| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 000 | INITIAL COMMENTS<br><br>An annual and follow up survey was completed on June 1, 2021. Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness.<br><br>A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff will be identified using the letter of the facility and a numerical identifier. | V 000 | | |
| V 108 | 27G .0202 (F-I) Personnel Requirements<br><br>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS<br>(f) Continuing education shall be documented.<br>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:<br>(1) general organizational orientation;<br>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;<br>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and<br>(4) training in infectious diseases and bloodborne pathogens.<br>(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 | V 108 | | |

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| V 108 | Continued From page 1<br>equivalence for relieving airway obstruction.<br>(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.<br><br>This Rule is not met as evidenced by:<br>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:<br><br>Review on 5/21/21 of staff #1's record revealed:<br>- hire date: 1/13/01<br>- no documented training specific to the clients' individualized treatment plans<br>- no documentation of a training log at the facility<br><br>A. Review on 5/24/21 of client #1's record revealed:<br>- admitted 4/5/13<br>- diagnoses of Tardive Dyskinesia, Anemia, Latent Syphillis, Psychosis, Major Depressive Disorder, Mood Disorder and Cerebrovascular accident<br>- an expired treatment plan dated 4/12/19<br><br>B. Review on 5/10/21 of client #2's record revealed:<br>- no documentation of a treatment plan<br><br>C. Review on 5/24/21 of client #3's record revealed: | V 108 | | |

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| V 108 | Continued From page 2<br>- admitted on 5/11/07<br>- diagnoses of Schizoaffective Disorder (Bipolar), History of Rheumatoid Arthritis, elevated Lipids & Hypertension<br>- a treatment plan dated 6/15/20 goals - increase social skills, life without stigma of a mental health disorder, increase activities of daily living and how to verbalize and express emotions<br><br>D. Review on 5/10/21 of client #4's record revealed:<br>- admitted 8/4/20<br>- Diagnoses of Constipation; Diabetes Insipidus (a disorder of salt and water metabolism marked by intense thirst and heavy urination); Hyperglycemia; Schizoaffective Disorder; Respiratory Insufficiency; Vitamin Deficiency & Tobacco Abuse<br>- no documentation of a treatment plan<br><br>During interview on 5/10/21 & 5/18/21 staff #1 reported:<br>- the QP (Qualified Professional) provided the facility's training<br>- she couldn't remember what goals were in the clients' treatment plans<br>- she wasn't familiar with Diabetes Insipidus<br>- she had not been trained on Diabetes Insipidus<br><br>During interview on 5/27/21 the QP reported:<br>- she was responsible for staff trainings<br>- any trainings completed with staff were in a training log at the facility<br><br>During interview on 6/1/21 the Licensee reported:<br>- the QP assisted her with staff trainings<br>- many trainings are done with staff each month<br>- she and the QP needed to develop a | V 108 | | |

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| V 108 | Continued From page 3<br>training's log book with the completed trainings<br>- there weren't any clients at the facility with Diabetes Insipidus<br><br>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<br><br>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS<br>(a) There shall be no privileging requirements for qualified professionals or associate professionals.<br>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.<br>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.<br>(d) Competence shall be demonstrated by exhibiting core skills including:<br>(1) technical knowledge;<br>(2) cultural awareness;<br>(3) analytical skills;<br>(4) decision-making;<br>(5) interpersonal skills;<br>(6) communication skills; and<br>(7) clinical skills.<br>(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.<br>(f) The governing body for each facility shall develop and implement policies and procedures | V 109 | | |

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| V 109 | Continued From page 4<br>for the initiation of an individualized supervision plan upon hiring each associate professional.<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on 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:<br><br>1. The following are examples of how the facility's QP failed to demonstrate competency:<br><br>Record review on 5/14/21 of the QP's job description revealed:<br>- shall use assessment information to develop care plans and goals to address needs<br>- identify a course of action arranging and collaborating with other agencies<br>- shall provide evaluation, weekly contact progress notes and monthly progress summaries<br>- shall review resident records on a monthly basis to assure record completeness and content of records<br>- ensure that standards for quality of services are met in accordance with state regulations<br><br>A. Review on 5/10/21 & 5/24/21 of client #1's treatment plan revealed:<br>- a treatment plan dated 4/12/19 with no documentation of a colostomy bag for client #1 | V 109 | | |

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| V 109 | Continued From page 5<br>- no documentation of treatment plans for client #2 & #4<br><br>During interviews on 5/10/21 none of the clients were familiar with the QP's name<br><br>During interview on 5/27/21 the QP reported:<br>- she visited the facility 3 - 5 days per week<br>- she talked with the Licensee about the facilities at least 2 - 3 times per week<br>- she couldn't recall all the clients' names in the facility<br>- she was responsible for the review of treatment plans<br>- the Licensee had the updated treatment plans<br>- the treatment plans were given to the Licensee to interview the guardians and sign the treatment plans<br>- treatment team meetings were not done as a team<br>- she, the Licensee and the clients were involved in the treatment plan meetings<br>- it was an oversight not adding the colostomy bag to client #1's treatment plan<br><br>B. During interview on 5/6/21 Client #3 alleged abused by staff #1<br><br>During interview on 6/1/21 clients and staff #1 denied being interviewed about abuse allegations<br><br>During interview on 5/27/21 the QP reported:<br>- staff and clients were interviewed and the investigation was completed<br>- staff #1 remained on the job while the investigation was being conducted<br><br>C. Review on 5/21/21 of staff #1's record revealed: | V 109 | | |

