STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-412	A. BUILDING: _____ B. WING _____	R 06/01/2021

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BRADLEY HOME EXTENSION-KIMBERLY HOUSE	6420 MALIBU DRIVE RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on June 1, 2021. The complaint was substantiated Intake #NC00174907. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and clients will be identified using the letter of the facility and a numerical identifier.	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;	V 105		

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V 105	Continued From page 1 (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; (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;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards for the CLIA waiver (Clinical Laboratory Improvement Amendments). The findings are: Review on 5/12/21 of a physician's order dated 6/6/20 for client #4 revealed: - check and record fasting blood sugars every morning During interview on 4/21/21 staff #1 reported: - she checked client #4's blood sugars once a day prior to breakfast. During interview on 4/21/21 the Licensee reported: - client #4 was a diabetic - staff checked his blood sugars once a day - "there was not a physician's order to check client #1's blood sugars" - since he was a diabetic, she requested staff to check his blood sugars - she was not aware of the CLIA waiver - she would follow up on the CLIA waiver	V 105		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be	V 108		

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V 108	Continued From page 3 provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of one staff (#1) was trained in goals and strategies as identified in the treatment plans. The findings are: Review on 4/26/21 of staff #1's record revealed:	V 108		

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V 108	Continued From page 4 - hire date: 5/7/02 - no documented trainings on the mh/dd needs as specified in the clients' treatment plans A. Review on 4/20/21 of client #1's record revealed: - Admitted 6/19/13 - A FL2 dated 4/14/20 revealed diagnoses of: Hypertension, Paranoid Schizophrenia & Gastroesophageal - A treatment plan dated 6/15/20 consisted of the following goals: maintain good personal hygiene, decrease the occurrence of incontinent bowel and bladder, stabilize his appetite, sleep pattern and energy level - No signature page B. Review on 5/3/21 of client #2's record revealed: - No documented admission date - Diagnosis: Schizophrenia - A treatment Plan dated 6/15/20 consisted of the following goals: cooperate with all assessments, learn and develop independent living skills, actively engage in Residential Service to prevent isolation, improve ability to control behaviors, and decrease the occurrence of incontinent bowel and bladder - Treatment plan signed only by the Qualified Professional (QP) C. Review on 4/22/21 of client #3's record revealed: - Admitted 1/29/07 - A FL2 dated 5/12/20 revealed diagnoses of Impulse disorder, Borderline Intellectual Functioning, Tourette's Syndrome, Enuresis, Abnormal Glucose, Hyperlipidemia and Psychosis - A treatment plan dated 5/1/20 consisted of	V 108		

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V 108	Continued From page 5 the following goals: develop the essential social skills that will enhance the quality of relationships in his life, reduce frequency of maladaptive behaviors, thoughts and feelings that interfere with attaining a reasonable quality of life, and healthy food choices - Treatment plan only had QP's signature D. Review on 4/22/21 of client #4's record revealed: - Admitted 8/28/18 - A FL2 dated 5/12/20 revealed diagnoses of: Schizophrenia, Hypertension, Hyperlipidemia, Tobacco abuse, Type II diabetes and a history of wandering - Treatment plan dated 6/15/20 with goals that consisted of: experience increased social acceptance because of improved appearance, develop the essential social skills that will enhance the quality of relationship life, will attend medical appointments as scheduled and adhere to a healthy diet, and improve ability to control behaviors - Treatment plan only had QP's signature During interview on 5/18/21 staff #1 reported: - she wasn't familiar with the goals in the clients' treatment plans - she worked with the clients on goals she thought they needed help with - the QP nor the Licensee had talked with her about the clients' goals During interview on 5/27/21 the QP reported: - she was responsible for staff trainings - any trainings completed with staff were in a training log at the facility During interview on 6/1/21 the Licensee reported: - many trainings are done with staff each	V 108		

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V 108	Continued From page 6 month - she and the QP needed to develop a training's log book with the completed trainings - there weren't any clients at the facility with Diabetes Insipidus This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) 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. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.	V 109		

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V 109	Continued From page 7 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on observation, record review and interview, 2 of 2 Qualified Professionals (QP & Licensee) failed to demonstrate knowledge and skills required by the population served. The findings are: 1. The following are examples of how the facility's QP failed to demonstrate competency: Record review on 5/14/21 of the QP's job description revealed: - shall use assessment information to develop care plans and goals to address needs - identify a course of action arranging and collaborating with other agencies - shall provide evaluation, weekly contact progress notes and monthly progress summaries - shall review resident records on a monthly basis to assure record completeness and content of records - ensure that standards for quality of services are met in accordance with state regulations A. Interview on 5/4/21 the QP reported:	V 109		

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V 109	Continued From page 8 - she went to the facility 3 - 4 times per week - she talked to the clients when she visited - couldn't name but one client that resided in the facility - she called the name of a client that didn't reside in the facility During interview on 4/27/21 the clients were not familiar with the QP B. Review between dates of 4/20/21 & 5/3/21 of the clients' (#1, #2, #3 and & #4) treatment plans revealed: - goals such as: hygiene; independent living skills, social skills & attending appointments - 3 of the treatment plans had only the QP's signature - one plan did not have a signature page at all - no strategies to address client #2 & #4's wandering behaviors Review on 5/5/21 & 5/12/21 of the call for service police report revealed: - the police were called to sister facility A for client #2 and client #4 - they were called 33 times between 7/20/20 and 3/30/21 During interview on 5/4/21 the QP reported: - one of her job duties was to review treatment plans - she met with staff #1 and the Licensee to complete treatment plans - client #4 had walked away on 3 occasions - she was not sure if there were goals or strategies to address his wandering behaviors - her main concern was the clients' hygiene - they needed to bathe and shower - she did not recall any guardians being part of the treatment plans	V 109		

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V 109	Continued From page 9 C. Review on 5/5/21 of a fax sent to the Division of Health Service Regulation (DHSR) for (Deceased Client) DC #5 revealed: - Date of death February 8, 2021 - Cause of death was natural causes During interview on 5/4/21 the QP reported: - she recalled 1 death at the facility - she could not recall his name - she did not complete an incident report for DC #5's death - she did not complete incident reports for police calls - the QP was responsible for completing incident reports - there were no specific reasons why she did not complete incident reports D. Review on 4/20/21 - 4/22/21 of the clients' medication records revealed the following: - a physician's order dated 6/6/20 for client #4: no concentrated sweets diet; record blood pressure weekly and record fasting blood sugars every morning - there was no documentation of the blood pressure and blood sugar readings During interview on 5/4/21 the QP reported: - she did not recall any health issues with client #4 - later recalled he was a diabetic - he liked to walk to the store and get sodas and candy - she did not recall a special diet - could not recall if staff #1 was supposed to check client #4's blood sugars - didn't recall if there was any documentation of client #4's blood sugar checks	V 109		

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V 109	Continued From page 10 E. During interview on 5/18/21 staff #1 reported: - the QP and the Licensee did not train her on the clients' goals - she doesn't contribute to the clients' treatment plans because she was not asked During interview on 5/27/21 the QP reported: - she was responsible for staff trainings - when asked about trainings on treatment plans, any trainings completed with staff was in a training log at the facility - the Licensee kept all the trainings in case a physician or the State requested trainings During interview on 6/1/21 the Licensee reported: - many trainings are done each month with staff - she and the QP needed to document in a log the completed trainings for staff 2. The following are examples of how the Licensee failed to demonstrate competency: Review on 5/21/21 of the Licensee's personnel record revealed: - she had a Master's of Science in Public Health - supervised staff at the facility...either directly or indirectly - responsible for ensuring adequate staff coverage to provide required level of care for all residents - responsible for flow of communication between agency employees, residents and their families - responsible for community relations on behalf of Bradley Homes including information and referral, interacting with other agencies - responsible for development and revision of policies and procedures as needed	V 109		

