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SUPREME LOVE 1	3001 NASH STREET WILSON, NC 27896

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on March 31, 2021. The complaint was substantiated (intake # NC00174108). 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 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 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.	V 111		

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V 111	Continued From page 1	V 111		

This Rule is not met as evidenced by:
Based on record reviews and interview the facility failed to complete an admission assessment prior to the delivery of services for 2 of 5 audited clients (#1 & #4). The findings are:

Review on 3/24/21 of client #1's record revealed:
- 35 year old.
- Diagnoses included Schizoaffective Disorder, depressed type, Intellectual/Developmental Disability, mild, type II Diabetes, and Hypertension.
- Undated and unsigned "Admission Assessment" included ". . . admitted on December 1, 2020 . . . "

Review on 3/26/21 of client #4's record revealed:
- 62 years old admitted 3/19/20.
- Diagnoses included Schizoaffective Disorder, bipolar type.
- Undated an unsigned "Admission Assessment" included ". . . was admitted to Supreme Love in March. . . . "

During interview on 3/31/21 the Licensee stated she was unaware the admission assessments were unsigned and undated. Admission assessments were completed prior to the delivery of services.

This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

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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. This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to 1)obtain written consent or agreement by the client or legally responsible person or a written statement by the provider stating why	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 3 such consent could not be obtained for 1 of 5 audited clients (#1), 2) to review the treatment plan annually for 2 of 5 audited clients (#2 & #4) and 3) to develop and implement strategies based on assessment for 2 of 5 audited clients (#3 and #4). The findings are: Review on 3/24/21 of client #1's record revealed: - 35 year old admitted 12/02/20. - Diagnoses included Schizoaffective Disorder, depressed type, Intellectual/Developmental Disability, mild, type II Diabetes, and hypertension. - Guardian of the Person qualified 1/13/21. - Person Centered Plan (PCP) completed 12/01/20. - No signatures on the PCP. - No written statement by the provider stating why client and guardian consent could not be obtained. Review on 3/26/21 of client #2's record revealed: - 68 year old admitted 1/01/20. - Diagnoses included Dementia and Bipolar Disorder. - PCP completed 2/01/20. - Signature page signed by the Qualified Professional (QP) 2/01/20 and by client #3's guardian representative 3/12/20. - No updated PCP. During interview on 3/23/21 client #2 seemed unable to focus on interview questions. Review on 3/26/21 of client #3's record revealed: - 25 year old admitted 5/11/20. - Diagnoses included "mental challenges," Depression, Type II Diabetes, Seizure Disorder, and Hypertension. - PCP completed 5/11/20.	V 112		

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V 112	Continued From page 4 - No strategies for ". . . Goal 4 - Within the plan year [client #3] will improve her focus and concentration as evidenced: A. Increasing knowledge & awareness of types of jobs available in accordance with his strengths and preferences B. Demonstrates increased focus, concentration & attention to assigned tasks C. Can fill out a standard job application D. Participates in a mock job interview giving appropriate answers to potential questions. . . . Who is Responsible [client #3] Supreme Love Group Home Staff . . . " During interview on 3/26/21 client #3 stated she was told to focus on learning her medications and help keep the house clean and organized. Review on 3/26/21 of client #4's record revealed: - 62 year old admitted 3/19/20. - Diagnoses included Schizoaffective Disorder, bipolar type. - PCP completed on 3/05/19. - No goal or strategies for behavior of changing clothing throughout the night. - Signature page signed and dated by the QP 3/05/19. - No updated person centered plan. During interview on 3/26/21 client #4's did not answer questions about his person centered plan or goals. During interviews on 3/26/21 and 3/31/21, the Licensee stated: - Client #4's clothing was kept in the laundry room because he would change clothes throughout the night. - Plans were updated annually and signed by the guardians as required; all updated plans were filed in the clients' records. - She would provide the surveyor with copies of	V 112		

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V 112	Continued From page 5 the updated and signed plans.	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; (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	V 113		

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V 113	Continued From page 6 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain a complete record for 5 of 5 audited clients (#1, #2, #3, #4, #5). The findings are: Review on 3/24/21 of client #1's record revealed: - 35 year old admitted 12/02/20. - Diagnoses included Schizoaffective Disorder, depressed type, Intellectual/Developmental Disability, mild, type II Diabetes, and hypertension. - Guardian of the Person qualified 1/13/21. - No face sheet with client's name, record number, date of birth, race, gender and marital status, or admission date. - No consent for treatment signed by guardian. - No emergency information. - No signed statement from the guardian granting permission to seek emergency care from a hospital or physician. Review on 3/26/21 of client #2's record revealed: - 68 years old admitted 1/01/20. - Diagnoses included Dementia and Bipolar Disorder. - The Director of a local Department of Social Services was his guardian.	V 113		

