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GRACELAND MANOR DDA #3	408 PELT DRIVE FAYETTEVILLE, NC 28301

(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, follow up, and complaint survey was completed on August 24, 2021. The complaint was unsubstantiated (intake #NC00178227). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations;	V 105		

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

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V 105	Continued From page 2 Based on record review, observation, and interviews, the facility failed to implement facility policies that assure applicable standards of practice amidst the COVID-19 (Coronavirus-Disease-2019) pandemic. The findings are: Review on 8/24/21 of the facility COVID-19 Policy and Procedure received 8/24/21 revealed: -"If any suspected positive cases... Facility will follow guidance of the Health Department..." -Policy had not been signed or dated by the Qualified Professional(QP)/Licensee. Observations on 8/17/21 at 2:00 pm the Residential Supervisor was in the group home; she was wearing a face covering. Interview on 8/20/21 the Residential Supervisor stated: -She had a COVID test done 8/19/21 because she had COVID like symptoms. -A rapid test was done and was negative, then a SARS (severe acute respiratory syndrome) COVID PCR (polymerase chain reaction) test was collected and she was waiting for the results. -She notified the QP/Licensee on 8/19/20 or maybe 8/18/20 when the QP/Licensee had contacted her looking for some books. -She did not recall a written policy and procedure for COVID 19. Interview on 8/24/21 the local health department Registered Nurse stated: -There was no record anyone from the facility had contacted the health department for guidance due to a potential positive COVID case. -If a facility had made a contact for guidance, they would have been referred to her department for a response.	V 105		

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V 105	Continued From page 3 Interviews on 8/20/21 and 8/24/21 the QP/Licensee stated: -On 8/20/21 she stated she had not been informed the Residential Supervisor had been tested for COVID. -On 8/24/21 stated she had not made any contact with the health department for guidance regarding a suspected COVID positive staff. -She could not recall specific dates when the policy was first developed and later revised. -She thinks it was revised around May 2021. -In accordance with her policy, she should have contacted the local health department for guidance.	V 105		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills;	V 110		

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V 110	Continued From page 4 (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 2 direct care staff audited (Staff #1) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 8/17/21 of Staff #1's record revealed: -Paraprofessional hired 7/11/17. -Training dated 8/17/20, "Overview of Developmental Disabilities; Understanding & Interpreting Human Behavior." -Training dated 8/4/20, "Client Specific Competencies." Observations on 8/17/21 between 10:15 am and 10:34 am (during facility tour) revealed clients #3 and #4 were non-verbal and communicated using gestures and some sign language. Interview on 8/19/20 client #3 wrote: -"[Staff #1] and I fought on July 21 because blame for steal from her body wash." -Staff #1 had accused client #3 of stealing.	V 110		

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V 110	Continued From page 5 Interview on 8/19/20 client #4 communicated in writing and gestures: -Client #4 wrote, "[Staff #1] hit [client #3] and me hit same." -Client #4 wrote, "She (Staff #1) is very mean." Interviews on 8/19/20 clients #1 and #2 denied seeing any altercations, abuse, or mistreatment of any client from Staff #1 or any other staff. Interview on 8/20/21 Staff #2 stated: -She had not seen any altercations between staff and clients. -She estimated a couple of months prior that client #3 wrote in a note that Staff #1 had grabbed her (client #3). -After she wrote that note client #3 then wrote a note that she "loved" Staff #1 and "would try to get along." -Staff #2 and #1 do not work at the same time. -Client #3 did not like to be told what to do and did not like to get up in the morning. Interview on 8/20/21 Staff #3 stated: -She worked day shift Monday through Friday with client #5, but was qualified to assist with all the clients. -Staff #1 was "loud" and sometimes she would try to communicate verbally in a loud voice to clients #3 and #4 rather than writing a note to the clients. -Staff #3 would say to Staff #1 to "calm down," and remind her clients #3 and #4 were deaf and could not hear her. -"The deaf clients can tell when she is upset with them." -Clients #3 and #4 do not like to be told "no." -She had not seen Staff #1 hit a client. Interviews on 8/17/21 and 8/20/21, Staff#1 stated: -She worked as a direct care staff.	V 110		