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V 109	Continued From page 11 A. During interview on 5/6/21 the Licensee reported: - she disposed of DC #5's records - she shredded the information and threw it in the trash - she threw away discharged and deceased client records During interview on 5/14/21 a representative with the Local Managed Entity/Managed Care Organization reported: - A level II incident report was required if a client passed away of an illness or natural causes - she had not received any incident reports from this facility since 2013 B. During interview on 4/20/21 the Licensee reported: - she visited the facility daily - no history of wandering behaviors from any of the clients Continued interview on 5/6/21 with the Licensee: - she continued to deny any history of wandering behaviors - after being told that police reports showed clients wandered off, she admitted issues with 2 clients wandering During interview on 5/7/21 the Licensee reported: - if staff requested the client to return to the facility and they refused, an incident report was not required - DC#5 did not pass away at the facility, therefore, an incident report was not completed C. Observations on several days from 4/20/21 - 5/18/21 at various times of the day revealed: - the clients at sister facility A daily	V 109		

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V 109	Continued From page 12 - no social interactions between the clients Interviews between 4/20/21 & 5/3/21 the clients reported the following: - they went to sister facility A everyday - they just sit, watch tv or take naps During interview on 4/21/21 and 5/6/21 the Licensee reported: - since the pandemic, the clients haven't been to their day program - the clients went to sister facility A to communicate with each other - clients left sister facility A when staff was ready to leave D. Review on 4/22/21 of a fax received from the pharmacy sent to DHSR revealed: - physician's order dated 6/6/20 - check and record client #4's blood pressure weekly - check and record client #4's fasting blood sugar every morning - check and record client #4's weight monthly During interview on 5/6/21 the Licensee reported: - there was no physician's order to check client #4's blood sugars, blood pressure or weight E. Observation on 4/20/21 at approximately 11:45am - 12:50pm revealed: - one side a closet door was missing - unused bedframe leaning against a wall - dresser drawer was missing 2 handles/knobs - floor was buckling and lifting up by the back window - toilet was dirty and had a ring stain inside of the bowl - paint around vent in the ceiling was peeling and had missing paint pieces around it	V 109		

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V 109	Continued From page 13 Interview on 4/20/21 with Licensee reported: - maintenance stopped coming to the facility during the pandemic - she couldn't recall maintenance name - she doesn't know if he got sick - she will reach back out to maintenance for repairs at the facility F. Review on 4/20/21 of all the clients' records revealed: - no face sheets - no emergency contacts - no physician summaries, physician orders or labwork Interview on 4/20/21, 5/6/21 and 5/18/21 the Licensee reported: - she was responsible for checking clients records and ensuring they were up to date This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
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	V 112		

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V 112	Continued From page 14 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 review and interview the facility failed to develop and implement strategies to address the needs for 2 of 4 clients (#2, #4). The facility also failed to develop the treatment plan in partnership with the client and legally responsible person affecting 4 of 4 clients (#1, #2, #3 #4). The findings are: A. Review on 4/20/21 of client #1's record revealed: -Admitted 6/19/13 -Diagnoses: Hypertension, Paranoid Schizophrenia, Gastroesophageal -A treatment plan dated 6/15/20 consisted of the following goals: maintain good personal hygiene, decrease the occurrence of incontinent bowel and bladder, stabilize his appetite, sleep pattern and	V 112		

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V 112	Continued From page 15 energy level -No signature page Interview on 4/27/21 client #1 reported: -his goal was music -he liked to sing and play instruments -he would like his own home Interview on 5/5/21 client #1's guardian reported: -he had been client's guardian since 2013 -he could not recall the last time he was part of a treatment plan meeting B. Review on 5/3/21 of client #2's record revealed: -No documented admission date -Diagnosis: Schizophrenia -A treatment plan dated 6/15/20 consisted of the following goals: cooperate with all assessments, learn and develop independent living skills, actively engage in Residential Service to prevent isolation, improve ability to control behaviors, and decrease the occurrence of incontinent bowel and bladder -no goals or strategies to address client #2's wandering behaviors -Treatment plan signed only by the Qualified Professional (QP) Review on 4/28/21 of a call for service police report from sister facility A's address revealed: -client #2 walked away from the premise: 7/3/20, 7/14/20, 7/28/20, 9/8/20, 11/16/20, 2/1/21, 2/15/21, 2/22/21, 3/11/21, 3/15/21, 3/17/21 & 3/30/21 -11/16/20 request for service revealed "[Client #2] is known to walk off the property" Interview on 5/3/21 client #2 reported: -he never walked off from the facility	V 112		

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-police never had to get him and bring him back to the facility
-"goals? I don't know but I study the bible on my own"
-he wanted to learn the presidents
-he didn't know the QP

C. Review on 4/22/21 of client #3's record revealed:
-Admitted 1/29/07
-Diagnoses: Impulse disorder, Borderline Intellectual Functioning, Tourette's Syndrome, Enuresis, Abnormal Glucose, Hyperlipidemia and Psychosis
-A treatment plan dated 5/1/20 consisted of the following goals: develop the essential social skills that will enhance the quality of relationships in his life, reduce frequency of maladaptive behaviors, thoughts and feelings that interfere with attaining a reasonable quality of life, and healthy food choices
-Treatment plan only had the QP's signature

Interview on 4/27/21 client #3 reported:
-he wanted to be stable on his medication
-he would like to see his therapist about his mental status
-he didn't know the QP

D. Review on 4/22/21 of client #4's record revealed:
-Admitted 8/28/18
-Diagnoses: Schizophrenia, Hypertension, Hyperlipidemia, Tobacco abuse, Type II diabetes and a history of wandering
-Treatment plan dated 6/15/20 with goals that consisted of: experience increased social acceptance because of improved appearance, develop the essential social skills that will enhance the quality of relationship life, will attend

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medical appointments as scheduled and adhere to a healthy diet, and improve ability to control behaviors
-Further review of the treatment plan revealed no goals or strategies to address his wandering behavior, panhandling or his diabetes
-Treatment plan only had QP's signature

Review on 4/28/21 of a call for service police report from sister facility A's address revealed:
-client #4 walked away from the premise: 10/12/20, 11/24/20, 11/26/20, 11/27/20, 11/30/20, 12/3/20, 12/28/20, 12/31/20, 1/1/21, 1/2/21, 1/5/21, 1/11/21, 1/18/21, 1/30/21, 2/2/21, 2/4/21, 2/8/21, 2/16/21, 2/22/21, 3/8/21 and 3/24/21
- 10/12/20 - walked off from group home....has possible onset of dementia
- 11/24/20 - staff A2 said he walked out of the group home without notifying anyone
- 1/5/21 - local grocery store called in concerns client #4 was lost...picked him and transported to group home
- 1/18/21 - walked away from group home...he was headed to the local grocery store to beg for money to buy himself two bags of BBQ chips and a soda

Interview on 4/20/21 & 4/27/21 client #4 reported:
-police haven't been called for him in a long time
-last time they were called, he walked away from the facility to go to the store for snacks
-police brought him back to facility
-one time, staff #1 came to get him telling him she was scared he would get hurt
-his cousin sends him money for snacks but he didn't recall the last time he received any money from her
-he sometimes panhandled while at the store
-he does not panhandle anymore
-he didn't know his goals