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V 113	Continued From page 7 - No face sheet with client's name, record number, date of birth, race, gender and marital status, or admission date. - No consent for treatment signed by guardian. - No emergency information. - No signed statement from the guardian granting permission to seek emergency care from a hospital or physician. Review on 3/26/21 of client #3's record revealed: - 25 years old admitted 5/11/20. - Diagnoses included "mental challenges," Depression, Type II Diabetes, Seizure Disorder, and Hypertension. - Guardian of the Person qualified 2/25/19. - No face sheet with client's name, record number, date of birth, race, gender and marital status, or admission date. - No signed statement from the guardian granting permission to seek emergency care from a hospital or physician. Review on 3/26/21 of client #4's record revealed: - 62 year old admitted 3/19/20. - Diagnoses included Schizoaffective Disorder, bipolar type. - The Director of a local Department of Social Services qualified as guardian 12/02/15. - No face sheet with client's name, record number, date of birth, race, gender and marital status, or admission date. - No consent for treatment signed by guardian. - No emergency information. - No signed statement from the guardian granting permission to seek emergency care from a hospital or physician. Review on 3/26/21 of client #5's record revealed: - 52 years old admitted "May 2019." - Diagnoses included Schizophrenia.	V 113		

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V 113	Continued From page 8 - Guardian of the Person qualified 4/06/15. - No face sheet with client's name, record number, date of birth, race, gender and marital status, or admission date. - No consent for treatment signed by guardian. - No emergency information. - No signed statement from the guardian granting permission to seek emergency care from a hospital or physician. During interviews on 3/23/21 and 3/31/21 the Licensee stated: - All guardians had given the required consents. - Every surveyor expected to see something different at every survey. - Previous surveyors had accepted different forms of documentation, including the FL-2, as the face sheet. This deficiency has been cited 3 times since the original cite on 3/10/20 and must be corrected within 30 days.	V 113		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies	V 114		

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V 114	Continued From page 9 accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: Review on 3/26/21 of the facility's fire and disaster drill documentation April 2020 - March 2021 revealed: - No fire drill documented for second shift April - June 2020. - No fire drill documented for second shift October - December 2020. - No disaster drill documented for second shift July - September 2020. - No disaster drill documented for first shift October - December 2020. - Two disaster drills documented January - March 2020 with no time or shift documented. During interview on 3/26/21 the Licensee stated: - The facility operated with "first, second, and third shifts." - Shift hours were 9:00 am - 8:00 pm and 8:00 pm - 9:00 am. - "Sometimes we leave at 10:00 pm; it just depends on what is going on with doctors appointments the next day." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 117	27G .0209 (B) Medication Requirements	V 117		

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V 117	Continued From page 10 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure medications for administration at the facility were packaged and labeled as required for 1 of 5 audited clients (#4). The findings are:	V 117		

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V 117	Continued From page 11 Review on 3/26/21 of client #4's record revealed: - 62 year old admitted 3/19/20. - Diagnoses included Schizoaffective Disorder, bipolar type. - Physician's orders for olanzapine 20 mg 1 tablet at bedtime; bisacodyl 1.5 mg 1 tablet twice daily; haloperidol drops 2 mg/ml take 4 mg (2ml) three times daily; benztropine 1 mg 1 tablet twice daily; fish oil 1000 mg 1 capsule daily; docusate 50 mg 1 tablet twice daily; Vitamin D3 1000 units 1 tablet daily; tamsulosin 0.4 mg 1 tablet at bedtime. Observation on 3/26/21 of client #4's medications on hand revealed: - Plastic monthly pill organizer, separated by days of the week with the individual boxes labeled with administration times for the morning, noon, evening and bedtime (for example: Sun (Sunday) Morn (morning) 7 am - 9 am). - Each individual box of the organizer contained various pills and capsules. - No pharmacy label on the pill organizer to identify the client, the prescribing medical provider, the date the medications were dispensed, the name, strength, quantity, and expiration dates of the medications; there was no information about the name, address, and phone number of the dispensing pharmacy or the dispensing practitioner. During interview on 3/29/21 the Outpatient Supervisor from a regional health care clinic stated: - All prescriptions sent to patients from any health care clinic were labeled by the pharmacy as required by law. - No prescriptions were sent from the health care clinic pharmacy without a label. - Information on the pharmacy label included the	V 117		

