated she must have sent it with his book to the provider he moved to.
-Not sure of the name of facility FC #7 moved to or the name of the provider.
- "We are on a text chain."
-FC #7 did move to a multi unit housing location.
-He may have moved around 11/3/20.
-Spoke to QP twice a month.
-let her know of any admission and discharges.
-The QP probably has a copy of the admission and discharge summaries for FC #7.
-Had no identifying information for FC #7.
-Had picked FC #8 up from a former provider the same day she picked up FC #7.
-Took FC #7 and #8 to the laundromat to wash their clothes.
-Another provider then picked up FC #8 from her at the laundromat.
-Not sure the name of the facility that picked FC

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V 105	Continued From page 11 #8 up from her. -FC #8 was never admitted or stayed in her facility. -FC #8 did not stay at her other location (multi unit-assisted housing with services). -The Licensee's boyfriend/staff #2 did have a multi-unit housing with services in the area. -When asked if FC #8 stayed at the Licensee's/staff#2 multi-unit housing with services the response was, "It's not my house, he did not stay here." -In another statement the Licensee stated FC #8 did not stay in Licensee's boyfriend/staff #2 multi unit housing. -FC #8's mother/legal guardian called her a week after he was placed asking about FC #8's location. -Provided her with the location of where FC #8 was staying in a neighboring town. -Assumed the previous provider had given the mother/legal guardian her phone number to contact. -FC #8's previous provider and county DSS knew he was not placed with her and where he went in a neighboring town. -Had not taken FC #8 to any doctor appointments. -Not sure how the doctor would have known to send his medication to the pharmacy she used for her clients. -"I guess someone must have told them he was staying here." -When questioned about why FC #8's medication was sent to her house, she shrugged her shoulders. -Medicine came for several months and she did send it back to the pharmacy. -The pharmacy should have a record of her sending FC #8's medications back. -Did not keep the sheet showing she sent	V 105		

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V 105	Continued From page 12 medications. -Not aware of any of FC #8's medical needs or medications he was taking. Further interview on 2/8/21 with Pharmacy revealed the following: -They do not have any record of the facility sending medications back to them for FC #8. -If medications would have been sent back, they would have called the Licensee to inquire if FC #8 had moved. -Then they would have stopped delivery of all his medications. -Had not ever received any notification that FC #8 was not residing in the facility. This deficiency is cross referenced into: 10A NCAC 27D .0304 Protection From Harm, Abuse, Neglect Or Exploitation (V512) for a Type A1 rule violation.	V 105		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.	V 110		

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V 110	Continued From page 13 (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of three staff (Licensee's boyfriend) demonstrated competency for the population served. The findings are: Review of Licensee's boyfriend/staff #2 record revealed: -No hire date. During interview on 12/15/20 the Licensee stated Licensee's boyfriend/staff #2 had been working in the home for over a year. Refer to tag v105 for evidence that Former Client (FC) #8 lived in the facility. Review on 1/7/21 of Division of Health Service Regulation (DHSR) website revealed the address where 911 calls originated from regarding FC #8	V 110		

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V 110	Continued From page 14 and he was picked up by Emergency Management Services (EMS) was registered as a multi-unit assisted housing with services. Further contact with DHSR adult care section revealed the certificate for the multi-unit assisted housing with services was registered to Licensee's boyfriend/staff #2 as the provider. Review on 1/7/21 of 911 calls revealed: -911 call on 11/26/20 regarding FC #8 hyperglycemic symptoms from FC #8 from the location of the Licensee's boyfriend/staff #2's the multi-unit assisted housing with services home. EMS picked FC #8 up from this location and transported to the hospital. -911 call on 11/29/20 regarding FC #8 hyperglycemic symptoms from the phone number of Licensee's boyfriend/staff #2 and was picked up by EMS from the location of the multi-unit assisted housing with services and transported to the hospital. Review on 1/7/21 of Hospital Records dated 11/26/20 and 11/29/20 listed the Licensee's boyfriend/staff #2 as contact person for FC #8. During interview on 1/7/20 hospital staff stated: -FC #8 was seen in their Emergency Room on 11/26/20 and 11/29/20 for hyperglycemic symptoms with blood sugar over 500. -FC #8 could not recall the name of the home he resided in, but had the phone number. -Hospital staff contacted the Licensee's boyfriend/staff #2 and he provided FC #8's mother/legal guardian's phone number. During interview on 2/5/21 the Licensee's boyfriend/staff #2 was contacted by the telephone number listed in the 911 calls and he stated:	V 110		