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V 112	Continued From page 18 -he just wanted to be closer to his family -he wanted to go to his family reunion in August 2021 -he didn't know the QP Interview on 5/4/21 client #4's guardian reported: -he's been his guardian for a year -last contact was virtually with client March 2021 -client told him he wanted to move closer to his family -he was looking into client moving closer to his family -not sure if he received a copy of client's treatment plan -he had not been involved in any treatment plan meetings since being client #4's guardian -client had a history of eloping -that should have been included in his treatment plan Interview on 4/30/21 the Police Officer reported: -multiple officers brought the clients back to the facility -he was concerned about the safety of the clients -the clients have to travel down a "pretty busy road" -he had talked to staff #1 to see what the problem was but hasn't been able to get a clear answer -it didn't seem like staff #1 was doing anything different to try and stop these elopements -client #4 told him his sister sent him money for snacks -staff #1 told him that client #4's sisters hadn't sent him any money -one time the officers had a domestic violence call in that area but they had to respond to the facility for a missing person -with all the calls, it took away from other emergency situations -the group home needed to do something	V 112		

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V 112	Continued From page 19 -it happened so frequently that the officers didn't go to the facility first, they just looked for the clients Interview on 4/20/21 staff #1 reported: -no clients have wandered from the facility -clients can walk in the yard -clients cannot walk in the road -no unsupervised time for any client -no police have been to facility -client #4 used to walk off the premise when he was first admitted but it was much better Interview on 5/3/21 staff #1 reported: -that there had not been any instances of clients wandering off -that client #2 & #4 would walk to the store -that client #4's cousin had sent him money 2-3 times last year that he could buy snacks with -The Licensee said to call 911 to try and scare the clients when they walked off -she would call the police about 15 minutes after she noticed client #2 and #4 were gone -when clients are outside in the yard, she looked out every 10 - 15 minutes to check on them -client #2 liked to sit in the backyard for long periods of time -client #4 gets agitated when asked to stay in the facility -client #4 told her that he had panhandled at the grocery store to get money for snacks -Licensee has not told her how to prevent the wandering behaviors of client #2 and #4 -she wasn't familiar with goals in any of the clients treatment plans -she worked on goals that she thought clients needed help with -client #2 doesn't speak much -client #3 has high anxiety...she encouraged him to speak with her	V 112		

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V 112	Continued From page 20 -she encouraged client #4 to decrease smoking -she does not write down the goals she worked on with the clients -the QP and the Licensee had not trained her on any of the clients' goals -she was not asked to be a part of the treatment team meetings -client #2 & #3 did not have guardians Interview on 5/4/21 the QP reported: -she went to the facility 3 - 4 times per week -she talked to the clients when she visited -couldn't name but one client that resided in the facility -she called the name of a client that didn't reside in the facility -she knew of 3 occasions where the police went to the facility to get client #4 -it was 2 this year and 1 in 2020 -staff needed to have "eyes on clients" at all times -if clients were outside then staff needed to be outside with them -staff had not spoken with her about client #2 wandering off -she didn't know anything about him wandering off -staff told her that client #4 went to the store to get soda and candy -she would speak with the Licensee about client #4's wandering behaviors -she and the Licensee created the treatment plans -she received her information for the treatment plans from hospital records, staff, observation of clients, and sometimes the guardian and family members -she didn't recall guardians being a part of the treatment meetings -she would include guardians next time -met with staff #1 and Licensee to complete the	V 112		

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V 112	Continued From page 21 treatment plans Interview on 4/20/21 the Licensee reported: -visited the facility daily -no history of wandering behaviors from any of the clients -anytime police were called, staff notified her immediately -no clients had unsupervised time -staff had to be outside with the clients Continued interview on 5/6/21 the Licensee reported: -she continued to deny any history of wandering behaviors -after being told that police reports showed clients wandered off, she admitted issues with client #2 & client #4 wandering -client #4 bought chips and soda when he went to the store -staff saw the clients leave and told the clients to return to the facility -when clients leave "you can't stop them" -she used to write the treatment plans -the QP completed the treatment plans now -the clients, staff, the QP, and herself were a part of the treatment team meeting -will update treatment plan to address client #4's wandering and diabetes This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each	V 113		

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V 113	Continued From page 22 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 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 23 This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain client records which contained: emergency information for each client, documentation of progress toward outcomes, medication orders, and copies of lab tests for 4 of 4 current clients (#1, #2, #3 and #4) and failed to maintain a client record for 1 of 1 Deceased Client (DC #5). The findings are: A. Review on 4/20/21 of client #1's record revealed: -no emergency contacts listed -no progress notes -no physician summaries B. Review on 4/20/21 of client #2's record revealed: -no emergency contacts listed -no progress notes -no physician summaries C. Review on 4/20/21 of client #3's record revealed: -no emergency contacts listed -no medication orders -no progress notes -no physician summaries D. Review on 4/20/21 of client #4's record revealed: -no emergency contacts listed -no medication orders -no progress notes	V 113		

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V 113	Continued From page 24 -no orders for lab test or results -no physician summaries E. Attempted review of DC #5's record on 4/20/21 revealed there was not a record available at the facility. Review of death certificate on 5/5/21 for DC #5 revealed: -Date of death February 8, 2021 -Cause of death was natural causes Interview on 5/3/21 staff #1 reported: -the Licensee and the QP checked and kept the records together -she didn't update the records -she was responsible for taking all the clients to their doctor appointments -DC #5 passed away on 2/8/21 Interview on 5/17/21 with the medical assistant at client #4's doctors office reported: -client #4 came in for a follow up every 3 - 6 months -he received a fasting comprehensive metabolic panel check during these visits -the last lab was 4/1/21 and his blood sugar reading was 66 -his A1C was repeated every 3 months (a percentage of his sugar) Interview on 5/4/21 the QP reported: -she documented clients' progress towards their goals once per month -progress notes were kept in her records not at the facility -facility should keep client records for 5 - 7 years after a client has died or has been discharged -there should have been a note in the record of DC #5's death	V 113		

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V 113	Continued From page 25 -the family should have been notified and an incident report completed Interview on 4/20/21, 5/6/21 and 5/18/21 the Licensee reported: -she was responsible for checking clients' records and ensuring they were up to date -she also took the clients to their doctor's appointments -everything at the doctor's office was electronic -they no longer gave orders or physician summaries -she didn't know how to get into the portal to print physician orders and summaries -she and the QP used to write progress notes but it's been awhile -she would start back writing progress notes -staff contacted her with any concerns and then she (Licensee) would contact the guardians -she was not sure if emergency contacts were in the records because she was all the clients emergency contacts -she disposed of DC #5's records -she shredded the information and threw it in the trash -her process for discharged/deceased clients was to throw the records away -she didn't complete a discharge summary for DC #5 -he didn't come back from the hospital This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 113		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS	V 114		

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V 114	Continued From page 26 AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were completed at least quarterly and repeated for each shift. The findings are: Review on 5/10/21 of the facility's fire and disaster log revealed: - one fire drill and one disaster drill done in 2020 - no current documentation of drills for 2021 During interview on 4/27/21 staff #1 reported: - fire & disaster drills were done every other week. - drills are practiced every other week because some got confused - she did not write the drills down - the Licensee was contacted each time a drill was conducted - the Licensee might write the drills down after she (staff #1) contacted her	V 114		

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V 114	Continued From page 27 During interview on 4/27/21 client #1 reported: - fire drills are practiced at the end of the driveway - disaster drills were practiced in the bathroom - they practiced drills every 2 weeks During interview on 4/27/21 client #2 reported: - if there was a fire he would go to the nearest exit - staff pulled the fire alarm during drills - if there was a tornado, he would get in a small place that could not cause damage like the bathroom During interview on 4/27/21 client #3 reported: - if there was a fire he would go outside - if there was a tornado, he went to the bathroom or closet During interview on 5/4/21 the Qualified Professional reported: - the Licensee ensured fire and disaster drills were completed by staff - she had not checked to ensure the drills were being conducted During interview on 5/6/21 the Licensee reported: - clients went to the mailbox for fire drills - disaster drills are practiced in the closet or bathroom - she and staff ensured the drills were completed - she called the staff and spoke to the clients to ensure drills were done - she could not locate the 2021 fire and disaster drills	V 114		