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V 117	Continued From page 12 patient's name, the medication name, strength, dosage, administration instructions, the date dispensed by the pharmacy, and the prescriber's name. - Prescription medications were packaged individually in bottles, vials, boxes, or plastic zip bags if necessary and the container was labeled. - The health care clinic did provide pill organizers to patients, but medications were not placed into the organizer by the pharmacy. - Use of the organizer was voluntary. During interviews on 3/23/21, 3/26/21 and 3/31/21 the Licensee stated: - She was responsible for making sure medications delivered to the facility were labeled according to the Physician's orders. - Client #4's medications were sent to the facility from a regional health care center pre-loaded in the pill organizer, with no labels. - Client #4's medications were not labeled by the pharmacy. - The pharmacy did not send client #4's medications pre-loaded in the pill organizer; she placed the pills in the organizer. - The containers the medications were received in were labeled by the pharmacy.	V 117		
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	V 118		

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V 118	Continued From page 13 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. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to 1) administer medications as ordered by a physician, 2) keep MARs current for 3 of 5 audited clients (#1, #2, #3) and 3) to obtain a physician's orders for self-administration of blood sugar checks and injections for 2 of 5 audited clients (#1 & #3). The findings are: Review on 3/24/21 of client #1's record revealed: - 35 year old.	V 118		

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V 118	Continued From page 14 - Diagnoses included Schizoaffective Disorder, depressed type, Intellectual/Developmental Disability, mild, type II Diabetes, and Hypertension. - Physician's orders for: Ozempic (used to treat type II diabetes) 1 mg dose pen, inject 1 mg subcutaneously every week signed 8/31/20; simvastatin (can treat high cholesterol) 10 mg 1 tablet every evening signed 11/06/20; check blood glucose four times daily, before meals and at bedtime signed 11/20/20; Lantus (can treat diabetes) 100 units (u)/ml inject 12 u subcutaneously at bedtime signed 2/19/20. - No Physician's order for albuterol inhaler (can treat or prevent bronchospasm) 2 puffs every 6 hours as needed. - No Physician's order for client #1 to self-check blood sugar or self-administer subcutaneous injections. Review on 3/24/21 of client #1's MARs for January 2021 - March 2021 revealed: - No transcription for blood glucose checks on the January MAR. - Transcription for Lantus 100u/ml inject 20 u subcutaneously at bedtime with staff initials for administration nightly 2/01/21 - 2/28/21. - No transcription for Lantus 100u/ml inject 12 u subcutaneously at bedtime on the February MAR. - Transcription for simvastatin 10 mg 1 tablet every evening with administration time of "7 am" and staff initials for administration on all reviewed MARs. - No transcriptions for Albuterol inhaler. Observation on 3/26/21 at 9:45 am of client #1's medications on hand revealed: - Lantus 100u/ml inject 20 u subcutaneously at bedtime, dispensed 11/09/20 and 12/22/20. - Simvastatin 10 mg 1 tablet every evening,	V 118		

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dispensed 3/23/21.
- Albuterol inhaler 2 puffs every 6 hours as needed, dispensed 6/23/20.

During interview on 3/26/21 client #1 stated:
- She took her medications daily with staff assistance.
- She performed her own blood sugar checks and self-administered her subcutaneous injections.
- Staff never did her blood sugar checks nor did staff administer her subcutaneous injections.

Review on 3/26/21 of client #2's record revealed:
- 68 year old admitted 1/01/20.
- Diagnoses included Dementia and Bipolar Disorder.
- Signed Physicians orders for chlorpromazine (anti-psychotic) 50 mg 2 tablets at bedtime signed 2/04/21; trazodone (antidepressant and sedative) 50 mg 1 tablet at bedtime signed 3/02/21.
- Physicians order to discontinue trazodone 50 mg 1/2 to 1 tablet at bedtime signed 11/05/20.

Review on 3/26/21 at 10:15 am of client #2's MARs for January 2021 - March 2021 revealed:
- Transcriptions for chlorpromazine 50 mg 1 tablet at bedtime with staff initials for administration nightly January - March 2021.
- No transcription for chlorpromazine 50 mg 2 tablets at bedtime on either the February or March MARs.
- Transcriptions for trazodone 50 mg 1/2 to 1 tablet at bedtime with staff initials for administration nightly January - March 2021.
- No documentation of trazodone dosage given (25 mg or 50 mg) January - March 2, 2021.
- No transcription for trazodone 50 mg 1 tablet at bedtime on the March 2021 MAR.