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| V 109 | Continued From page 6<br>- no documented training specific to the clients' individualized treatment plans<br>- no documentation of a training log at the facility<br><br>During interview on 5/27/21 the QP reported:<br>- she was responsible for staff trainings<br>- any trainings completed with staff were in a training log at the facility<br><br>2. The following are examples of how the Licensee failed to demonstrate competency:<br><br>Review on 5/21/21 of the Licensee's personnel record revealed:<br>- she had a Master's of Science in Public Health<br>- supervised staff at the facility...either directly or indirectly<br>- responsible for ensuring adequate staff coverage to provide required level of care for all residents<br>- responsible for flow of communication between agency employees, residents and their families<br>- responsible for community relations on behalf of Bradley Homes including information and referral, interacting with other agencies<br>- responsible for development and revision of policies and procedures as needed<br><br>A. Review on 5/10/21 of the clients records revealed:<br>- no emergency contacts listed<br>- no physician summaries<br><br>Interview on 5/18/21 the Licensee reported:<br>- she was responsible for checking client's records and ensuring they were up to date<br>- everything at the doctor's office was | V 109 | | |

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| V 109 | Continued From page 7 | V 109 | | |

electronic
- she didn't know how to get into the portal to print physician orders and summaries
- she would update the clients' records to include emergency contacts

B. During interview on 5/10/21 the Licensee reported:
- she was responsible for psychotropic reviews
- no psychotropic reviews had been completed since the pandemic
- she will call the pharmacist today

C. During interview on 5/10/21, 5/18/21 & 6/1/21 the Licensee reported:
- on 5/10/21 she would have the QP to complete the 5 day working report investigation and submit through IRIS (Improvement Response Incident System)
- on 5/18/21 she nor the QP had completed IRIS or the 5 working day investigation
- on 6/1/21 staff #1 remained at the facility and continued to work with client #3 during the investigation
- she would ask the QP for the documentation of the investigation

D. During interview on 5/10/21 & 5/18/21 staff #1 reported:
- she wasn't familiar with Diabetes Insipidus
- she had not been trained on Diabetes Insipidus

During interview on 6/1/21 the Licensee reported:
- 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

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| V 109 | Continued From page 8<br>days. | V 109 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(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.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation and | V 112 | | |

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| V 112 | Continued From page 9<br>interview the facility failed to develop and implement strategies to address the needs for 3 of 4 clients (#1, #2, #4). The facility also failed to develop the treatment plans in partnership with the client and legally responsible person affecting 4 of 4 clients (#1, #2, #3 & #4). The findings are:<br><br>A. Review on 5/24/21 of client #1's record revealed:<br>- admitted 4/5/13<br>- diagnoses of Tardive Dyskinesia, Anemia, Latent Syphilis, Psychosis, Major Depressive Disorder, Mood Disorder and Cerebrovascular accident<br>- a treatment plan dated 4/12/19 with no documentation of a colostomy bag<br><br>Observation at 2:30pm on 4/20/21 of client #1's colostomy bag revealed:<br>- it was full<br><br>Observation at 2:07pm on 5/10/21 of client #1's colostomy bag revealed:<br>- it was full<br><br>Interview on 5/10/21 client #1 reported:<br>- he was his own guardian<br>- his goal was to exercise more<br>- staff #1 changed the colostomy bag twice a week<br>- there were no issues with his colostomy bag<br>- he didn't know the Qualified Professional (QP)<br><br>Interview on 5/18/21 staff #1 reported:<br>- client #1's bag would burst if too much pressure was put on it<br>- his bag could burst if he pulled his shirt over it too tight or moved the wrong way<br>- this would cause him to "break wind" and the | V 112 | | |

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| V 112 | Continued From page 10<br>bag to burst<br>- no time frame or schedule to empty the colostomy bag<br>- she changed it when it was full<br>- she checked the bag 2 to 3 times a day<br>- bag would sag when it was full<br><br>Interview on 5/27/21 the QP reported:<br>- she couldn't think of the client's name that had the colostomy bag<br>- she recalled client #1's name after surveyors said his name<br>- staff could not tell her how long client #1 had the bag so she didn't know<br>- client #1 had the colostomy bag since she had been the QP<br>- she previously watched staff #1 change the colostomy bag as a training<br>- she was not sure how often it should have been emptied<br>- she told staff #1 that she waited too long to empty the bag<br>- in the past the bag looked as if it was going to burst<br>- she asked staff #1 how often did the doctor recommend changing the bag but did not get an answer<br>- she spoke with staff #1 about getting it on a schedule as to not let the bag fill up<br>- she had recommended to staff #1 about a year or 2 ago about documenting when and how often the bag should be changed<br>- she came up with a bowel/bladder sheet about 2 years ago to keep track<br>- she trained the staff on the sheet<br>- she had not seen the sheet in the record since December 2020<br>- it was an oversight not adding the colostomy bag to the treatment plan | V 112 | | |