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V 118	Continued From page 28	V 118		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by:	V 118		

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Based on observation, record review and interview the facility failed to ensure medications were administered on the written authorization of a physician's order affecting 2 of 3 audited clients (#3, #4); failed to ensure medications administered were recorded immediately after administration affecting 3 of 3 audited clients (#1, #3, #4) & failed to ensure 2 of 2 Qualified Professionals (QP & Licensee) demonstrated compentency in medication administration. The findings are:

1. The following are examples of how the facility failed to follow physician orders:

A. Review on 4/22/21 of client #3's record revealed:
-Admitted 1/29/07
-A FL2 dated 5/12/20 revealed diagnoses of Impulse disorder, Borderline Intellectual Functioning, Tourette's Syndrome, Enuresis, Abnormal Glucose, Hyperlipidemia and Psychosis

A FL2 dated 5/12/20 signed by the physician:
-Pimozide 2mg (milligrams) 1 tablet twice a day (used to treat Tourette syndrome)
-Sertraline HCL 100mg 1 1/2 tablets every morning (treat depression & social anxiety disorder)

Review on 4/20/21 & 4/21/21 of client #3's March & April 2021 MARs revealed:
-March 2021 MAR did not list Pimozide Tab 2mg
-April 2021 MAR showed Sertraline 100mg 2 tablets everyday started on 4/7/21
-No physician order for Sertraline 100mg 2 tablets daily

Observation on 4/20/21 at 12:37pm of client #3's

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V 118	Continued From page 30	V 118		

medication box revealed:
-Blister pack labeled Pimozide 2mg 1 tab twice a day
-Blister pack labeled Sertraline HCL 100 mg (200mg) take 2 tablets by mouth daily

Interview on 4/22/21 the Pharmacist reported:
-Client #3's Sertraline was increased on 4/5/21 to 2 tabs (200mg) daily

Interview on 5/3/21 staff #1 reported:
-client #3's Sertraline was increased due to behaviors
-didn't have a doctor's order for the increased Sertraline because everything was electronic through the physician's portal
-she didn't know how to access the physician's office portal
-she didn't know that Pimozide Tab 2mg was not listed on the MAR for March 2021
-client #3 received his Pimozide Tabs twice a day in March 2021
-the Licensee looked at MARs for errors several times per month
-she couldn't remember the last time the Licensee had looked at the MARs

Interview on 5/6/21 the Licensee reported:
-she wasn't aware that client #3's Pimozide medication was not on the March 2021 MAR
-the pharmacy forgot to put it on the MAR

B. Review on 4/22/21 of client #4's record revealed:
-Admitted 8/28/18
-Diagnoses: Schizophrenia, Hypertension, Hyperlipidemia, Tobacco abuse, Type II diabetes and a history of wandering
-client prescribed Metformin 850mg for diabetes
-client prescribed Ramipril 5mg for high blood

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V 118	Continued From page 31 pressure -No physician's orders to check blood pressure or blood sugar Review on 4/22/21 of physician's orders dated 6/6/20 for client #4 revealed: -check and record blood pressure weekly -check and record fasting blood sugar every morning Review on 4/20/21 of client #4's February - April 2021 MARs revealed: -see back of MAR for recorded blood sugar and blood pressure readings -no documentation of readings were written on the back of the MARs Review on 4/20/21 of a fax from the facility to the Division of Health Service Regulation (DHSR) revealed: -documentation of blood sugar and blood pressure readings without a client's name -documentation of the readings were on a piece of notebook paper -April's readings were on a sheet by itself -there was no year following the month of April -the month and day were listed on each line followed by the glucose reading -blood sugar readings were to be done before breakfast but there were no times listed -the blood pressure reading was written on the right side of the paper (BP - date/no year and then the reading) Observation on 4/20/21 at 1:30pm of client #4's blood glucose machine and strips revealed: -a red and black blood glucose machine -last date, time and reading on the machine was 2/12(no year) at 5:05am with a blood sugar reading of 145	V 118		

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V 118	Continued From page 32 -the blood sugar strips had an expiration date of 05/2016 Interview and observation on 4/20/21 at 12:00pm staff #1 reported: -she checked client #4's blood sugars once a day -there was no physician order to check blood sugar -the blood glucose machine needed to be reset -she didn't know about the glucose strips being expired -she shrugged her shoulders when asked about the expired blood glucose strips Interview on 4/22/21 the Pharmacist reported: -the blood sugar test strips had enzymes and chemicals in them -the strips can lose effectiveness over time -should be replaced if strips are expired in order to get an accurate reading Interview on 5/17/21 with the nurse at the Physician's office reported: -client #4 came in for a follow up every 3 - 6 months -his A1C was repeated every 3 months (gives you a percentage of their sugar level) -considering his past history of high A1C blood sugar levels (highest being 8.6 in 2018), his blood sugars have been stable -any A1C reading under 7 is considered stable During interview on 5/4/21 the QP reported: -she does not recall if staff #1 was supposed to check client #4's blood sugars -she doesn't recall if there was any documentation of his blood sugars -the Licensee and staff were responsible for ensuring medications were not expired and physician orders were in the records	V 118		

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V 118	Continued From page 33 During interview on 4/20/21 & 5/6/21 the Licensee reported: -no order to check blood sugar or blood pressure -staff #1 checked the blood sugar because he was a diabetic -she checked the blood sugar level like she was supposed to and there were no issues -staff #1 needed to reset the blood glucose machine 2. The following are examples of how medications weren't recorded immediately. A. Review on 4/20/21 of client #1's record revealed: -Admitted 6/19/13 -A FL2 dated 4/14/20 revealed diagnoses of: Hypertension, Paranoid Schizophrenia, Gastroesophageal -Medications on the FL2: -Aspirin 81mg daily (can reduce the risk of heart attack) -Atenolol 25mg in the morning (treat high blood pressure) -Fluticasone 50mg daily (can prevent asthma) -Risperidone 4mg 1 1/2 bedtime (can treat schizophrenia) -Benztropine 1mg bedtime (can treat Parkinson and side effects of other drugs) Review on 4/22/21 of client #1's March 2021 MAR revealed: -no staff initials documented for the following medications on 3/30/21 & 3/31/21: Aspirin, Atenolol, Fluticasone, Risperidone, and Benztropine B. Review on 4/22/21 of client #3's medications on his FL2 dated 5/12/20 revealed:	V 118		

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V 118	Continued From page 34 -Lorazepam .5 mg as daily (used to treat anxiety) -Metformin 500mg twice a day (diabetes) -Olanzapine 10mg daily (schizophrenia) -Omeprazole 20mg daily (acid reflux, ulcers) -Pravastatin 40mg daily (cholesterol) -Gabapentin 300mg daily (neurotic pain) -Fish Oil 1000mg twice a day -Aspirin 81mg daily -Vitamin D3 50mcg daily -Boost Glucose Control Vanilla (nutritional supplement) Review on 4/22/21 of client #3's March 2021 MAR revealed the following: -no staff initials documented for the evening medications on the 30th for the following medications: Fish Oil, Pravastatin, Olanzapine, Metformin, and Gabapentin -no staff initials documented on the 31st for the following medications: Sertraline, Lorazepam, Vitamin D3, Aspirin, Fish Oil, Pravastatin, Olanzapine, Metformin, Omeprazole, Gabapentin, and Boost C. Review on 4/22/21 of client #4's medications on his FL2 dated 5/12/20 revealed: -Amitriptylin 50mg daily (mental/mood issues) -Olanzapine 10mg daily (schizophrenia) -Trazodone 100mg daily (depression) -Divalproex 250 mg 3 tablets daily (mental/mood disorders) -Bupropion 150mg twice a day (antidepressant and also used to help people stop smoking) -Ammonium Lotion 12% as needed -Atorvastatin 40mg daily (treat high cholesterol and lower the risk of a stroke) -Metformin 850mg twice a day (diabetes) -Jardiance 10mg daily (control high blood sugar) -Clopidogrel 75mg daily (lower risk of having a stroke or heart attack)	V 118		