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V 110	Continued From page 6 -She was an over night staff. -Typical schedule was to work a Monday and Tuesday, and get off on Wednesday. -She was not aware of any allegations of mistreatment of clients and had not seen anything that she considered mistreatment. -Her sign language skills were limited, but she communicated with clients #3 and #4 with some sign language and by writing notes. -Clients #3 and #4 were the "hardest" clients. -Clients #3 and #4 took their shower at night and did not like to wash their face in the morning. -It was a "challenge" to get clients #3 and #4 to wash their face in the morning. She would tell them she had to try to get them to wash their face because she had to fill out their personal care log. They (clients #3 and #4) had an "attitude" with her. -Clients #3 and #4 did not like to get up in the morning. She would go in their room and "tap" them on the shoulder and pull their covers back from "right to left," and turn the light on. -Client #3 would "flail" at her; if she would not get up, she would call the Qualified Professional(QP)/Licensee. -She may tap them a couple of times to get them to get out of bed; she knew this "startles" them. -To get client #4 out of bed she would pull her covers down just below her breast.	V 110		
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	V 112		

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V 112	Continued From page 7 of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement strategies based on assessment for 1 of 3 audited clients (#3). The findings are: Review on 8/17/21 and 8/19/21 of client #3's record revealed: -47 year old female admitted 9/17/03. -Diagnoses included Schizophrenia, Mild Intellectual Disability, Deafness, and Diabetes. -Self guardian. -Next of kin was her father who lived out of state.	V 112		

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V 112	Continued From page 8 Review on 8/17/21 and 8/19/21 of client #3's Person Centered Profile dated 7/13/21 revealed: -"How Best to Support...[client #3] continues to need support to learn to reduce lying and telling things that are untrue about peers and staff." -"What's Not Working... [client #3] will have temper tantrums when she does not get her way... is demanding to clients and staff and get upset if she does not have her way." -4 short range goals addressed personal hygiene, household chores, medication management and medical/psychiatric appointments, and school attendance. -No strategies for the short range goals. -Date goals last reviewed was 7/13/20 with a "target date" not to exceed 7/13/21. -No goals or strategies to address client #3's behaviors, (not being truthful; temper tantrums, upset when she does not get her way). -No goals or strategies to address how to awaken client in the morning. -No goals or strategies to address how to facilitate communication with client #3. -No goals or strategies to address use of Stimulus funds received during the pandemic. -Plan was signed by client on 8/19/21. Interview on 8/19/21 client #3 wrote: -"I need a TTY" to talk communicate with friends or family. -"I need buy IPAD (a brand of a tablet computer)." -She did not have money to buy an IPAD, "I'm trying save money but I do not have job." -She did not know she had Stimulus money. -Her family never wrote to her and were not available to help her manage her money. Interviews on 8/20/21, Staff#1 stated: -Client #3 was a "challenge" in the morning when she was trying to get her to wash her face.	V 112		

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V 112	Continued From page 9 -Client #3 did not like to get up in the morning and would "flail" at Staff #1 when she tied to awaken her. -There was no procedure for how to get client #3 out of bed in the morning. Interview on 8/19/21 the Qualified Professional (QP)/Licensee stated: -Client #3 would tell lies. -Client #3 had told the QP/Licensee she wanted an IPAD, but she had called it something else. -She had not seen the memo that had recommended a treatment team meeting to support clients in spending stimulus money. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
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	V 118		

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V 118	Continued From page 10 MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure medications were given as ordered, MARs kept current/accurate, and medications recorded immediately after administration for 3 of 3 clients audited (#1, #2, #3). The findings are: Finding #1: Review on 8/17/21 and 8/19/21 of client #1's record revealed: -53 year old female admitted 9/17/03. -Diagnoses included Epilepsy, Anemia, Anxiety, Diabetic, Mental Disorder; Mild Seizure Disorder, Mild Intellectual Disability. -Order dated 5/6/21: Diflucan 150 mg (milligrams) one dose, and repeat in 48 hours. (antifungal) -Order dated 9/30/20: Pioglitazone Hcl (hydrochloride) 30 mg (milligrams) every morning (blood sugar control). -Order dated 6/4/20 (FL2): Venlafaxine Hcl ER (extended release) 75 mg, 3 capsules daily with	V 118		