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V 110	Continued From page 15 -Been working at the facility about three to four years. -No set time, part time when the Licensee needed him. -Worked about 30-40 hours some weeks. -When questioned about FC #7 living in the home, he stated, "that was before my time." -"That must have been the guy that stayed for a day or two." -Not familiar with FC #8. -Saw FC #8 at the homeless shelter one time. -FC #8 had been dropped off with his bags at the homeless shelter. -Tried to talk to FC #8 to see if he needed a place to stay. -FC #8 didn't want the help, he wanted to run the streets. -When he saw FC #8 he seemed normal, not aware of any health issues. -FC #8 never stayed at the facility, not sure who keeps calling in these complaints.	V 110		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon	V 111		

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V 111	Continued From page 16 admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure two of two former clients (FC #7 and FC #8) had Assessments completed at the time of admission. The findings are: Refer to tag 105 regarding evidence FC #7 and FC #8 lived in the facility. Attempted record review on 1/5/21 and 2/8/21 revealed there were no records for FC #7 and FC #8. Interview on 2/8/21 the Licensee stated: -Did not have a record for FC #8. -Had a record for FC #7. -The Qualified Professional (QP) may still have a copy.	V 111		

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V 111	Continued From page 17 -Must have sent FC #7's record with the provider he moved to. This deficiency is cross referenced into: 10A NCAC 27D .0304 Protection From Harm, Abuse, Neglect Or Exploitation (V512) for a Type A1 rule violation.	V 111		
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		

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V 112	Continued From page 18 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure two of two former clients (FC #7 and FC #8) had a Treatment Plans. The findings are: Refer to tag 105 regarding evidence FC #7 and FC #8 lived in the facility. Attempted record review on 1/5/21 and 2/8/21 revealed there were no records for FC #7 and FC #8. Interview on 2/8/21 the Licensee stated: -Did not have a record for FC #8. -Had a record for FC #7. -The Qualified Professional (QP) may still have a copy. -Must have sent FC #7's record with the provider he moved to. This deficiency is cross referenced into: 10A NCAC 27D .0304 Protection From Harm, Abuse, Neglect Or Exploitation (V512) for a Type A1 rule violation.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number;	V 113		

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V 113	Continued From page 19 (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.	V 113		

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V 113	Continued From page 20 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure two of two former clients (FC #7 and FC #8) had a record maintained with identifying information. The findings are: Refer to tag 105 regarding evidence FC #7 and FC #8 lived in the facility. Attempted record review on 1/5/21 and 2/8/21 revealed there were no records for FC #7 and FC #8. Interview on 2/8/21 the Licensee stated: -Did not have a record for FC #8. -Had a record for FC #7. -The Qualified Professional (QP) may still have a copy. -Must have sent FC #7's record with the provider he moved to. This deficiency is cross referenced into: 10A NCAC 27D .0304 Protection From Harm, Abuse, Neglect Or Exploitation (V512) for a Type A1 rule violation.	V 113		
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.	V 118		

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V 118	Continued From page 21 (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. This Rule is not met as evidenced by: Based on record review and interview the facilty failed to ensure medications were administered on the order of a physician and MAR's were kept current for one of one audited former clients (FC #8) who was receiving medications at the facility. The findings are: Refer to tag 105 regarding evidence FC #8 lived in the facility. During interviews on 1/5/21 and 2/8/21 the Licensee/staff stated she had never maintained	V 118		

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any medications or MAR's for FC #8.

Review on 2/4/21 of FC #8's medical records provided by local physician dated 10/1/20 revealed
-"Continue Sertraline HCl tablet 100 milligram (mg), Benzotropine Mesylate 2mg, Haldol Decanoate Solution 100 mg, Intramuscular once a month, Haldoperidol 5 mg, Depakote 500 mg."

Review on 1/26/21 of Pharmacy "Delivery Manifest" dated 10/5/20 for FC #8 revealed the following medications were delivered to facility address:
-"Sertraline 100 mg, Haloperidol 100 mg, Benzotropine 2mg, Haloperidol 5 mg, Divalproex DR 500mg."

Review on 2/4/21 of FC #8's medical records provided by local physician dated 11/2/20 revealed:
-"Continue Sertraline HCl tablet 100 mg, Benzotropine Mesylate 2mg, Haldol Decanoate Solution 100 mg, Intramuscular once a month, Haldoperidol 5 mg, Depakote 500 mg."