Observation on 3/26/21 at 10:15 am of client #2's

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medications on hand revealed:
- Chlorpromazine 50 mg 2 tablets at bedtime, dispensed 3/23/21.
- Trazodone 50 mg 1/2 - 1 tablet at bedtime, dispensed 3/23/21.

During interview on 3/23/21 client #2 stated staff gave him his medications every day.

Review on 3/26/21 of client #3's record revealed:
- 25 years old admitted 5/11/20.
- Diagnoses included "mental challenges," Depression, Type II Diabetes, Seizure Disorder, and Hypertension.
- Physicians orders signed 11/10/20 for Trulicity (used to treat type II diabetes) 3 mg/0.5 ml pen inject 3mg subcutaneously weekly.
- FL-2 signed by the Physician 1/20/21 included levetiracetam (anti-convulsant) 1000 mg 1.5 tablets twice daily.
- No Physician's order for client #3 to self check blood sugar or self-administer Trulicity injections.

Review on 3/26/21 of client #3's MARs for January - March 2021 revealed:
- Transcription for Trulicity 3 mg/0.5 ml inject 1.5 mg weekly with staff initials for administration weekly January and February MARs.
- Transcription for levetiracetam 1000 mg 1/2 tablet twice daily with staff initials for administration twice daily January - March.

During interview on 3/26/21 client #3 stated:
- She took her medications daily with staff assistance.
- She checked her own blood sugar; staff never checked her blood sugar.
- She self-administered her Trulicity injections; staff never gave her the injection.

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V 118	Continued From page 17 Review on 3/26/21 of client #4's record revealed: - 62 years old admitted 3/19/20. - Diagnoses included Schizoaffective Disorder, bipolar type. - Physicians orders signed 3/12/20 for olanzapine (anti-psychotic) 20 mg 1 tablet at bedtime; bisacodyl (laxative) 1.5 mg 1 tablet twice daily; docusate (stool softener) 50 mg 1 tablet twice daily; Vitamin D3 25 mcg 1 tablet daily; signed 4/09/20 for haloperidol drops (anti-psychotic) 2 mg/ml take 4 mg (2 ml) three times daily; benztropine (anti-tremor and can treat side effects of other medications) 1 mg 1 tablet twice daily; Fish Oil 1000 mg 1 capsule daily; tamsulosin (can treat enlarged prostate) 0.4 mg 1 capsule at bedtime. Observation on 3/26/21 at 10:40 am of client #4's medications on hand revealed: - A plastic monthly pill organizer contained numerous pills of varying sizes and colors. - No pharmacy labels for any medications. During interview on 3/26/21 client #4 stated: - He took his medications two times a day and three times a day. - Staff gave him his medications. During interviews on 3/23/21, 3/26/21, and 3/31/21 the Licensee stated: - Medications for clients #1, #2, #3, and #5 were delivered from the pharmacy weekly in bubble cards pre-loaded for each administration time. - She was responsible for receiving the medications and ensuring the MARs reflected current physician's orders and the pharmacy label information. - Clients #1 and #3 sometimes did their blood sugar checks independently but staff monitored the glucometer readings.	V 118		

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V 118	Continued From page 18 - Staff sometimes did the finger sticks for the blood sugar checks. - Clients #1 and #3 self-administered their subcutaneous injections; staff never administered the injections. - Client #1 never used her albuterol inhaler; if client #1 ever needed or used the inhaler, she would handwrite a transcription on the MAR and document the use. - Staff always gave client #2 a whole tablet. - Client #4's medications were delivered to the facility in the organizer without labels. - Client #4's medications were delivered to the facility in labeled containers and staff put the pills in the organizer. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency has been cited 3 times since the original cite on 8/28/19 and must be corrected within 30 days.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container;	V 120		