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| V 112 | Continued From page 11<br>B. Review on 5/10/21 of client #2's record revealed:<br>- no documentation of a treatment plan with goals or strategies<br><br>-Review on 5/24/21 of a fax from the facility to the Division of Health Service Regulation (DHSR) revealed:<br>- a treatment plan for client #2<br>- dated 4/29/21<br>- the goals were: prepare an inventory of positive and negative experiences with performing activities of daily living (ADL) and identify areas that contribute to his depression<br>- signed by the client, staff #1 and QP<br><br>-Interview on 5/10/21 client #2 reported:<br>- he didn't know what his goals were<br>- he didn't have any goals<br>- he didn't know the QP<br><br>C. Review on 5/24/21 of client #3's record revealed:<br>- admitted on 5/11/07<br>- diagnoses of Schizoaffective Disorder (Bipolar), History Rheumatoid Arthritis, elevated Lipids & Hypertension<br>- treatment plan dated 6/15/20 goals - increase social skills, life without stigma of a mental health disorder, increase activities of daily living and how to verbalize and express her emotions<br><br>Interview on 5/7/21 & 5/26/21 client #3's guardian reported:<br>- she had been working with client #3 for 10 years<br>- saw her every 3 months<br>- her last visit was about a month ago at the facility<br>- she could not recall being a part of any | V 112 | | |

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| V 112 | Continued From page 12<br>treatment team meetings<br>- didn't know the QP's name<br>- she had signed paperwork within the last 10 years<br>- did not recall any of the paperwork being a treatment plan<br>- goals that should be implemented into client #3's plan were hygiene; compliance with medication for mental health; smoking and regulating her emotions<br><br>Interview on 5/18/21 & 6/1/21 staff #1 reported:<br>- was working with client #3 on eating more to gain weight<br>- made sure client #3 was eating by watching her<br>- would talk to her if she didn't eat<br>- was working with client #3 on hygiene and how to bathe<br><br>D. Review on 5/10/21 and 5/18/21 of client #4's record revealed:<br>- admitted 8/4/20<br>- diagnoses of Diabetes Insipidus; Hyperglycemia; Schizoaffective Disorder; Respiratory Insufficiency & Constipation<br>- no treatment plan with goals or strategies<br><br>Interview on 5/18/20 staff #1 reported:<br>- she was still trying to get used to client #4 as he was a newer client in the facility<br>- he had only been at the facility a short period of time<br>- he liked to stay in his bedroom and sleep<br>- she encouraged him to come out of his bedroom and socialize<br>- she worked with him on participation of the fire and disaster drills<br>- can't remember what goals are in the treatment plans | V 112 | | |

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| BRADLEY HOME | 1505 KELLY ROAD GARNER, NC 27529 |

| (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 |
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| V 112 | Continued From page 13<br><br>Interview on 5/27/21 the QP reported:<br>- she visited the facility 3 - 5 days per week<br>- she talked to the Licensee about the facilities at least 2 - 3 times per week<br>- she couldn't remember all the clients in the facility<br>- she, the Licensee and the clients were involved in the treatment plan meetings<br>- the treatment plans were given to the Licensee to talk to the guardians and have them sign it<br>- they didn't sit down as a team for treatment team meetings<br>- the Licensee was supposed to put the updated treatment plans in the clients' records<br>- she suggested that the Licensee informed the guardians to be at the facility for treatment team meetings<br>- guardians were not there when she got there for the treatment team meetings<br>- she would call Licensee if treatment plans were not updated in the chart<br>- the Licensee didn't always put them in the charts when QP told her to<br><br>Interview on 5/10/21, 5/18/21 & 5/21/21 the Licensee reported:<br>- the QP completed the treatment plans<br>- they were saved on her (QP) computer and she had not printed it off<br>- she would fax client #1, client #2 and client #4's treatment plans<br>- she could go home and write the treatment plans because she used to write them<br><br>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 | | |

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| V 113 | 27G .0206 Client Records<br><br>10A NCAC 27G .0206 CLIENT RECORDS<br>(a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:<br>(1) an identification face sheet which includes:<br>(A) name (last, first, middle, maiden);<br>(B) client record number;<br>(C) date of birth;<br>(D) race, gender and marital status;<br>(E) admission date;<br>(F) discharge date;<br>(2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;<br>(3) documentation of the screening and assessment;<br>(4) treatment/habilitation or service plan;<br>(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;<br>(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;<br>(7) documentation of services provided;<br>(8) documentation of progress toward outcomes;<br>(9) if applicable:<br>(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);<br>(B) medication orders;<br>(C) orders and copies of lab tests; and<br>(D) documentation of medication and administration errors and adverse drug reactions.<br>(b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed | V 113 | | |

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| V 113 | Continued From page 15<br>only in accordance with the communicable disease laws as specified in G.S. 130A-143.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to maintain required documentation in the client records for 3 of 3 audited clients (#1, #3 and #4). The findings are:<br><br>A. Review on 5/10/21 of client #1's record revealed:<br>- admitted 4/5/13<br>- diagnoses of Tardive Dyskinesia, Anemia, Latent Syphilis, Psychosis, Major Depressive Disorder, Mood Disorder and Cerebrovascular accident<br>- no emergency contacts listed<br>- no progress notes<br>- no physician summaries<br><br>C. Review on 5/10/21 of client #3's record revealed:<br>- admitted on 5/11/07<br>- diagnoses of Schizoaffective Disorder (Bipolar), History Rheumatoid Arthritis, elevated Lipids & Hypertension<br>- no emergency contacts listed<br>- no medication orders<br>- no progress notes<br>- no physician summaries<br><br>D. Review on 5/10/21 of client #4's record revealed:<br>- admitted 8/4/20 | V 113 | | |