Review 1/26/21 of Pharmacy "Delivery Manifest" dated 11/3/20 for FC #8 revealed the following medications were delivered to facility address:
-"Sertraline 100 mg, Haloperidol 100 mg, Benzotropine 2mg, Haloperidol 5 mg, Divalproex DR 500mg."

Review on 2/4/21 of FC #8's medical records provided by local physician dated 11/13/20 revealed:
-"Continue Sertraline HCl tablet 100 mg, Benzotropine Mesylate 2mg, Haldol Decanoate Solution 100 mg, Intramuscular once a month, Haldoperidol 5 mg, Depakote 500 mg, Metformin

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V 118	Continued From page 23 500 mg and Atorvastatin 40 mg, Start taking these medications immediately, start checking your blood sugar daily and recording it in a chart." Review 1/26/21 of Pharmacy "Delivery Manifest" dated 11/16/20 for FC #8 revealed the following medications were delivered to facility address -"Metformin 500 mg, Easy Touch monitor, Advocate Safety Lancets 2, Easy Touch HP test strips and Atorvastatin 40 mg." Review 2/4/21 of FC #8's medical records provided by local physician dated 12/1/20 revealed: -"Increase Metformin HCl tablet 1000 mg twice a day." Review on 1/26/21 of Pharmacy "Delivery Manifest" dated 12/1/20 for FC #8 revealed the following medications were delivered to facility address -"Metformin 1000 mg tablet" Review on 1/26/21 of Pharmacy "Delivery Manifest" dated 12/20/20 for FC #8 revealed the following medications were delivered to facility address -"Sertraline 100 mg, Haloperidol 100 mg, Benzotropine 2mg, Haloperidol 2 mg, Divalproex DR 500mg, Atorvastatin 40 mg, Metformin 1000 mg tablet." During interview on 2/5/21 the Licensee's boyfriend/staff #2 stated: -The Licensee is in charge of the medications in the home. -When medications are delivered from the pharmacy, she is the one who sorts them and organizes everyone's medications.	V 118		

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V 118	Continued From page 24 During interview on 2/8/21 the Licensee stated: -Not sure why FC #8's medications were delivered to her facility. -Never took FC #8 to the doctor. -Not aware of how someone would have known to send his medications to the pharmacy she used. -Never kept his medications or a record of them. -Sent his medications back to the pharmacy. -Who ever is working is responsible for getting the medications and storing them. Further interview on 2/8/21 with Pharmacy revealed the following: -All medications for FC #8 were ordered from his primary care clinic in the town of the facilty. -They do not have any record of the facility sending medications back to them for FC #8. -If medications would have been sent back, they would have called the Licensee to inquire if FC #8 had moved. -Then they would have stopped delivery of all his medications. -Had not ever received any notification that FC #8 was not residing in the facility This deficiency is cross referenced into: 10A NCAC 27D .0304 Protection From Harm, Abuse, Neglect Or Exploitation (V512) for a Type A1 rule violation.	V 118		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to	V 291		

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V 291	Continued From page 25 provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure coordination was maintained for one of two former clients (FC#8). The findings are: Refer to tag 105 regarding evidence FC #8 lived in the facility. During interview on 1/6/21 of FC #8's mother/legal guardian stated: -FC #8 lived in the Licensee's home after he was moved from his previous placement a few	V 291		

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months ago.
-Had spoke on the phone multiple times to the Licensee and Licensee boyfriend/staff #2 during his initial admission to the home.
-Did everything over the phone with Licensee because she had to find a place quickly.
-Emailed the Licensee a signed medical release.
-Sent the Licensee the bank card that FC #8's social security check was deposited on.
-The Licensee told her she was not going to apply for Special Assistance for FC #8.
-The Licensee stated to her she would just use his social security money for everything and if he needed other stuff she would take care of it.
-"I thought [Licensee] was a great person for saying she would do this for [FC #8]."
-Had talked to FC #8 on the phone and he said he liked it there.
-Never visited him at the group home because of Covid.
-Talked to the Licensee several times over the course of the time he was there and along with a man who stated he was the Licensee's boyfriend.
-The Licensee's boyfriend/staff #2 also sounded like he was over the facility.
-The Licensee's boyfriend/ staff #2 was calling it, "his group home."
-"How would I know [the Licensee] phone number and address to the home if [FC #8] had not stayed there."
-Called the Licensee on Christmas day to inquire about taking some presents,
-The Licensee stated FC #8 no longer lived in the home.
-The Licensee stated she put him "on the streets" because he was leaving he facility.
-He was walking up and down the street, asking for cigarettes, hitting on a young girl and he jumped out the window.
-The Licensee stated she put him out around