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V 120	Continued From page 19 (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure medications stored in a refrigerator used for food items were secured in a separate locked container or compartment for 2 of 5 audited clients (#1 and #3). The findings are: Observation on 3/26/21 at approximately 9:45 am of the facility kitchen refrigerator revealed supplies of Lantus and Ozempic labeled for client #1 and supply of Trulicity labeled for client #3 stored in an unlocked, clear plastic produce drawer. During interview on 3/26/21 the Licensee stated she did not know medications stored in the refrigerator were to be secured in a separate locked container or compartment. She would purchase locking boxes to store the medications.	V 120		
V 505	27D .0201(a-c) Client Rights - Informing Clients 10A NCAC 27D .0201 INFORMING CLIENTS (a) A written summary of client rights as specified in G.S. 122C, Article 3 shall be made available to	V 505		

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V 505	Continued From page 20 each client and legally responsible person. (b) Each client shall be informed of his right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD), the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities. (c) Each client shall be informed regarding the issues specified in Paragraph (d) and, if applicable in Paragraph (e), of this Rule, upon admission or entry into a service, or (1) in a facility where a day/night or periodic service is provided, within three visits; or (2) in a 24-hour facility, within 72 hours. Explanation shall be in a manner consistent with the client's or legally responsible person's level of comprehension. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 5 of 5 audited clients (#1, #2, #3, #4, and #5) were provided a written copy of clients rights. The findings are: Review on 3/24/21 of client #1's record revealed: - 35 year old. - Diagnoses included Schizoaffective Disorder, depressed type, Intellectual/Developmental Disability, mild, type II Diabetes, and Hypertension. - Guardian of the Person qualified 1/13/21. - Unsigned and undated copy of Licensee's "Informing Consumer and Guardian of Consumer's Rights" policy. - No documentation the Guardian or client was provided a written summary of clients rights. During interview on 3/26/21 client #1 stated she	V 505		

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V 505	Continued From page 21 did not want to talk about her rights. Review on 3/26/21 of client #2's record revealed: - 68 years old admitted 1/01/20. - Diagnoses included Dementia and Bipolar Disorder. - The Director of a local Department of Social Services was his guardian. - Copy of Licensee's "Informing Consumer and Guardian of Consumer's Rights" policy signed by client #1 and dated 10/20/20. - No documentation the Guardian or client was provided a written summary of clients rights. During attempted interview on 3/23/21 client #2 seemed to have difficulty focusing on surveyor's questions and did not answer questions about his rights. During interview on 3/30/21 client #2's Guardian Representative stated she was "pretty sure" she signed a copy of the facility's clients rights policy yearly. Review on 3/26/21 of client #3's record revealed: - 25 years old admitted 5/11/20. - Diagnoses included "mental challenges," Depression, Type II Diabetes, Seizure Disorder, and Hypertension. - Guardian of the Person qualified 2/25/19. - Copy of Licensee's "Informing Consumer and Guardian of Consumer's Rights" policy with client #3's name hand printed and dated 5/11/20. - No documentation the Guardian or client was provided a written summary of clients rights. During interview on 3/26/21 client #3 stated her client's rights had been explained to her. Review on 3/26/21 of client #4's record revealed:	V 505		

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V 505	Continued From page 22 - 62 year old admitted 3/19/20. - Diagnoses included Schizoaffective Disorder, bipolar type. - The Director of a local Department of Social Services qualified as guardian 12/02/15. - Unsigned and undated copy of Licensee's "Informing Consumer and Guardian of Consumer's Rights" policy. - No documentation the Guardian or client was provided a written summary of clients rights. During interview on 3/26/21 client #4 stated his clients rights had been explained to him. Review on 3/26/21 of client #5's record revealed: - 52 years old admitted "May 2019." - Diagnoses included Schizophrenia. - Guardian of the Person qualified 4/06/15. - Unsigned and undated copy of Licensee's "Informing Consumer and Guardian of Consumer's Rights" policy. - No documentation the Guardian or client was provided a written summary of clients rights. During interview on 3/26/21 client #5 stated: - She knew some of her rights, but not all of them. - She had the right to send mail and to see her family. - She was never given a copy of her clients rights. - She did not remember if her clients rights had been explained to her. During interview on 3/31/21 the Licensee stated the client records were up to date and a summary of the clients rights had been proveded to all clients as required. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 505		