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V 118	Continued From page 35 -Ramipril 5mg daily (hypertension) -Amlodipine 10mg daily (hypertension) -Boost High Protein supplement daily Review on 4/22/21 of client #4's March 2021 MAR revealed the following: -no staff initials documented for the evening medications on the 30th for the following: Boost, Amitriptylin, Bupropion, Divalproex, Olanzapine, Trazodone, Metformin -no staff initials documented on the 31st for the following medications: Boost, Amitriptylin, Bupropion, Memantine, Divalproex, Olanzapine, Trazodone, Ramipril, Metformin, Clopidogrel, Atorvastatin, Amlodipine, Jardiance, Interview on 5/3/21 staff #1 reported: - on 3/30/21 and 3/31/21 she forgot to sign off on the MARs for the clients -they did get their medication -she went back to sign the MARs and the surveyor made her aware it was a medication error. Interview on 5/6/21 the Licensee reported: -came to the facility daily -she looked at the client's medication -she looked at the MARs to ensure medications were given as ordered -she made sure staff signed off on medications given -there were no physician orders in the client records -she matched the MARs to what the doctor told staff about medications at doctors' appointments -there were no medication errors in the last 3 months During interview on 5/4/21 the QP reported: -she looked over the medication books once a	V 118		

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V 118	Continued From page 36 month for errors -she last reviewed the MARS for errors March 2021 -she had not found any errors 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 is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 3 of 3 audited clients (#1, #3 &	V 121		

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V 121	Continued From page 37 #4) had psychotropic drug regimen reviews at least every six months. The findings are: Review on 4/22/21 of client #1's record revealed: - admitted 6/19/13 - diagnoses of Paranoid Schizophrenia, Hypertension and Gastroesophageal Reflux Disease - a FL2 dated 4/14/20 of the following psychotropic medications: Risperidone 4mg (milligrams) 1 1/2 at bedtime (QHS) & Benztropine 1mg at QHS - no evidence of a psychotropic drug regimen review completed Review on 5/14/21 of client #3's record revealed: - admitted 1/29/07 - diagnoses of Tourette Syndrome, Boderline Intellectual Functioning, Impulse Disorder and Psychosis - a FL2 dated 5/12/20 of the following psychotropic medications: Lorazepam .5mg at (QHS) , Olanzapine 10mg at QHS and Sertraline 100mg 1 1/2 in the morning - no evidence of a psychotropic drug regimen review completed Review on 5/14/21 of client #4's record revealed: - admitted 8/28/18 - diagnoses of Schizophrenia, Hypertension, Hyperlipidemia, Tobacco abuse and Type II diabetes and a history of wandering - a FL2 dated 5/12/20 of the following psychotropic medications: Trazodone 100mg at (QHS), Olanzapine 10mg at (QHS) and Divalproex 250mg (3) by mouth daily - no evidence of a psychotropic drug regimen review completed During interview on 5/6/21 the Licensee reported:	V 121		

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V 121	Continued From page 38 - no pharmacy reviews had been completed since the beginning of the pandemic - she contacted the pharmacist in January 2021 - the pharmacist said the psychotropic medication reviews could be completed remotely - she would follow up with the pharmacist This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 121		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other	V 289		

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V 289	Continued From page 39 diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by:	V 289		

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V 289	Continued From page 40 Based on observation, record review and interview the facility failed to ensure 4 of 4 clients (#1, #2, #3 and #4) had a home environment where the primary purpose of these services were the care and rehabilitation of individuals who have a mental illness and developmental disability. The findings are: A. Cross reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108). Based on record review and interview the facility failed to ensure one of one staff (#1) was trained in goals and strategies as identified in the treatment plans. B. Cross reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record review and interview, 2 of 2 Qualified Professional (QP & Licensee) failed to demonstrate knowledge and skills required by the population served. C. Cross reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112). Based on record review and interview the facility failed to develop and implement strategies to address the needs for 2 of 4 clients (#2, #4). The facility also failed to develop the treatment plan in partnership with the client and legally responsible person affecting 4 of 4 clients (#1, #2, #3 #4). D. Cross reference: 10A NCAC 27G .0206 CLIENT RECORDS (V113). Based on record review and interview the facility failed to maintain client records which contained: emergency information for each client, documentation of progress toward outcomes, medication orders, and copies of lab tests for 4 of 4 current clients	V 289		

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V 289	Continued From page 41 (#1, #2, #3 and #4) and failed to maintain a client record for 1 of 1 Deceased Client (DC #5). E. Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118). Based on observation, record review and interview the facility failed to ensure medications were administered on the written authorization of a physician's order affecting 2 of 3 audited clients (#3, #4); failed to ensure medications administered were recorded immediately after administration affecting 3 of 3 audited clients (#1, #3, #4) & failed to ensure 2 of 2 Qualified Professionals (QP & Licensee) demonstrated compentency in medication administration. F. Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V121). Based on record review and interview the facility failed to ensure 3 of 3 audited clients (#1, #3 & #4) had psychotropic drug regimen reviews at least every six months. G. Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V290). Based on record review and interview the facility failed to ensure a minimum of one staff member was present at all times when any adult client was on the premises, except when the client's treatment plan documented they were able to be in the community affecting 4 of 4 clients (#1, #2, #3 and #4). H. Cross reference: 10A NCAC 27G .5603 OPERATIONS (V291). Based on observation, record review and interview the facility failed to coordinate with the Qualified Professional (QP) who is responsible for treatment/habilitation affecting 1 of 3 audited clients (#4). The facility also failed to have activity opportunities based on	V 289		

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V 289	Continued From page 42 clients choices, needs and the treatment/habilitation plan affecting 4 of 4 clients (#1, #2, #3, #4). I. Cross reference: 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V366). Based on record review and interview the facility failed to develop and implement a written policy for Level I, II or III incidents. J. Cross reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V367). Based on record review and interview the facility failed to ensure Level II incident reports were completed within 72 hours. K. Cross reference: 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (V736). Based on observation and interview the facility failed to be maintained in a safe, clean, attractive and orderly manner. L. Cross reference: 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (V744). Based on observation and interview, the facility failed to provide minimal furnishings affecting 1 of 3 audited clients (#4). Review on 6/1/21 of the facilities Plan of Protections (POP) revealed the following: (The QP referenced in this POP was the Licensee's daughter not the facility's QP) POP #1: Review on 6/1/21 of a Plan of Protection dated 6/1/21 written by the Licensee revealed: (there were several mark throughs and rewrites). What immediate action will the facility take to ensure	V 289		

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V 289	Continued From page 43 the safety of the consumers in your care? "The facility will ensure that all the corrections are made. The QP (mark through QP) and the director (mark through director) with another [QP/Registered Nurse) RN/Licensee's daughter] will work together to ensure the corrections are made. Describe your plans to make sure the above happens. "[QP] another [QP QP/RN/Licensee's daughter] will assist with the corrections. [QP] will provide training for the personnel, client records, the plans, medicaton training and incident report, starting on 6/1/21. POP#2: Review on 6/1/21 of a Plan of Protection dated 6/1/21 written by the Licensee revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? "The facility (mark through facility) [QP/RN/Licensee's daughter] will ensure that all the corrections are made. The QP (mark through QP) and the director (mark through director) with another [QP/RN/Licensee's daughter] will work together to ensure the corrections are made." Describe your plans to make sure the above happens. "[QP/RN/Licensee's daughter] will assist with the corrections. [QP/RN/Licensee's daughter] another QP (mark through another QP) will assist with the corrections. [QP/RN/Licensee's daughter] will provide training for the personnel, client records, treatment plans, medication training and incident reports, starting today 6/1/21." Staff #1, the QP and Licensee failed to provide residential treatment services for client #1 - #4 with diagnoses consisting of Schizophrenia,	V 289		