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(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 291	Continued From page 27 11/30/20. -The Licensee never told her the name of the young lady he was hitting on. -The Licensee stated after that she put him out. -After she put him out, he kept trying to go back to the home to see the young lady. -The Licensee's boyfriend/staff #2 told her in an earlier conversation a month ago, he was leaving the home and walking the streets. - The Licensee stated they called the police when he came back to the home. -They had no business to put him out without calling his guardian first. -The Licensee knew she was his legal guardian. -The Licensee explained she didn't know he was not his own guardian. -Called the local police and made a missing person report. -Local police acted like they didn't know who FC #8 was. -They took her info and went looking for him. -FC #8 was found at a local homeless shelter by local police department. -After speaking with the officer and FC #8, she felt like he needed to go to the hospital because he was delusional. -FC #8 stated he had not taken his medications in weeks. -FC #8 is currently still in the hospital now to get stabilized. -When he was admitted to the hospital on 12/31/20, his blood sugar was over 500 due to not taking his medications for his diabetes. During interview on 1/5/21 the Licensee stated: -Knew of FC client #8. - "He has never stayed here before." -"I knew of him from around town, I know a lot of the clients around here." -He used to be at a Day Program her clients	V 291		

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V 291	Continued From page 28	V 291		

attended.
-Police came three times last week and over the weekend with FC #8.
-Police brought FC #8 to the facility because he was looking for him a place to stay.
-The police and FC #8 came two days before Christmas, then he came two times in one night with an officer and she told them he couldn't stay.
-FC #8 stated he had been living in a shelter in a neighboring town.
-FC #8 told the police he wanted to stay at her group home, "probably because everyone wants to stay here."
-Not sure why people would think FC #8 lived at her group home.
-Police stated FC #8's mother/legal guardian had put out a missing person for him.
-Never served him in any capacity.
-No one has ever called on the phone about him.
-He is telling people he lived there.
-Never spoke to his guardian.
-Called her several times by the number police provided to let her know he was found.
-She did not answer, so she texted her.
-Did not keep that number.
-Never had a record for FC #8.
-Never had any medications, Medication Administration Record (MAR), assessments or treatment plan for FC #8.
-FC #8 has never stayed at any of her homes.

During interview on 1/8/21 the local police officer stated the following,
-FC #8 was reported missing 12/31/20 at 10:00 am by his mother/legal guardian.
-FC #8 was located at homeless shelter in town around 8:00 pm.
-FC #8 had been at the homeless shelter a few hours.
-FC #8 stated he had been staying at different

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V 291	Continued From page 29	V 291		

addresses.
-FC #8 stated he was put out of his group home.
-The Licensee's boyfriend/staff #2 of the group home took him to his own personal residence.
-FC #8 stated he was hitting on Licensee's boyfriend/staff #2's daughter,
-The Licensee's boyfriend/staff #2 took him to a homeless shelter in town.
-The Licensee/staff #2 was charging him 200.00 a month to stay at his personal residence.
-FC #8 stated that the Licensee's boyfriend/staff #2 had his benefit card with his money on it.
-FC #8 said he wanted to go home at which time he stated was on Atlantic Ave.
-FC #8 stated he could not remember the address only the street name.
-Drove him to Atlantic Ave and shined the lights on houses to see if he could recognize which one.
-FC #8 picked 616 Atlantic Ave as the house he used to live in.
-FC #8 continued to say this location is where he once lived.
-They approached the door and spoke to lady who was working.
-Description of the female staff matched the description of the Licensee.
-Asked the Licensee asked if FC #8 stayed in the home.
-The Licensee stated no, he stayed at another home.
-The Licensee said she put him out a few weeks prior and he was moved to a different group home.
-She said he had stayed there a day or two before he was moved to another group home because she was over capacity.
-The Licensee seemed upset and appeared bothered they were there.
-The Licensee had the mom/guardian's number

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V 291	Continued From page 30	V 291		

and provided it to him to contact.
-The Licensee knew exactly who FC #8 was.
-FC #8 seemed "a little let down" when she would not let him in.
-FC #8 seemed coherent in what he was talking about.
-The police officer stated he had not had contact with FC #8 prior to 12/31/20.
-FC #8 stated he was schizophrenic.
-After a conversation with him and his mother, she felt he needed medications so he took him to the hospital.
-FC #8's mother/legal guardian and was concerned because she was never notified he had been discharged.
-He said he had not had medications in a month.