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V 118	Continued From page 11	V 118		

food. (antidepressant)
-Order dated 7/23/21: Venlafaxine Hcl ER 75 mg 2 capsules daily with food.
-Order dated 6/4/20 (FL2): Levothyroxine 25mcg (micrograms) daily. (thyroid hormone replacement)

Review on 8/19/21 of client #1's May 2021 and August 2021 MARs revealed:
-Diflucan 150 mg (Fluconazole) documented as given on 5/6/21 at 7 am, second dose documented as given 36 hours later at 7 am on 5/9/21.
-August 2021 MAR transcribed Pioglitazone Hcl 30 mg to be administered at 7 pm and was documented as given at 7 pm 8/1/21 - 8/18/21.
-Venlafaxine Hcl ER 75 mg, 3 capsules daily had been documented 8/1/21 - 8/9/21 then crossed out by a single line.

Observation on 8/19/21 between 4:00pm - 4:45pm of client #1's medications on hand revealed:
-No Levothyroxine 25 mcg on hand.

Interview on 8/17/21 client #1 stated:
-Staff administered her medications in the morning and at 7 pm.
-She took about 12 medications.
-She did not know the names of her medications.

Finding #2:
Review on 8/17/21 of client #2's record revealed:
-52 year old female admitted 12/3/14.
-Diagnoses included Mild Intellectual Disorder, Depressive Disorder, Schizoaffective disorder; and Psychotic Disorder.
-Order dated 7/23/21: Benztropine 1 mg at bedtime. (involuntary movements)
-Order dated 9/23/20: Metformin Hcl ER 500 mg

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V 118	Continued From page 12 twice daily. (blood sugar control) -Order dated 1/28/20: Omega-3 Fish Oil 1,000 mg 2 twice daily. (dietary supplement) -Order dated 5/12/21: Discontinue Fish oil per patient's request. Review on 8/19/21 of client #2's MARs for June, July, and August 2021 revealed: -Omega-3 Fish Oil 1,000 mg documented at 7 am and 7 pm from 6/1/21 - 7/16/21, then crossed out by a single line. -Omega-3 Fish Oil 1,000 mg documented at 7 am and 7 pm from 8/1/21 - 8/19/21. -Benztropine 1 mg, 8 pm dose, not documented on 8/17/21. -Metformin Hcl ER 500 mg, scheduled to be administered at 7 am and 7 pm, was not documented at 7 pm on 8/17/21. Interview on 8/17/21 client #2 stated: -She took medications about 7 am and 7:30 pm. -Staff administered her medications; she always had medications on hand. Finding #3: Review on 8/17/21 and 8/19/21 of client #3's record revealed: -47 year old female admitted 9/17/03. -Diagnoses included Schizophrenia, Mild Intellectual Disability, Deafness, and Diabetes. -Order dated 12/31/20: Fluticasone 50 mcg nasal spray, 1-2 sprays in each nostril twice daily. (allergy symptom relief) -Order dated 12/31/20: Metformin 500 mg 3 times daily. -Order dated 7/25/21: Metronidozole 500 mg 1 twice daily for 7 days. (antibiotic) -Order dated 7/25/21: Fluconazole 150mg daily. -Order dated 4/5/19 and 8/18/21:Trazodone 50 mg at bedtime.	V 118		

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V 118	Continued From page 13 -Order dated 10/28/20: Restasis 0.05% eye drops, 1 drop in each eye twice daily. (dry eyes) Review on 8/19/21 of client #2's MARs for July 2021 and August 2021 revealed: -Metformin 500 mg 3 times daily, scheduled to be given at 6 am, 3 pm, and 8 pm. Medication not documented at 3 pm and 8 pm on 8/17/21. -Trazodone 50 mg, 8 pm dose, not documented 8/17/21. -Restasis 0.05% eye drops, 7 pm dose, not documented 8/17/21. -Metronidozole 500 mg was not started until 7/29/21, 4 days after it was ordered. -Fluconazole 150mg daily was not started until 7/29/21, 4 days after it was ordered. Observations on 8/19/21 between 4:00 pm - 4:45 pm of client #1's medications on hand revealed: -Fluticasone 50 mcg nasal spray given to surveyor as medication on hand/in use was dispensed 8/13/19; Label read, "Use by 8/12/20." Bottle was approximately ¾ full. -Staff #2 located an additional 6 bottles of Fluticasone 50 mcg nasal spray with the following dispense dates: 1/8/21, 6/11/21, 4/14/20, 2/4/21, 6/18/19, 5/21/19. -Restasis 0.05% eye drops, dispense date 5/10/21; 60 single use vials dispensed and 21 remained on hand. Interview on 8/20/21 Staff #1 stated: -She had documented the medications on 8/17/21 before she went off duty 8/18/21. -She could not locate the MARs when she administered the medications the evening of 8/17/21; she thought the Qualified Professional (QP)/Licensee had taken the MARs and did not realize they were in a folder in the kitchen where they had been reviewed earlier.	V 118		