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| V 113 | Continued From page 16<br>- diagnoses of Diabetes Insipidus; Hyperglycemia; Schizoaffective Disorder; Respiratory Insufficiency & Constipation<br>- no emergency contacts listed<br>- no medication orders<br>- no progress notes<br>- no orders for lab test or results<br>- no physician summaries<br><br>Interview on 5/18/21 staff #1 reported:<br>- the Licensee was responsible for updating the client records<br>- she didn't have any doctor's notes/summaries because she didn't take the clients to the doctors<br>- staff A2 took clients to their appointments and would have that information<br>- Licensee was all the clients emergency contacts<br><br>Interview on 5/27/21 the Qualified Professional (QP) reported:<br>- she documented client's progress towards their goals once per month<br>- progress notes were kept in her records not at the facility<br>- the Licensee "controlled" the client records<br>- the Licensee was responsible for keeping the records updated<br>- she was not responsible for getting information in the client records<br>- she told the Licensee that they needed more information in the client records<br>- she offered to help get the client records together<br>- the Licensee always said she had it<br>- there was no information in the record about guardians<br>- she didn't know who any of the guardians were<br>- she requested the guardian contact | V 113 | | |

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| V 113 | Continued From page 17<br>information from the Licensee but never received it<br><br>Interview on 5/18/21 the Licensee reported:<br>- she was responsible for checking client records and ensuring they were up to date<br>- everything at the doctor's office was electronic<br>- they no longer gave orders or physician summaries<br>- she didn't know how to get into the portal to print physician orders and summaries<br>- she and the QP used to write progress notes but it's been awhile<br>- she did not have any progress notes and would start writing them again<br>- she did not think emergency contacts were listed in the client records<br>- she would update the client records to include emergency contacts<br>- she was all of the clients emergency contact<br>- she wasn't sure who client #4's guardian was<br>- she would get the information and fax it (the guardian information was not received by the exit survey date)<br>- staff contacted her with any concerns and then she would contact the guardians<br><br>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<br><br>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES<br>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and | V 114 | | |

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| V 114 | Continued From page 18<br>shall be approved by the appropriate local authority.<br>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.<br>(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.<br>(d) Each facility shall have basic first aid supplies accessible for use.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview the facility failed to ensure disaster drills were completed quarterly and repeated on each shift. The findings are:<br><br>Review & observation on 5/10/21 of the facility's disaster drill records revealed:<br>- a form labeled disaster drills<br>- a disaster drill was completed on the 10th of each month from January - April<br>- no year documented on form<br>- the Licensee attempted to write the year at the top of the form<br><br>During interview on 5/10/21 staff #1 reported:<br>- disaster drills are completed 3 times a month<br>- the clients got in the bathtub or under their bed<br><br>During interview on 5/10/21 the Licensee reported:<br>- disaster drills are done at the facility<br>- she forgot to write the year 2021 on the disaster form | V 114 | | |

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| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(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:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug.<br>(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.<br><br>This Rule is not met as evidenced by: | V 118 | | |

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| V 118 | Continued From page 20<br><br>Based on observation, record review and interview the facility failed to administer 1 of 3 audited client's (#4) medications on the written order of a physician and failed to ensure 1 of 2 Qualified Professionals (Licensee) demonstrated compentency in medication administration. The findings are:<br><br>Review on 5/10/21 of client #4's record revealed:<br>- admitted 8/4/20<br>- Diagnoses of Constipation; Diabetes Insipidus; Hyperglycemia; Schizoaffective Disorder; Respiratory Insufficiency; Vitamin Deficiency & Tobacco Abuse<br>- a FL2 dated 7/15/20 listed Melatonin 9 milligram (mg) at bedtime (used for insomnia)<br>- no physician's order for Omeprazole 20mg everyday (can treat heartburn) and Melatonin 5mg 3 PO (by mouth) bedtime<br><br>Observations on 5/25/21 between 3:29pm and 3:38pm of client #4's medications revealed the following :<br>- Melatonin 5mg once a day<br>- Melatonin 5mg 3 PO bedtime<br><br>Review on 5/25/21 and 5/26/21 of client #4's March, April and May 2021 MARs revealed:<br>- Melatonin 5mg 3 PO bedtime<br>- Melatonin 5mg daily<br>- Omeprazole 20mg was given daily<br><br>During interview on 5/6/21 & 6/1/21 the Licensee reported:<br>- she came to the facility daily<br>- she looked at the clients' medications<br>- she looked at the MARs to ensure medications were given as ordered<br>- there were no physician orders in the client records | V 118 | | |

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| V 118 | Continued From page 21<br>- she matched the MARs to what the doctor told staff about medications at doctor's appointments<br>- the physician's order could have been sent to the pharmacist electronically<br>- the pharmacist needed to notify her if the medication order changed<br>- there were no medication errors in the last 3 months | V 118 | | |
| V 121 | 27G .0209 (F) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(f) Medication review:<br>(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.<br>(2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to ensure 2 of 2 audited clients (#3 & #4) who were taking psychotropic medications for more than 6 months had drug regimen reviews every 6 months. The findings are:<br><br>A. Review on 5/24/21 of client #3's record | V 121 | | |

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| V 121 | Continued From page 22<br>revealed:<br>- admitted on 5/11/07<br>- diagnoses of Schizoaffective Disorder (Bipolar), History of Rheumatoid Arthritis, elevated Lipids & Hypertension<br>- a FL2 dated 5/13/20 with the following psychotropic medication: Olanzapine 20mg (milligrams) every evening<br>- no psychotropic drug reviews had been completed<br><br>B. Review on 5/10/21 and 5/18/21 of client #4's record revealed:<br>- admitted 8/4/20<br>- diagnoses of Diabetes Insipidus; Hyperglycemia; Schizoaffective Disorder; Respiratory Insufficiency & Constipation<br>- a FL2 dated 7/15/20 with the following psychotropic medications: Clozapine 100mg 3 at bedtime and 200mg once a day<br>- no psychotropic reviews had been completed<br><br>During interview on 5/10/21 the Licensee reported:<br>- No psychotropic drug reviews had been completed since the pandemic<br>- she would call the pharmacist today<br><br>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 132 | G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection<br><br>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY<br>(g) Health care facilities shall ensure that the | V 132 | | |