During interview on 2/8/21 the Licensee stated:
-Had picked FC #8 up from a former provider same day she picked up FC #7.
-Took FC #7 and #8 to the laundromat to wash their clothes.
-Another provider then picked up FC #8 from her at the laundromat.
-Not sure the name of the facility or provider who picked him up.
-FC #8 never was admitted or stayed in her facility.
-FC #8 did not stay at her other location.
-The Licensee's boyfriend/staff #2 did have a multi-unit assisted housing services housing in the area.
-When asked if FC #8 stayed at the Licensee's/staff#2 multi unit housing the response was, "It's not my house, he did not stay here."
-In another statement the Licensee stated FC #8 did not stay at Licensee's boyfriend/staff #2 multi-unit assisted housing with services housing.
-FC #8's mother/legal guardian called her a week

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V 291	Continued From page 31 after he was placed asking about FC #8's location. -Provided her with the location of where FC #8 was staying in a neighboring town. -Assumed the previous provider had given the mother/legal guardian her phone number to contact. This deficiency is cross referenced into: 10A NCAC 27D .0304 Protection From Harm, Abuse, Neglect Or Exploitation (V512) for a Type A1 rule violation.	V 291		
V 502	27D .0102 Client Rights - Suspension and Expulsion 10A NCAC 27D .0102 SUSPENSION AND EXPULSION POLICY (a) Each client shall be free from threat or fear of unwarranted suspension or expulsion from the facility. (b) The governing body shall develop and implement policy for suspension or expelling a client from a service. The policy shall address the criteria to be used for an suspension, expulsion or other discharge not mutually agreed upon and shall establish documentation requirements that include: (1) the specific time and conditions for resuming services following suspension; (2) efforts by staff of the facility to identify an alternative service to meet the client's needs and designation of such service; and (3) the discharge plan, if any.	V 502		

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V 502	Continued From page 32 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure one of two former clients (FC#8) was subjected to unwarranted expulsion from the facility. The findings are: Review on 2/5/21 of the facility policy on Suspension and Expulsion revealed the following: -"Each consumer will be free from threat or fear of unwarranted suspension or expulsion from New Day New Beginning. Consumers will be expelled or suspended when the facility can no longer meet the consumer's needs or guarantee their safety. -The following will be documented following a suspension/expulsion: -The specific time and conditions for resuming services following a suspension -Efforts by staff to identify an alternative service to meet the consumer's needs and designation of such service. -The discharge plan, if any." Refer to tag 105 regarding evidence FC #8 lived in the facility. Interviews and record reviews revealed FC #8 was admitted to the facility on 9/28/20 expelled on or around the end of November 2020. A. Review on 2/4/21 of medical note from FC #8 primary care physician dated 11/13/20 revealed: -Diagnoses of Schizophrenia, Anxiety, Seizure Disorder and Type II diabetes. -"Labs show uncontrolled diet and cholesterol levels abnormal. Patient needs immediate follow up appointment with Primary Care Physician (PCP) in clinic to go over these labs in details...I have sent Metformin for diabetes which he needs to take twice daily with meals, also starting	V 502		

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Atorvastatin once at bedtime daily for cholesterol. Start taking these medications immediately, start checking your blood sugar daily and recording it in a chart.
-Blood Glucose 436"

B. Review on 1/7/21 of 911 calls revealed:
-911 call on 11/26/20 regarding FC #8 hyperglycemic symptoms from FC #8 at the location of the multi-unit assisted housing with services home owned and operated by Licensee's boyfriend/staff #2. Emergency Management Services (EMS) picked FC #8 from this location and transported to the hospital.

Review on 2/5/21 of medical record from local hospital dated 11/26/20 revealed:
-"Presents to Emergency Department (ED) with elevated blood glucose with no symptoms.
-Patient states he was diagnosed with diabetes about two weeks ago...He had a bowl of cereal for breakfast. When he checked his glucose it was over 500. EMS reports glucose was 600 upon their arrival.
-Glucose 587
-Will give 10 units IV insulin..."

C. Review on 1/7/21 of 911 calls revealed:
- 911 call on 11/29/20 regarding FC #8 hyperglycemic symptoms from the phone number of Licensee's boyfriend/staff #2 at the location of his multi- unit assisted housing with services housing.