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V 289	Continued From page 44 Psychosis and Boderline Intellectual Functioning. The Licensee instructed staff #1 to take the clients daily to sister facility A. They arrived at 8am and left at 5pm. There were no interactions observed between the clients. Sister facility A clients remained in their bedrooms while the facility clients slept or wandered in and out of the facility. The QP reported she visited the facility 3-4 times a week but only knew 1 client's name. The clients were not familiar with the QP's name or any of their goals. The clients, staff nor the guardians participated in treatment team meetings. Client #2 and client #4 wandered from Sister facility A 33 times from July 2020 - March 2021. There was no documenation of the wandering behaviors in client #2 or #4's treatment plans. The LME/MCO had not received an incident report from the facility since 2013. Client #4 had diagnoses of Diabetes and Hypertension. There was a physician's order to check client #4's weight, BS, BP and a no concentrated sweets diet. Staff #1, the QP and the Licensee were not aware of the physician's order. Client #4 was observed with regular soda, sweet tea and chips. A fax was later sent from the facility with a list of BS, BP & weight checks documented from January 2021 - March 2021 on a piece of notebook paper. There wasn't a name, no times of the weight, BP or BS checks documented. The last date on client #4's glucometer was 2/12 (no year). The BS strips had expired May 2016. The pharmacist said the staff didn't receive an accurate reading due to the strips losing effectiveness over a period of time. The QP was responsible for staff training but staff #1 was not trained on the clients' treatment plans. DC#5's record could not be reviewed because it was shredded by the Licensee. If any clients had an appointment, staff #1 took them while the rest of the clients remained at sister facility A with one	V 289		

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V 289	Continued From page 45 staff. There were several environmental issues like doors off the hinges, a floor buckled and lifted & the paint around a vent in the ceiling was peeling. The Licensee acknowledged as the owner she was responsible for a homelike environment and maintenance of the group home. Due to the collective lack of services demonstrated by staff #1, the QP and Licensee, such as care and rehabilitation of the clients, this constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000 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 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance	V 290		

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V 290	Continued From page 46 abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a minimum of one staff member was present at all times when any adult client was on the premises, except when the client's treatment plan documented they were able to be in the community affecting 4 of 4 clients (#1, #2, #3 and #4). The findings are: A. Review on 4/20/21 of client #1's record revealed: - Admitted 6/19/13	V 290		

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V 290	Continued From page 47 - diagnoses of: Hypertension, Paranoid Schizophrenia, Gastroesophageal - no documentation of unsupervised time B. Review on 5/3/21 of client #2's record revealed: - No documented admission date - Diagnosis of Schizophrenia - no documentation of unsupervised time C. Review on 4/22/21 of client #3's record revealed: - Admitted 1/29/07 - diagnoses of Impulse disorder, Borderline Intellectual Functioning, Tourette's Syndrome, Enuresis, Abnormal Glucose, Hyperlipidemia and Psychosis - no documentation of unsupervised time D. Review on 4/22/21 of client #4's record revealed: - Admitted 8/28/18 - diagnoses of Schizophrenia, Hypertension, Hyperlipidemia, Tobacco abuse and Type II diabetes and a history of wandering - no documentation of unsupervised time During interview on 4/21/21 & 5/3/21 staff #1 reported: - she was the only staff that worked at the facility - she was the driver for the facilities if clients had appointments - any clients at her facility or sister facility A with appointments went with her - any of her clients without appointments remained at sister facility A with staff A2 During interview on 4/27/21 staff A2 reported: - she watched staff #1's clients, if the others	V 290		

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V 290	Continued From page 48 had appointments - psychiatric or medical appointments could last an hour to hour in a half - appointments could be once or twice a week - she was the only staff that worked at sister facility A - she could meet the clients' needs without the help of other staff - there were no diabetics from the sister facility - all the clients had Schizophrenia During interview on 5/27/21 the Qualified Professional reported: - she was not sure why the clients would be at sister facility A from 8am - 5pm - they needed to be at their own facility for that amount of time - unless there was an activity, they should not be at sister facility A all day - staff A2 could not monitor her clients and the sister facility clients alone - the staff-client ratio would be too much - staff A2 had physical limitations that affected her mobility - if a client wandered away, staff A2 could not follow the client During interview on 4/21/21 and 5/6/21 the Licensee reported: - she, her husband and 2 daughters were also staff at the facility - whenever staff #1 had client appointments, she remained at sister facility A to monitor the clients This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 290		

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V 291	Continued From page 49	V 291		
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 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 observation, record review and interview the facility failed to coordinate with the Qualified Professional (QP) who is responsible for	V 291		

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V 291	Continued From page 50	V 291		

treatment/habilitation affecting 1 of 3 audited clients (#4). The facility also failed to have activity opportunities based on clients choices, needs and the treatment/habilitation plan affecting 4 of 4 clients (#1, #2, #3, #4). The findings are:

I. The following is an example of how the facility failed to coordinate with other QP's in regards to the care of client #4.

A. Review on 4/20/21 of client #4's record revealed:
-Admitted 8/28/18
-Diagnoses of: Schizophrenia, Hypertension, Hyperlipidemia, Tobacco abuse, Type II diabetes and a history of wandering
-February- April 2021's MARs (medication administration record) to check weight monthly
-no documentation on the MARs of the weight checks

Review on 4/20/21 of a fax from the facility to the Division of Health Service Regulation (DHSR) revealed:
-documentation of weight checks without a client's name
-documentation was on a piece of notebook paper
-April's documentation did not have a year

Review on 4/22/21 of a fax received from the pharmacy sent to DHSR revealed:
-a physician's order dated 6/6/20
-check and record client #4's weight monthly

Observation on 4/27/21 at 2:32pm revealed:
- a scale kept at sister facility A
-staff #1 stepped on the scale to show that it worked

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V 291	Continued From page 51 Interview on 5/18/21 client #1 reported: -he did get weighed -didn't know the last time or how often -says that staff #1 weighed him Interview and observation on 4/20/21 at 12:00pm staff #1 reported: -the weight checks were not documented on the back of the MAR -it was recorded on a separate sheet of paper -she could not find the documentation -it must be in her other folder at sister facility A -she would meet surveyors at sister facility A with the weight checks -surveyors and Licensee proceeded to go to sister facility A to meet staff #1 -staff #1 did not show up and Licensee called her -she told Licensee that she found the paper with the readings -they would be faxed to surveyors Interview on 4/27/21 & 5/3/21 staff #1 reported: -client #4 was weighed every month -if his weight was decreased or increased by 5 pounds they called the doctor -scale was kept at sister facility A due to the number of clients that needed to be weighed Interview on 4/20/21 the Licensee reported: -staff #1 took client #4's weight monthly like she was supposed to -she had it documented but just couldn't find it -she would fax the information to surveyors B. Review on 4/22/21 of a fax sent to DHSR by the Pharmacist for client #4 revealed: -a physician's order dated 6/6/20 for a no concentrated sweets diet Review on 4/20/21 of client #4's February - April	V 291		