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| V 132 | Continued From page 23<br>Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:<br>a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.<br>b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.<br>c. Misappropriation of the property of a healthcare facility.<br>d. Diversion of drugs belonging to a health care facility or to a patient or client.<br>e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).<br>Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. | V 132 | | |

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| V 132 | Continued From page 24 | V 132 | | |

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to have evidence an alleged abuse was investigated, failed to protect a client from harm during the investigation and failed to report within five working days to Healthcare Personnel Registry (HCPR). The findings are:

Review on 5/24/21 of client #3's record revealed:
- admitted on 5/11/07
- age 84
- diagnoses of Schizoaffective Disorder (Bipolar), History Rheumatoid Arthritis, elevated Lipids & Hypertension

Observation and interview with client #3 at 12:17pm on 5/6/21 revealed the following:
- client #3 tapped the surveyor on the shoulder and whispered "I need" but was immediately sent to her room by staff A2
- she later stated staff mistreated her and called her "all kinds of Son of B*****s"
- staff #1 hit her and knocked her down
- she was not scared to be at the facility
- she had told her guardian she was being mistreated at the facility

An attempted call was made to the Licensee on 5/7/21...phone rang continuously without a voicemail picking up to leave a message

During interview on 6/1/21 clients denied being interviewed by management

During interview on 5/7/21 & 5/26/21 client #3's

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| V 132 | Continued From page 25 | V 132 | | |

guardian reported:
- she had been client #3's guardian for 10 years
- she visited client #3 every 3 months
- saw her a month ago
- since she's been the guardian, client #3 had said "she (staff #1) don't like me or she was mean"
- nothing about being hit
- client #3 would exaggerate & complain but wasn't dishonest
- she was shocked to know client #3 voiced staff #1 hit her
- she had spoken with the Licensee and staff #1 in the past about client #3's concerns of mistreatment
- she had witnessed no marks or bruises on client #3
- there was no evidence to support the allegations of mistreatment in the past
- client #3 denied to her (guardian) she told surveyors she was hit by staff
- after these allegations, it was in the best interest for client #3 to be moved to another facility

During interview on 6/1/21 staff #1 reported:
- management had not spoken with her about abuse allegations for client #3
- the QP (Qualified Professional) and Licensee do not believe client #3's allegations of abuse
- she was not mean to client #3
- she did everything she could for client #3

During interview on 5/26/21 a representative with HCPR reported:
- a 5 working day report of abuse was not received from the facility

During interview on 5/27/21 the QP reported:

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| V 132 | Continued From page 26<br>- 2 weeks ago she completed an internal investigation into the abuse allegations of client #3<br>- she spoke with client #3 and she said it was a misunderstanding<br>- staff and clients were interviewed and the investigation was given to the Licensee<br>- the Licensee was supposed to complete and submit the 5 day working investigation through the Incident Response Improvement System (IRIS)<br>- staff #1 remained on the job while the investigation was being conducted<br>- she and the Licensee monitored staff #1 during the investigation<br>- the Licensee made unannounced day visits and she (QP) made unannounced night visits<br>- The investigation was completed within 5 days<br>- She spoke with staff A2 and staff #1 about the abuse policy<br>- she informed both there should be no hitting of the clients<br>- she explained verbal abuse was considered abuse<br>- she told them the clients needed to be respected<br><br>During interview on 5/10/21, 5/18/21 & 6/1/21 the Licensee reported:<br>- on 5/10/21 she was not aware of any abuse allegations for client #3<br>- any staff that abused clients would be fired because she loved her clients<br>- she would have the QP complete the 5 day working report investigation and submit through IRIS<br>- on 5/18/21 she nor the QP had the 5 working day investigation<br>- on 6/1/21 the allegations were investigated | V 132 | | |

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| V 132 | Continued From page 27<br>and unsubstantiated<br>- staff #1 had "no hard feelings" towards client #3<br>- staff #1 remained at the facility and continued to work with client #3 during the investigation<br>- she (staff #1) did everything she could for client #3 like shampoo her hair and took care of her<br>- staff #1 was very "Godly"<br>- she would ask the QP about the documentation of the investigation<br><br>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 132 | | |
| V 289 | 27G .5601 Supervised Living - Scope<br><br>10A NCAC 27G .5601 SCOPE<br>(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.<br>(b) A supervised living facility shall be licensed if the facility serves either:<br>(1) one or more minor clients; or<br>(2) two or more adult clients.<br>Minor and adult clients shall not reside in the same facility.<br>(c) Each supervised living facility shall be licensed to serve a specific population as designated below:<br>(1) "A" designation means a facility which serves adults whose primary diagnosis is mental | V 289 | | |

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| V 289 | Continued From page 28<br>illness but may also have other diagnoses;<br>(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;<br>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;<br>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;<br>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or<br>(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). | V 289 | | |

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| V 289 | Continued From page 29 | V 289 | | |

This Rule is not met as evidenced by:
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. 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 Professionals (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, observation and interview the facility failed to develop and implement strategies to address the needs for 3 of 4 clients (#1, #2, #4). The facility also failed to develop the treatment plans 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