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V 118	Continued From page 14 -She was sure she had not omitted any medications. Interview on 8/19/21 the QP/Licensee stated: -She would fill in the blanks on the MARs from 8/17/21. Surveyor informed QP/Licensee this did not correct the deficiency unless she administered the medications and followed her policy for making a late entry. QP/Licensee then requested Staff #2 to fill in the blanks. -Staff #2 looked at the MARs and stated she was not on duty when these medications should have been given. -QP/Licensee thought client #3 had the antibiotic and antifungal ordered 7/25/21 to treat a urinary track infection; she had no explanation for the delay in starting these medications 4 days after they had been ordered. -QP/Licensee was unaware client #3 was getting eye drops dispensed in May 2021, with 20 vials remaining. She had no explanation how the client could be receiving eye drops as ordered when the medication on hand would only have lasted for 30 days if given as ordered. -Client #3's Flonase nose drops given to the surveyor (dispensed in 2019) should not have been in use. She had no explanation why the bottle dispensed in 2019 was still in use or why there were be 6 additional bottles of Flonase on hand. -Client #2 had requested the fish oil to be discontinued because she did not want to pay for the medication. The QP/Licensee bought the medication, so staff had continued administering the medication. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.	V 118		

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V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to store medications in a securely locked cabinet. The findings are: Observations on 8/17/21 between 10:15 am 10:34 am and again at 2:30 pm revealed: -Medication cart was located in a room across from the dining area of the kitchen/dining room. -Door to the room was open. -Medication cart was unlocked.	V 120		

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V 120	Continued From page 16 Interview on 8/17/21 the Residential Supervisor stated the cart was unlocked because she had taken the keys to the medication cart the prior day.	V 120		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to report all allegations against health care personnel to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of the allegation. The findings are: Review on 8/24/21 of the North Carolina Incident Response Improvement System (IRIS) revealed no level II incident reports for allegations reported to the Qualified Professional (QP)/Licensee on 8/19/21.	V 318		

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V 318	Continued From page 17 Interviews between 8/17/21 and 8/24/21 the QP/Licensee stated: -She was not aware of any allegation against staff by client #3. "She will lie if she does not get her way." -Now that she was made aware of allegations from client #3 and #4 about Staff #1, she would investigate, but she did not believe it happened because nothing had been said to her by the clients. -(8/24/21) She did not recall any allegations. When reminded about the allegations made during interviews on 8/19/21, stated she had not considered their comments to be allegations because client #3 "lies all the time." -She had not done an investigation of the allegations made against Staff #1 by clients #3 or #4 on 8/19/20, or made a report to the HCPR. Refer to V366 for additional information about interviews and allegations by clients #3 and #4. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 318		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense	V 364		

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V 364	Continued From page 18	V 364		

and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and
(3) Contact and consult with a client advocate if there is a client advocate.
The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times.
(b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to:
(1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;
(2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies;
(3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals;
(4) Make visits outside the custody of the facility unless:
a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;
b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or
c. The client is being held to determine capacity

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V 364	Continued From page 19 to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10)Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise.	V 364		

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V 364	Continued From page 20 Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use	V 364		

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V 364	Continued From page 21 personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10)Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the	V 364		