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V 291	Continued From page 52 2021's MARs revealed: -no concentrated sweets diet -no documentation to address his no concentrated sweets diet Observations for client #4 revealed the following: - on 4/20/21 at 1:23pm he went into the refrigerator and poured sweet tea -on 5/6/21 at 12:11pm his snack cabinet contained a bag of barbecue chips and a can of regular soda Interview on 4/20/21 client #4 reported: -he did not eat a lot of cakes and sweets -he did drink sweet tea and sweet drinks -he loved soda and chips Interview on 5/3/21 staff #1 reported: -doctor did not specify a diet because of client #4's diabetes -he was not restricted from any food -she was not aware of the no concentrated sweets diet -no one has ever discussed the no concentrated sweets diet with her Interview on 5/18/21 staff #1 reported: -they now purchased diet sodas for him -he had chips with no salt and baked chips -the Licensee needed to purchase more bake chips and diet sodas During interview on 5/4/21 the QP reported: -she did not recall any health issues with client #4 -she didn't recall him being a diabetic -client #4 liked to walk to the store and get soda and candy -a goal was to limit his sugar content -they wanted him to drink diet sodas -didn't recall him being on a special diet	V 291		

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V 291	Continued From page 53 Interview on 5/6/21 the Licensee reported: -he was not on a special diet -he was not on a concentrated sweets diet -they didn't follow a menu for a no concentrated sweets diet -they didn't give him sweet sodas -he liked his chips II. The following are examples of how the facility staff failed to have available client activities: A. Review on 4/22/21 of client #1's record revealed: - admitted 6/19/13 - diagnoses of Paranoid Schizophrenia, Hypertension and Gastroesophageal Reflux Disease B. Review on 5/3/21 of client #2's record revealed: - No admission date documented - Diagnosis: Schizophrenia C. Review on 5/14/21 of client #3's record revealed: - admitted 1/29/07 - diagnoses of Tourette Syndrome, Boderline Intellectual Functioning, Impulse Disorder and Psychosis D. Observations & interviews between 4/20/21 & 6/1/21 and at various times during visits to sister facility A revealed the following: - staff #1 and clients were found at sister facility A during each visit at varying times of the day - there was very little socialization between the clients and staff - staff A2 moved at a slow pace - client #1, #2 and #4 wandered inside and	V 291		

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V 291	Continued From page 54 outside the facility - 4/20/21: arrived to sister facility A at 10:38am - there was a small living room area with a television (TV) - 3 kitchen chairs, love seat, couch and an accent chair were in the living room - staff A2 in the kitchen area with staff #1 - client #1 sat in a kitchen chair in the living room - client #2 wandered in the yard - client #3 was curled up on the accent chair with his hood over his head - his head rested on the arm of the chair - client #4 sat outside and greeted surveyors when they arrived - client A4 sat on the couch E. 4/27/21: Arrived at the sister facility at 12:13pm - client A1 sat in the front yard - client #1, #3 and #4 were in the living room - client #2 wandered around in the backyard - client #3 had his head resting on the arm of the chair - client A4 sat on the couch in the living room - staff #1 was in the facility - staff A2 was in the backyard in her garden F. 5/3/21: Arrived at sister facility A at 3:32pm - client #1 was sitting in a chair on the back porch asleep - client #2 walked through the kitchen area - client #3 was in the accent chair with his hood over his head - his head rested on a pillow on the arm of the chair - client #4 was outside - staff #1 and staff A2 were in the kitchen - staff A2 prepared spaghetti G. 5/6/21: Arrived at sister facility A at 12:13pm -all clients were present from both facilities	V 291		

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V 291	Continued From page 55 H. 5/10/21: Arrived at sister facility A at 1:08pm - client #1 sat in the kitchen chair with his head down as if he was sleepy - client #2 walked in the yard alone - client #3 sat in the small accent chair - told surveyor he was sleepy and wanted to go to his facility - staff #1 and staff A2 were in the kitchen area - 4 - 5 boxes of depends in the middle of the living room floor - staff A2 said 3 of her clients were in their bedrooms and 1 outside - 1:17pm: client #2 stretched out on the couch resting in the living room I. 5/18/21: Arrived at the facility at 11:30am - client #1, #3 & #4 in the living room area - client #2 walked in the backyard alone - client #3 in the accent chair with his head down on the arm rest - 4-5 boxes of depends in the middle of the living room floor - staff #1 and staff A2 in the kitchen area Review on 5/12/21 of client #2's treatment plan revealed: -dated 6/15/20 -goal was to actively engage in Residential Service to prevent isolation -strategies included: social/activity planning, engagement in residential events, community events and supervised outings Interview on 5/10/21 client #A5 reported: - he was fine with the clients from sister facility coming over - they come at 7:45 in the morning (am) and left at 5:30 in the evening (pm) - they usually watched television (TV)	V 291		

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V 291	Continued From page 56 - the TV has not worked in the last 2 weeks Interview on 5/10/21 client #A6 reported: - the clients came to their facility Monday- Friday from 8am - 5pm - they have lunch daily at their facility and sometimes dinner - he was OK with the clients coming over from the sister facility Interview on 5/3/21 client #2 reported: -they went to sister facility A everyday -they just sit, watch tv or take naps -there was not much room to work with so they were not able to do too much Interview on 4/20/21 client #3 reported: -went to sister facility A everyday -they just sit, watch TV or take naps while there -when he's at home, he would spend time in his room and watch TV -he liked board games but didn't have any -he liked to go to fast food restaurants -he hasn't been to a fast food restaurant since before the pandemic Interview on 4/20/21 client #4 reported: -he used to go to the gym a long time ago -he went to sister facility A everyday and just sat around -didn't play any games they just sat around and watched TV Interview on 4/20/21 staff #1 reported: - the facility was her place of residence - she was the only staff that worked at the facility - clients go to sister facility A to "socialize" with the other clients - they arrived at sister facility A at 8am and left at 5pm	V 291		

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V 291	Continued From page 57 - they used to go to the library before the pandemic - Licensee wanted the clients to go to sister facility to socialize -they ride around in the van Continued interview on 5/18/21 with staff #1 reported: -there was not much they could do because of the pandemic -there were no games in the facility for the clients -no one said anything to her about any other activities During interview on 4/27/21 & 5/10/21 staff A2 reported: - her clients (sister facility A) liked to stay in their rooms, therefore it was fine that sister facility clients occupied the living room Interview on 5/4/21 the QP reported: -she knew the clients visited sister facility A -they visited so they could "socialize" -she did not know the clients were there every day -that would be a problem because they needed to spend some time at their own facility doing activities Interview on 4/20/21 & 5/6/21 the Licensee reported: -the clients went to sister facility A to interact -they didn't go every day, only when they felt bored -since the pandemic, the clients haven't been to their day program -going to sister facility A was the only way they could communicate and interact with others -the clients liked to laugh and talk to each other	V 291		

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V 291	Continued From page 58 Interview on 6/1/21 the Licensee reported: -they would start going to the park and taking rides -she would start talking to them about activities they would be interested in This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 291		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in	V 366		

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V 366	Continued From page 59 Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and	V 366		

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V 366	Continued From page 60 (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement a written policy for Level I, II or III incidents. The findings are:	V 366		

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V 366	Continued From page 61 Review on 4/21/21 of the facility's record revealed: - no written incident reports Review on 5/6/21 of the facility's policy manual revealed the following: - the pages in the policy manual were not in numerical order based on their table of contents - the incident reporting policy could not be located in the policy manual - the Licensee was not able to locate the incident report policy Review on 5/5/21 & 5/12/21 of the call for service police report revealed: - the police were called to sister facility A for client #2 and client #4 - they were called approximately 33 times between 7/20/20 and 3/30/21 - the majority of the calls revealed clients walked to the local grocery store to buy chips and soda - majority of the calls revealed they were gone approximately an hour or less - the callers were staff #1 and staff A2 Review on 5/5/21 of a death certificate for Deceased Client (DC#5) revealed: - he passed away on 2/8/21 - death of manner: natural causes During interview on 5/6/21 the Licensee reported: - she does not require an incident report if staff observed the client leave and requested the client to return but they refused - DC#5 did not pass away at the facility, therefore an incident report was not completed - she would locate the incident report policy and fax to surveyor - the incident policy was not received prior to	V 366		