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| V 289 | Continued From page 30<br>review and interview the facility failed to maintain required documentation in the client records for 3 of 3 audited clients (#1, #3 and #4).<br><br>E. Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V121). Based on record review and interview the facility failed to ensure 2 of 2 audited clients (#3 & #4) who were taking psychotropic medications for more than 6 months had drug regimen reviews every 6 months.<br><br>F. Cross reference: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (V132). Based on observation, record review and interview the facility failed to have evidence an alleged abuse was investigated, failed to protect a client from harm during the investigation and failed to report within five working days to Healthcare Personnel Registry (HCPR).<br><br>G. Cross reference: 10A NCAC 27G .5603 OPERATIONS (V291). Based on record review, observation and interview the facility failed to operate within their licensed capacity affecting 4 of 4 clients (#1 - #4). The facility also failed to have activity opportunities based on client's choices, needs and the treatment/habilitation plan affecting 4 of 4 clients (#1, #2, #3, #4).<br><br>H. 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.<br><br>I. Cross reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V367). | V 289 | | |

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| V 289 | Continued From page 31<br><br>Based on record review and interview the facility failed to ensure a Level II incident report was completed within 72 hours.<br><br>J. 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.<br><br>Review on 6/1/21 of a (Plan of Protection) POP dated 6/1/21 written by the Licensee revealed: (The QP referenced in this POP was the Licensee's daughter not the facility's QP) What immediate action will the facility take to ensure the safety of the consumers in your care? (there were several mark throughs and rewrites). "The facility (mark through facility) will ensure that all the corrections are made. The QP and the Director with another (mark through the QP and the director with another) [QP/(Registered Nurse (RN)/Licensee's daughter] will work to ensure that the corrections are made. [QP/RN/Licensee's daughter] will provide training for the personnel, clients records, treatment plans, medication training and incident report starting from today 6/1/21."<br><br>Describe your plans to make sure the above happens. "[QP] another (mark through another) [QP/RN/Licensee's daughter] will assist with the corrections starting today 6/1/21. [QP/RN/Licensee's daughter] will provide training for the personnel, client records, treatment plans, medication training and incident report starting from day 6/1/21."<br><br>Staff #1, the QP and the Licensee failed to provide residential treatment services for client #1 - #4 with diagnoses consisting of Major | V 289 | | |

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| V 289 | Continued From page 32<br><br>Depressive Disorder, Mood Disorder & Schizophrenia. Client #1 had an expired 2019 treatment plan with no documentation of his colostomy bag. The colostomy bag was observed to be full on 2 different occasions. Client #2 didn't initially have a treatment plan but one was later faxed in. Client #3's guardian of 10 years had not participated in any treatment team meetings. There was no treatment plan for client #4 who had a diagnosis of Diabetes Insipidus. Staff #1 was not familiar or trained on this diagnosis. The Licensee didn't know client #1 had Diabetes Insipidus. The clients were not familiar with the QP's name or any of their goals. The QP reported she was at the facility several times a week but couldn't recall all the clients' names. The clients' records had very little information with no guardian or emergency contact information. Client #4 had a guardian but staff, QP nor the Licensee knew who the person was. Client #3 alleged she was abused by staff #1, however, there was no documented facility investigation, HCPR wasn't notified and staff #1 continued to work with client #3. Clients from sister facility A came daily to socialize with the clients at the facility. However, the facility's clients stayed in their bedrooms majority of the time, while sister facility A clients slept in the living room chairs or wandered in and out of the facility. There were several environmental issues like water stains in the ceiling, the smell of urine, a door hanging off the hinges, the stove door broken and floors peeling and lifting. 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 the 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 | V 289 | | |

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| V 289 | Continued From page 33<br>days. An administrative penalty of $5,000 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 291 | 27G .5603 Supervised Living - Operations<br><br>10A NCAC 27G .5603 OPERATIONS<br>(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.<br>(b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.<br>(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.<br>(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. | V 291 | | |

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| V 291 | Continued From page 34<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation and interview the facility failed to operate within their licensed capacity affecting 4 of 4 clients (#1 - #4). The facility also failed to have activity opportunities based on client's choices, needs and the treatment/habilitation plan affecting 4 of 4 clients (#1, #2, #3, #4). The findings are:<br><br>A. The following is an example of how the facility failed to stay within their licensed capacity.<br><br>Review on 5/24/21 of client #1's record revealed:<br>- admitted 4/5/13<br>- diagnoses of Tardive Dyskinesia, Anemia, Latent Syphilis, Psychosis, Major Depressive Disorder, Mood Disorder and Cerebrovascular accident<br><br>Record review on 5/24/21 of client #3's record revealed:<br>- admitted on 5/11/07<br>- diagnoses of Schizoaffective Disorder (Bipolar), History of Rheumatoid Arthritis, elevated Lipids & Hypertension<br><br>Record review on 5/10/21 of client #4's record revealed:<br>- admitted 8/4/20<br>- Diagnoses of Constipation; Diabetes Insipidus; Hyperglycemia; Schizoaffective Disorder; Respiratory Insufficiency; Vitamin Deficiency, Tobacco Abuse and Constipation<br><br>Review on 5/6/21 of the facility's public file maintained by the Division of Health Service Regulation (DHSR) revealed the facility was licensed for a capacity of 6. | V 291 | | |