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V 511	27D .0303 Client Rights - Informed Consent 10A NCAC 27D .0303 INFORMED CONSENT (a) Each client, or legally responsible person, shall be informed, in a manner that the client or legally responsible person can understand, about: (1) the alleged benefits, potential risks, and possible alternative methods of treatment/habilitation; and (2) the length of time for which the consent is valid and the procedures that are to be followed if he chooses to withdraw consent. The length of time for a consent for the planned use of a restrictive intervention shall not exceed six months. (b) A consent required in accordance with G.S. 122C-57(f) or for planned interventions specified by the rules in Subchapter 27E, Section .0100, shall be obtained in writing. Other procedures requiring written consent shall include, but are not limited to, the prescription or administration of the following drugs: (1) Antabuse; and (2) Depo-Provera when used for non-FDA approved uses. (c) Each voluntary client or legally responsible person has the right to consent or refuse treatment/habilitation in accordance with G.S. 122C-57(d). A voluntary client's refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available at the facility. (d) Documentation of informed consent shall be placed in the client's record.	V 511		

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V 511	Continued From page 24 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure the client or legally responsible person had the right to consent or refuse treatment for 4 of 5 audited clients (#1, #2, #4, and #5). The findings are: Review on 3/24/21 of client #1's record revealed: - 35 year old. - Diagnoses included Schizoaffective Disorder, depressed type, Intellectual/Developmental Disability, mild, type II Diabetes, and Hypertension. - Guardian of the Person qualified 1/13/21. - COVID-19 vaccination record included " . . . 1st Dose COVID-19 . . . Date 12/30/20 . . . 2nd Dose COVID-19 . . . Date 1/27/21 . . ." - No prior written consent for the COVID-19 vaccination signed by client #1's guardian. During interview on 3/26/21 client #1 stated she got the COVID vaccine and experienced no side effects. Review on 3/26/21 of client #2's record revealed: - 68 years old admitted 1/01/20. - Diagnoses included Dementia and Bipolar Disorder. - The Director of a local Department of Social Services was his guardian. - COVID-19 vaccination record included " . . . 1st Dose COVID-19 . . . Date 12/30/20 . . . 2nd Dose COVID-19 . . . Date 1/27/21 . . ." - Email dated 3-23-21 from client #2's Guardian Representative giving consent for the COVID-19 vaccine. - No prior written consent for the COVID-19 vaccination signed by client #2's Guardian.	V 511		

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V 511	Continued From page 25 During attempted interview on 3/23/21 client #2 seemed to have difficulty focusing on surveyor's questions and did not answer questions about receiving a vaccination. During interview on 3/30/21 client #2's Guardian Representative stated: - The Licensee contacted her in December 2020 to get consent for the vaccine. - The Director of the Department of Social Services wanted to get input about the vaccine from client #2's Physician prior to giving consent. - She assumed client #2 had gotten the vaccine without consent. - "If they have the opportunity to get the shot, they should go ahead and get it." - "Rules are rules" and she understood the requirement for written guardian consent. Review on 3/26/21 of client #4's record revealed: - 62 year old admitted 3/19/20. - Diagnoses included Schizoaffective Disorder, bipolar type. - The Director of a local Department of Social Services qualified as guardian 12/02/15. - COVID-19 vaccination record included " . . . 1st Dose COVID-19 . . . Date 12/30/20 . . . 2nd Dose COVID-19 . . . Date 1/27/21 . . ." - No prior written consent for the COVID-19 vaccination signed by client #4's Guardian. During interview on 3/26/21 client #4 did not answer question about receiving the COVID-19 vaccine. During interview on 3/19/21 client #4's Guardian Representative stated: - Client #4 was given the COVID-19 vaccine without consent from the guardian. - The Director of the Department of Social	V 511		

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V 511	Continued From page 26 Services wanted to get input from the client's primary care Physician prior to consenting to the vaccination. - It was the Guardian's opinion that client #4 did not have the capacity to consent to medical treatments and vaccinations. Review on 3/26/21 of client #5's record revealed: - 52 years old admitted "May 2019." - Diagnoses included Schizophrenia. - Guardian of the Person qualified 4/06/15. - COVID-19 vaccination record included " . . . 1st Dose COVID-19 . . . Date 12/30/20 . . . 2nd Dose COVID-19 . . . Date 1/27/21 . . ." - No prior written consent for the COVID-19 vaccination signed by client #5's Guardian. During interview on 3/26/21 client #5 stated she could not remember if she had gotten a shot recently. During interviews on 3/23/21 and 3/26/21 the Licensee stated: - All facility clients received the 2 part COVID-19 vaccinations at the same time. - Shots were given by the local health department on 12/30/20 and 1/27/21. - None of the clients suffered any side effects from the vaccination. - Client #1 did not have a guardian at the time of the first vaccine and she gave her own verbal consent. - The Guardians gave verbal consent; she did not have written consents for the clients to be vaccinated.	V 511		