Review on 1/26/21 of medical records from local hospital dated 11/29/20 revealed:
-"Presents to ED with elevated blood glucose symptomatic
-Blood Glucose 586
-Differential diagnosis- Hyperglycemia, DKA

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(Diabetic Ketoacidosis), dehydration, electrolyte imbalance, poor diet, non compliance
-Will give 10 units of IV insulin
-Received tow liters of fluids
-Increase Metformin to 1000 milligram (mg) BID (twice a day)"

D. Review on 2/5/21 of medical note dated 12/1/20 from primary care physician revealed:
-"Increase Metformin HCl 1000 mg
-Giving him a Blood glucose chart to fill and bring back in six weeks.
-Will reassess regimen then and if no control with try to add GLP1 (Glucagen-like peptide 1) or Insulin next..."

Review on 1/26/21 of medical record from local hospital on 12/25/20:
-"Patient states he is homeless and was told to come to ED to sleep until the morning as well as get assessed. The patient does state he is a diabetic and has not used his insulin in a couple of week because he cannot afford the needles. He does admit the guy at the shelter told him to come in for assessment because of his hallucinations. He admits to auditory and visual hallucinations. He states that the voices that he is hearing and seeing are aggressive and they are telling to hurt others however he does not want to hurt others. They are not telling him to hurt himself.
-Homeless due to being turned out of group home...
-"I'm schizophrenic and I have a cold. Yesterday I didn't have a place to stay and I was cold. I don't have a place to stay tonight. I'm supposed to call a guy tomorrow about taking me to a shelter.
-Patient stated he has no way to afford his medications and does not have a place to go...
-Behavioral Health Consult Note dated 12/25/20

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V 502	Continued From page 35 -Presents to ED with auditory and visual hallucinations. Patient is lethargic and disoriented during the assessment, presenting with confusion and thought blocking. Patient has paucity of speech...not recall last time he received medication management for mental health stabilization...reports being brought to ED by the housing manager at the group home he was living in because he was walking around talking to himself saying he was hearing voices and seeing things...endorse visual hallucinations of glowing lights... History of cutting himself, but not done so in years...Staff called the home [number provided by FC #8] and spoke to [client living in the Licensee's boyfriend/staff #2's multi unit housing] who advised no housing manager or staff is available at night...Patient reports he does not know if he can return to the home because he was kicked out...Patient reports the housing manager [the Licensee's boyfriend/staff #2] has his disability funds... Mental Status Exam- Disheveled and Malodorous, Depressed, Decreased range and Depressed, Thought blocking and Visual, Hallucinations of glowing lights... -Last use of marijuana- two weeks ago. -His affect is blunt. He is actively hallucinating (visual and auditory), patient appears disheveled. -Blood Glucose 559 -12/25/20- 10 units of insulin given and sodium chloride 1,000 mili liters -12/26/20- 10 units of insulin given -It is possible patient's tachycardia could be due to dehydration, the patient does appear clinically dehydrated. -12/26/20- Patient eloped from facility. D/c'd (discharged) his IV and threw it in trashcan. -RN (registered nurse) at the bedside to administer medication to patient- patient not seen in room. Per surrounding staff, patient was seen	V 502		

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using telephone and hadn't been seen since. IV catheter noted to be removed and lying on patients bed."

E. During interview on 1/8/21 the local police officer stated the following:
-FC #8 was reported missing 12/31/20 at 10:00 am by his mother/legal guardian.
-FC #8 was located at homeless shelter in town around 8:00 pm.
-FC #8 had been at the homeless shelter a few hours.
-FC #8 stated he had been staying at different addresses.
-FC #8 stated he was put out of his group home.
-The Licensee's boyfriend/staff #2 of the group home took him to his own personal residence.
-FC #8 stated he was hitting on Licensee's boyfriend/staff #2's daughter, so he took him to a homeless shelter in town.
-The Licensee/staff #2 was charging him 200.00 a month to stay in his home.
-FC #8 stated that the Licensee's boyfriend/staff #2 had his benefit card with his money on it.
-FC #8 said he wanted to go home at which time he stated was on Atlantic Ave.
-FC #8 stated he could not remember the address only the street name.
-Drove him to Atlantic Ave and shined the lights on houses to see if he could recognize which one.
-FC #8 picked 616 Atlantic Ave as the house he used to live in.
-FC #8 continued to say this location is where he once lived.
-They approached the door and spoke to lady who was working.
-Description of the female staff matched the description of the Licensee.
-Questioned the Licensee asked if FC #8 stayed