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| V 291 | Continued From page 35<br><br>Interview on 4/20/21 & 5/10/21 client #1 reported:<br>- clients from sister facility A were there Monday - Friday, all day<br>- they ate lunch with them<br>- staff A2 left when a client had a doctor's appointment<br>- she was the only one that took them to the doctor<br>- staff #1 stayed with the rest of the clients<br><br>Interview on 4/20/21 & 5/10/21 client #2 reported:<br>- clients from sister facility A came over Monday - Friday<br>- staff A2 left her clients there if someone had an appointment<br>- she was the only one that took them to the doctors<br>- staff #1 was the only one that was there during the week with all the clients from this facility as well as sister facility A if someone had an appointment<br><br>Interview on 4/27/21 staff #1 reported:<br>- she watched sister facility A's clients if other clients had appointments<br>- appointments could be 1 - 2 times per week<br><br>Interview on 5/3/21 staff A2 reported:<br>- she left her clients with staff #1 for appointments<br>- she only took the clients that had appointments that day<br><br>Interview on 5/27/21 the Qualified Professional (QP) reported:<br>- she didn't feel that staff #1 was capable of watching her clients and sister facility A's clients<br>- staff #1 had some physical limitations<br>- it would have been out of ratio if she watched | V 291 | | |

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| V 291 | Continued From page 36<br>all the clients<br><br>Interview on 4/20/21 the Licensee reported:<br>- she and staff A2 took the clients to the doctors<br>- she was at the facility to help with the clients if there was a doctor's appointment<br><br>B. The following is an example of how the facility staff failed to have available client activities:<br><br>Observation & interview on 5/10/21 at 1:08pm:<br>- the facility's 4 clients were not observed in the common living area<br>- staff #1 said 3 clients were in their bedrooms and 1 outside<br><br>Observations on 5/18/21 at 1:03pm<br>- all 4 clients in their bedrooms<br><br>Interview on 4/20/21 client #1 reported they:<br>- didn't do anything<br>- just sat there when the other clients came over<br>- had no games or anything to play<br><br>Interview on 4/20/21 client #2 reported they:<br>- had no activities<br>- couldn't go out because of the pandemic<br><br>Interview on 5/18/21 staff #1 reported:<br>- clients did not have any activities<br>- clients stayed in their rooms, therefore it was fine that sister facility clients occupied the living room<br><br>Interview on 4/20/21 & 5/18/21 with staff A2 reported:<br>- the Licensee wanted sister facility A clients to go and interact with clients from this facility | V 291 | | |

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| V 291 | Continued From page 37<br>- there was not much they could do because of the pandemic<br>- there were no games in the facility for the clients<br>- no one said anything to her about any other activities<br>- both facilities did ride around in the van<br><br>Interview on 5/4/21 & 5/27/21 the QP reported:<br>- she knew the sister facility A clients visited the facility<br>- they visited so they could "socialize"<br>- she did not know the clients were there every day<br>- she didn't know if anyone has sat down with the clients to discuss activities<br><br>Interview on 4/20/21 & 5/6/21 & 5/18/21 the Licensee reported:<br>- the clients from sister facility A would visit to interact<br>- they didn't come over every day<br>- this was their only way to "communicate and interact"<br><br>Interview on 6/1/21 the Licensee reported:<br>- they would start going to the park and taking rides in the facility van<br>- she would start talking to them about activities they would be interested in<br><br>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<br><br>10A NCAC 27G .0603 INCIDENT | V 366 | | |

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| V 366 | Continued From page 38<br>RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) attending to the health and safety needs of individuals involved in the incident;<br>(2) determining the cause of the incident;<br>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;<br>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;<br>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;<br>(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<br>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.<br>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.<br>(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:<br>(1) immediately securing the client record by: | V 366 | | |

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| V 366 | Continued From page 39<br>(A) obtaining the client record;<br>(B) making a photocopy;<br>(C) certifying the copy's completeness; and<br>(D) transferring the copy to an internal review team;<br>(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:<br>(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;<br>(B) gather other information needed;<br>(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<br>(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 | V 366 | | |

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| V 366 | Continued From page 40<br>(3) immediately notifying the following:<br>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;<br>(B) the LME where the client resides, if different;<br>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;<br>(D) the Department;<br>(E) the client's legal guardian, as applicable; and<br>(F) any other authorities required by law.<br><br>This Rule is not met as evidenced by:<br>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:<br><br>Review on 5/10/21 & 5/18/21 of the facility's record revealed:<br>- no written incident reports<br><br>Review on 5/7/21, 5/18/21 & 6/1/21 of the Incident Response Improvement System (IRIS) revealed:<br>- no incident reports entered in system since 2013<br><br>Review on 5/6/21 of the facility's policy manual revealed the following:<br>- the pages in the policy manual were not in numerical order based on their table of contents | V 366 | | |

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| V 366 | Continued From page 41<br>- the incident reporting policy could not be located in the policy manual<br>- the Licensee was not able to locate the incident report policy<br><br>Observation and interview with client #3 at 12:17pm on 5/6/21 revealed the following:<br>- she tapped the surveyor on the shoulder and whispered "I need" but was immediately sent to her room by staff A2<br>- she later stated staff mistreated her and called her "all kinds of Son of B*****s"<br>- staff #1 hit her and knocked her down<br><br>During interview on 5/10/21 & 5/18/21 the Licensee reported:<br>- on 5/10/21 she was not aware of any abuse allegations for client #3<br>- she would have the QP (Qualified Professional) complete the 5 day working report investigation and submit through IRIS (Incident Response Information System)<br>- on 5/18/21 she nor the QP had completed the IRIS report<br>- she would locate the incident report policy and fax to surveyor<br>- the incident policy was not received prior to the close of survey<br><br>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<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS | V 367 | | |