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V 366	Continued From page 62 the close of survey During interview on 5/14/21 a representative with the Local Managed Entity/Managed Care Organization reported: - A level II incident report was required if a client passed away of an illness or natural causes - she had not received any incident reports from this facility since 2013 This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident;	V 367		

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V 367	Continued From page 63 (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided.	V 367		

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V 367	Continued From page 64 The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure Level II incident reports were completed within 72 hours. The findings are: Review on 4/21/21 revealed: - the facility had no written incident reports Review on 5/5/21 & 5/12/21 of the call for service police report revealed: - the police were called to sister facility A for client #2 and client #4 - they were called approximately 33 times between 7/20/20 and 3/30/21	V 367		

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V 367	Continued From page 65 - the majority of the calls revealed clients walked to the local grocery store to buy chips and soda - majority of the calls revealed they were gone approximately an hour or less - the callers were staff #1 and staff A2 Review on 5/5/21 of a death certificate for Deceased Client (DC#5) revealed: - he passed away on 2/8/21 - death of manner: natural causes During interview on 5/4/21 the Qualified Professional (QP) reported: - she did not complete an incident report for DC#5's death but the Licensee could have - she did not complete incident reports for client #2 or #4 police calls to the facility - the QP was responsible for completing the incident reports - there was no specific reason why she did not complete incident reports During interview on 5/7/21 the Licensee reported: - she required staff to write an incident report if the client wandered from the facility - the client had to be gone more than an hour or two before an incident report was written - the clients walked to the local grocery store to purchase drinks and chips - the clients do not have unsupervised time - if staff requested the client to return to the facility and they refused, an incident report was not required - staff called the police when clients walked away from the facility - DC#5 did not pass away at the facility, therefore, an incident report was not completed - she and the QP were responsible for completing incident reports	V 367		

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V 367	Continued From page 66 During interview on 5/14/21 a representative with the Local Managed Entity/Managed Care Organization reported: - A level II incident report was required if a client passed away of an illness or natural causes - she had not received any incident reports from this facility since 2013 This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 542	27F .0105(a-c) Client Rights - Client's Personal Funds 10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS (a) This Rule applies to any 24-hour facility which typically provides residential services to individual clients for more than 30 days. (b) Each competent adult client and each minor above the age of 16 shall be assisted and encouraged to maintain or invest his money in a personal fund account other than at the facility. This shall include, but need not be limited to, investment of funds in interest-bearing accounts. (c) If funds are managed for a client by a facility employee, management of the funds shall occur in accordance with policy and procedures that: (1) assure to the client the right to deposit and withdraw money; (2) regulate the receipt and distribution of funds in a personal fund account; (3) provide for the receipt of deposits made by friends, relatives or others; (4) provide for the keeping of adequate financial records on all transactions affecting	V 542		

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V 542	Continued From page 67 funds on deposit in personal fund account; (5) assure that a client's personal funds will be kept separate from any operating funds of the facility; (6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client or legally responsible person upon or subsequent to admission of the client; (7) provide for the issuance of receipts to persons depositing or withdrawing funds; and (8) provide the client with a quarterly accounting of his personal fund account. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to provide receipt of deposits made by relatives and failed to keep adequate financial records on all transactions affecting affecting 4 of 4 clients (#1, #2, #3 and #4). The findings are: Review on 5/11/21 of the facility's personal fund accounts for the clients revealed: - each client signed they received a monthly allowance of $66.00 - no deductions from the $66.00 were documented Observation on May 6, 2021 at 12:18pm revealed: - 4 different plastic containers labeled with the clients' names - each container had money located inside the plastic container During interview on 5/3/21 client #1 reported:	V 542		

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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 542	Continued From page 68 - he received $10.00 a month but a couple months ago he started to get $20.00 a month - he used to keep his money in a bank but was not sure what happened - he paid medication copayments - he purchased cigarettes - he received no receipts - he was not sure what his monthly balance was During interview on 5/3/21 client #3 reported: - he received a little money - he did not get any receipts for money to know how much money he had left During interview on 5/3/21 client #4 reported: - he received $15.00 to $20.00 a month During interview on 5/3/21 staff #1 reported: - all the clients received a monthly allowance of $66.00 - they had to pay medication copayments - they signed for their funds. - none of the clients kept their own money - they would lose or forget where the money was - they let her know when they wanted to go to the store - client #4's cousin would send him money when she could - last time was December 2020 or January 2021 in the amount of $30.00 - she would let the Licensee know when the clients needed money - the Licensee was responsible for all their funds During interview on 5/3/21 client #1's guardian reported: - he received a call from social security that the	V 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-412	A. BUILDING: _____ B. WING _____	R 06/01/2021

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V 542	Continued From page 69 facility could no longer be the payee - he didn't know why - he appointed an attorney's office to be client #1's payee - this happened in January or February 2021 During interview on 5/6/21 the Licensee reported: - she was not the payee for any of the clients - the clients received $66.00 a month minus their medication copayments - she kept any remaining funds from the $66.00 - they could do what they wanted with the rest of their money - she did not document deductions or deposits in the client records	V 542		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility failed to be maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 4/20/21 from 11:45am - 12:50pm revealed: Client #3's bedroom: -windows were very dusty around the frame	V 736		

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V 736	Continued From page 70 -one side of the closet door was missing -unused bedframe leaning against the wall -dresser drawer was missing 2 handles/knobs -light switch on wall at the door was very dirty and stained -light fixture in the ceiling was very dirty with dark spots inside the light fixture Bathroom #1: -ceiling above the bathtub had peeling paint around it Client #1 & client #4's shared bedroom: -1 side of the closet door was missing -dirty clothes were piled on the dresser -floor was buckling and lifting up by the back window -Bathroom #2 (located in client #1 & #4's bedroom): -floors had soft spots on it and was stained with dirt -toilet was dirty and had a ring stain inside of the bowl -paint around vent in the ceiling was peeling and had missing paint pieces around it -paint peeling around the edge of the ceiling in the corner around the shower -vent on the bottom portion of the wall by the door was partially unattached from the wall -Client #2's bedroom: -light switch on the wall by the door was very dirty and stained Empty/Unused bedroom: -had a twin mattress sitting on the floor (no frame) -a bedframe was leaning against the wall -pieces of flooring (vinyl or linoleum) was being	V 736		

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V 736	Continued From page 71 stored in the room Interview on 4/20/21 with client #4 reported: -Dirty clothes on his dresser were waiting to get washed Interview on 4/20/21 the Licensee reported: -client #3's closet was in the process of being fixed -maintenance was going to fix client #1 & #4's closet door but didn't know maintenance name -maintenance stopped coming to the facility during the pandemic -she doesn't know if he had got sick -since things have lifted, she will get back on top of maintenance This is a recited deficiency. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 736		
V 774	27G .0304(d)(7) Minimum Furnishings 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client.	V 774		

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V 774	Continued From page 72 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide minimal furnishings affecting 1 of 3 audited clients (#4). The findings are: Observation on 4/20/21 at 12:20pm of client #4's bedroom revealed: -A twin size bed against the wall -No other furniture in the room -There was a closet with clothes in it Interview on 4/20/21 with Licensee revealed: -She needed to get a "sturdier" dresser -Client #4 is rough on furniture so she removed the dresser -she was not sure when she removed it -She would get him another dresser This is a recited deficiency. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 774		