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V 502	Continued From page 37 in the home. -The Licensee stated no, he stayed at another home. -The Licensee said she put him out about a few weeks prior and he was moved to a different group home. -She said he had stayed there a day or two before he was moved to another group home because she was over capacity. -The Licensee seemed upset and appeared bothered they were there. -The Licensee had the mother/guardian's number and provided it to him to contact. -The Licensee knew exactly who he was. -FC #8 seemed "a little let down" when she would not let him in. -FC #8 seemed coherent in what he was talking about. -The police officer stated he had not had contact with FC #8 prior to 12/31/20. -FC #8 stated he was schizophrenic. -After a conversation with him and his mother. she felt he needed medications so he took him to the hospital. -FC #8's mother/legal guardian was concerned because she was never notified he had been discharged. -He said he had not had medications in a month. -FC #8 was talking about he was dead and did not have a heart. -He kept saying, "when I get to the hospital, they will see I have not heart in my body." -Felt bad for him as he seemed in and out of delusions with reality. During interview on 1/6/21 FC #8's mother/legal guardian stated: -FC #8 lived in the Licensee's home after he was moved from his previous placement a few months ago.	V 502		

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V 502	Continued From page 38 -Had spoke on the phone multiple times to the Licensee and Licensee's boyfriend/staff #2 during his initial admission to the home. -Did everything over the phone with Licensee because she had to find a place quickly. -Emailed the Licensee a signed medical release. -Sent the Licensee the bank card that FC #8's social security check was deposited on. -The Licensee told her she was not going to apply for Special Assistance for FC #8. -The Licensee stated to her she would just use his social security money for everything and if he needed other stuff she would take care of it. -"I thought [Licensee] was a great person for saying she would do this for [FC #8]." -Had talked to FC #8 on the phone and he said he liked it there. -Never visited him at the group home because of Covid. -Talked to the Licensee several times over the course of the time he was there and along with a man who stated he was the Licensee's boyfriend. -The Licensee's boyfriend/staff #2 also sounded like he was over the facility. -The Licensee's boyfriend/ staff #2 was calling it, "his group home." -"How would I know [the Licensee] phone number and address to the home if [FC #8] had not stayed there." -Called the Licensee on Christmas day to inquire about taking him some presents. -The Licensee stated FC #8 no longer lived in the home. -The Licensee stated she put him "on the streets." -FC #8 was leaving the facility, walking up and down the street, asking for cigarettes, hitting on a young girl and he jumped out the window. -The Licensee stated she put him out around 11/30/20.	V 502		

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V 502	Continued From page 39 -The Licensee never told her the young lady he was hitting on. -The Licensee stated after she put him out, he kept trying to go back to the home to see the young lady. -The Licensee's boyfriend/staff #2 told her in an earlier conversation a month ago he was leaving the home and walking the streets. - The Licensee stated they called the police when he came back to the home. -They had no business to put him out without calling his guardian first. -The Licensee knew she was his legal guardian. -The Licensee explained she didn't know he was not his own guardian. -Called the local police and made a missing person report. -Local police acted like they didn't know who FC #8 was. -They took her information and went looking for him. -FC #8 was found at a local homeless shelter by local police department. -After speaking with the officer and FC #8, she felt like he needed to go to the hospital because he was delusional. -FC #8 stated he had not taken his medications in weeks. -FC #8 is currently still in the hospital now to get stabilized. -When he was admitted to the hospital his blood sugar was over 500 due to not taking his medications for his diabetes. During interview on 1/5/21 the Licensee stated: -Knew of FC #8. - "He has never stayed here before." -"I knew of him from around town, I know a lot of the clients around here." -He used to be at a Day Program her clients	V 502		

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NEW DAY NEW BEGINNING	616 ATLANTIC AVENUE ROCKY MOUNT, NC 27801

(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 502	Continued From page 40	V 502		

attended.
-Police came three times last week and over the weekend with FC #8.
-Police brought FC #8 to her facility because he was looking for him a place to stay.
-The police and FC #8 came two days before Christmas, then he came two times in one night with an officer and she told them he couldn't stay.
-FC #8 stated he had been living in a shelter in Wilson.
-FC #8 told the police he wanted to stay at her group home, "probably because everyone wants to stay here."
-Not sure why people would think FC #8 lived at her group home.
-Police stated FC #8's mother/legal guardian had put out a missing person for him.
-Never served him in any capacity..
-He is telling people he lived there.
-Never spoke to his guardian.
-Called her several times by the number police provided to let her know he was found.
-She did not answer, so she texted her.
-Did not keep that number.
-Never had a record for FC #8.
-FC #8 has never stayed at any of her homes.