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| V 367 | Continued From page 42<br>(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:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and<br>(6) other individuals or authorities notified or responding.<br>(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:<br>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or<br>(2) the provider obtains information required on the incident form that was previously unavailable.<br>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:<br>(1) hospital records including confidential | V 367 | | |

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| V 367 | Continued From page 43<br>information;<br>(2) reports by other authorities; and<br>(3) the provider's response to the incident.<br>(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).<br>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:<br>(1) medication errors that do not meet the definition of a level II or level III incident;<br>(2) restrictive interventions that do not meet the definition of a level II or level III incident;<br>(3) searches of a client or his living area;<br>(4) seizures of client property or property in the possession of a client;<br>(5) the total number of level II and level III incidents that occurred; and<br>(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. | V 367 | | |

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| V 367 | Continued From page 44<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to ensure a Level II incident report was completed within 72 hours. The findings are:<br><br>Review on 5/10/21 & 5/18/21 revealed:<br>- the facility had no written incident reports<br><br>During interview on 5/27/21 the Qualified Professional (QP) reported:<br>- she did not complete an incident report for client #3's abuse allegation<br>- the Licensee was responsible for the Incident Response Information System (IRIS) report<br>- the Licensee said that she would take care of reporting the information<br><br>During interview on 5/14/21 a representative with the Local Managed Entity/Managed Care Organization reported:<br>- she had not received any incident reports from this facility since 2013<br><br>During interview on 6/1/21 the Licensee reported:<br>- she was not sure if the QP reported the allegations to IRIS<br>- didn't think she had to report the abuse allegations because nothing was founded<br>- she did not complete the IRIS report<br><br>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 | | |

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| V 736 | 27G .0303(c) Facility and Grounds Maintenance<br><br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview the facility failed to be maintained in a safe, clean, attractive and orderly manner. The findings are:<br><br>Observation on 5/10/21 1:30pm - 2:20pm revealed:<br><br>Bathroom #1<br>- 1 lightbulb not working<br>- a lot of dust surrounding the lightbulb's<br>- water stains on the ceiling over the bathtub<br>- no toilet paper<br>- dirt stains on the floor<br><br>Kitchen<br>- counters cluttered with dishes, pots & pans<br>- 3 totes stacked on top of each other beside the stove<br>- very slow drain in the right side of the kitchen sink causing dirty standing water<br>- under the table was cluttered with bags and boxes<br>- the door to the stove was broken<br><br>Dining room<br>- wood was chipping all over the table | V 736 | | |

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| V 736 | Continued From page 46<br>- chairs were ripped and torn<br><br>Laundry room closet<br>- one side of the door was off the hinge (not connected)<br>- it was just leaning against the wall<br><br>Living room<br>- vent cover in the floor between the living and dining room didn't fit the hole leaving a gap<br>- boxes piled up in the middle of the floor causing you to walk around them<br><br>Hallway<br>- dirty light fixture on the ceiling<br><br>Bathroom #2<br><br>- no toilet paper<br>- ceiling over the bathtub stained & had peeling paint<br>- slow drain in bathtub causing water to sit there<br>- paint was peeling off the wall between the bathtub & the toilet<br>- strong urine smell<br><br>Client #1's bedroom<br>- 4 full plastic bags of washcloths on his dresser<br>- black dirt spots on the floor<br>- sliding window very hard to close<br>- window sill very dirty and dusty<br>- unused dresser in room had a broken handle on one of the drawers<br><br>Client #2 & #4's bedroom<br>- client #2 had boxes piled up beside his bed<br>- Strong urine smell around client #2's bed<br>- client #4's clothes were in 1 box on the floor | V 736 | | |

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| V 736 | Continued From page 47<br>in the closet, nothing hung up<br>- empty soap boxes were on client #4's dresser<br>- a lot of dust around the window sills<br>- screen in window didn't fit in the window area<br>- screen was not fully in the window<br><br>Client #3's bedroom<br>- lamp in room did not have a bulb (there is a ceiling light)<br>- antenna to TV had a lot of dust on it<br>- door hinge was taped up to prevent door from latching shut<br>- floor was peeling and lifting<br><br>Dirty walls and light switches throughout the facility<br><br>Interview on 5/10/21 staff #A2 reported:<br>- client #3's door locked when you closed it<br>- there was no way to unlock it and that's why it was taped<br><br>Interview on 5/26/21 client #3's guardian reported:<br>- she received a call from emergency services (EMS) on December 20, 2020<br>- they were concerned about the appearance of the facility<br>- no safety issues were reported by EMS but the appearance of the facility<br><br>Interview on 5/18/21 the Licensee reported:<br>- she ensured environmental issues were fixed<br>- it was hard to get people to come to the facility due to the pandemic<br>- client #2 didn't want anyone touching or moving his boxes<br>- client #2 stored magazines and books in the boxes | V 736 | | |

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| V 736 | Continued From page 48<br><br>Interview on 5/27/21 the Qualified Professional (QP) reported:<br>- she and the Licensee discussed the facility at least 2 times a week<br>- they discussed the condition of the facility (personal care issues; cleanliness of the facility)<br>- she told the Licensee that the facility needed improvement<br>- the Licensee said that she knew that<br>- she told the Licensee that they needed to come up with something to get the facility cleaned<br>- she had cleaned the facility before<br>- the Licensee told her that staff #1 was a hoarder<br>- she explained to the Licensee that it was still her facility and it needed to be cleaned<br><br>This deficiency has been cited 2 times since the original cite on 6/8/17 and must be corrected.<br><br>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 | | |