During interview on 2/8/21 The Licensee stated:
-The Licensee's boyfriend/staff #2 did have a multi unit housing in the area.
-When asked if FC #8 stayed at the Licensee's/staff#2 multi unit housing the response was, "It's not my house, he did not stay here."
-In another statement the Licensee stated FC #8 did not stay Licensee's boyfriend/staff #2 multi unit housing.

Interview on 1/7/21 a nurse in the Behavioral Health Unit stated FC #8 would not be eligible to

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V 502	Continued From page 41 interview due to his active hallucinations and providing accurate information. This deficiency is cross referenced into: 10A NCAC 27D .0304 Protection From Harm, Abuse, Neglect Or Exploitation (V512) for a Type A1 rule violation	V 502		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on interviews and record review one of	V 512		

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V 512	Continued From page 42	V 512		

three staff (Licensee) neglected two of two former clients (FC #7 & FC #8). The findings are:

A. Cross Reference 10A NCAC 27G .0201 GOVERNING BODY POLICIES (Tag 105) Based on record review and interview the facility failed to implement their policy for admission and discharge for two of two former clients (FC #7 & FC #8).

B. Cross Reference 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (Tag 111) Based on record review and interview the facility failed to ensure two of two former clients (FC #7 and FC #8) had Assessments completed at the time of admission.

C Cross Reference 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (Tag 112) Based on record review and interview the facility failed to ensure two of two former clients (FC #7 and FC #8) had a Treatment Plans.

D. Cross Reference 10A NCAC 27G .0206 CLIENT RECORDS (Tag 113) Based on record review and interview the facility failed to ensure two of two former clients (FC #7 and FC #8) had a record maintained with identifying information

E Cross Reference 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (Tag 118) Based on record review and interview the facilty failed to ensure medications were administered on the order of a physician and MAR's were kept current for one of one audited former clients (FC #8) who was receiving medications at the facility.

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V 512	Continued From page 43 F. Cross Reference 10A NCAC 27G .5603 OPERATIONS (Tag 291) Based on interviews and record reviews the facility failed to ensure coordination was maintained for one of two former clients (FC#8). G. Cross Reference 10A NCAC 27D .0102 SUSPENSION AND EXPULSION POLICY (Tag 502) Based on record review and interviews the facility failed to ensure one of two former clients (FC#8) was subjected to unwarranted expulsion from the facility. Review on 2/8/21 of "Plan of Protection" completed by the Licensee on 2/8/21 revealed the following, -"What immediate action will the facility take to ensure the safety of the consumers in your care? -I will make sure everyone is safe and their needs are met. My Qualified Professional (QP) will do all my admission assessments and discharge summaries to ensure proper placement. I will do more training with staff. I will keep record of all admissions for at least six years. -Describe you plans to make sure the above happens. -Make sure staff know the client and detailed information. Communicate with the clients and staff to ensure compliance of all rules." FC #8 was diagnosed with Schizophrenia, Anxiety, Seizure Disorder and Type II diabetes. FC #8 and FC #7 were picked up on 9/28/21 by the Licensee from another provider. The Licensee did not follow her admissions policy by failing to complete an admission assessment to determine individual needs when admitting FC #7 and FC #8. The QP was not aware the Licensee	V 512		

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V 512	Continued From page 44 had admitted FC #7 and FC #8 to the facility. There were no records of admission assessment, treatment plan, identifying information or discharge summary for FC #7 and FC #8. There were no MARs maintained for FC #8 and no way to determine if medications of Metformin, Divalproex, Benzotropine, Haloperidol, Atorvastatin and Sertraline were administered as needed. The pharmacy delivered medications for FC #8 to the facility multiple times in the month of October, November and December. The Licensee could not explain why FC #8 thought he lived in the facility or why his medications were sent there over the previous months. FC #8's mother/legal guardian had communicated multiple times with the Licensee and the Licensee's boyfriend/staff #2 during his stay in the facility. At some point around the end of November 2020, FC #8 was expelled from the facility and possibly sent to a multi unit housing that is owned and operated by the Licensee's boyfriend/staff #2. The mother/legal guardian was not contacted and informed that FC #8 had been expelled and put out on the street. After FC #8's expulsion he was seen multiple times at the local hospital for elevated blood sugars over 500 as well as mental health symptoms of visual and auditory hallucinations. The Licensee denied FC #8 ever lived in her facility. The failure of the above mentioned areas constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty in the amount of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		