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V 364	Continued From page 22 reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure that clients kept the right to make and receive confidential telephone calls affecting 1 of 3 clients audited (client #3). The findings are: Review on 8/17/21 and 8/19/21 of client #3's record revealed: -47 year old female admitted 9/17/03. -Diagnoses included Schizophrenia, Mild Intellectual Disability, Deafness, and Diabetes. During interview on 8/19/20 client #3 wrote: - She did not have access to a telephone to call family or friends. -She needed a "tty." (text telephone, a telecommunications device for the deaf) -No one had assisted her in making any type of face time communication using a cell phone or computer. -She needed an "IPAD" (a type of computer tablet). During interviews between 7/29/21 and 8/24/21 the Qualified Professional (QP)/Licensee stated: -There were 2 clients that were deaf. -All staff were trained in sign language. -She had installed a TTY but it got "damaged," was not working, so she had it removed. -She had not replaced the TTY.	V 364		

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V 364	Continued From page 23 -She could not recall when it broke. -(8/24/21) Stated she had bought a special phone for the hearing impaired clients and they "tore it up." Did not know what she should do. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 364		
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 Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.	V 366		

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V 366	Continued From page 24 (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 (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	V 366		

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V 366	Continued From page 25 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 observations, record reviews and interviews the facility failed to develop and implement written policies governing their response to level II incidents. The findings are: Observations on 8/17/2021 between 10:15 am and 10:34 am revealed client #3 and client #4	V 366		

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V 366	Continued From page 26 were deaf and unable to communicate verbally. Observations on 8/19/21 between 2 pm and 3 pm revealed clients #3 and #4 communicated with the Qualified Professional (QP)/Licensee, using sign language and gestures, that Staff #1 had hit them. Interview on 8/19/21 client #3 wrote: -"[Staff #1] and I fought on July 21 because blame for steal from her body wash." -Staff #1 had accused client #3 of stealing. -Client #3 hit Staff #1 and then Staff #1 pushed client #3 and took client #3's cross. -No one saw this happen but she had told client #4. Interview on 8/19/21 client #4 wrote: -"[Staff #1] hit [client #3] and me hit same." -"She (Staff #1) is very mean." Interviews between 8/17/21 and 8/24/21 the Qualified Professional (QP)/Licensee stated: -There had been no allegations against staff in the past year. -If there were allegations, true or false, she would report to the Health Care Personnel Registry (HCPR), do a report, and investigate to see what occurred. -(8/19/21) She was not aware of any allegation against staff by client #3. "She will lie if she does not get her way." -Now that she was made aware of allegations from client #3 and #4 against Staff #1, she would investigate, but she did not believe it happened because nothing had been said to her by the clients before 8/19/21. -(8/24/21) She did not recall any allegations. When reminded about the allegations made during interviews on 8/19/21, stated she had not	V 366		

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	mhl026-655	A. BUILDING: _____ B. WING _____	R 08/24/2021

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V 366	Continued From page 27 considered comments by clients #3 and #4 to be allegations because client #3 "lies all the time." -She had not done an investigation of the allegations made by clients #3 or #4, completed an incident report, reported Staff #1 to the HCPR, or made a report to the department of social services. This deficiency constitutes a re-cited deficiency and must be corrected within 30 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; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified	V 367		

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V 367	Continued From page 28	V 367		

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. 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

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V 367	Continued From page 29 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 reviews and interviews the facility failed to report all level II incidents to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 8/24/21 of the North Carolina Incident Response Improvement System (IRIS) revealed no level II incident reports from the facilty since 6/28/2017. Interviews on 8/19/21 and 8/24/21 the Qualified Professional (QP)/Licensee stated: -She was not aware of any allegation against staff by client #3. "She will lie if she does not get her way." -Now that client #3 and #4 had made her aware	V 367		

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V 367	Continued From page 30 of allegations against Staff #1 she would investigate, but she did not believe it happened because nothing had been said to her by the clients prior to 8/19/21. -(8/24/21) She did not recall any allegations. When reminded about the allegations made during interviews on 8/19/21, stated she had not considered their comments to be allegations because client #3 "lies all the time." -She had not done an investigation of the allegations made by clients #3 or #4, or completed an incident report. Refer to V366 for additional information about interviews and allegations by clients #3 and #4. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.	V 500		

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V 500	Continued From page 31 (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement	V 500		

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V 500	Continued From page 32 over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to report all instances of alleged or suspected abuse to the County Department of Social Services . The findings are: Review on 8/24/21 of the North Carolina Incident Response Improvement System (IRIS) revealed no level II incident reports for allegations reported to the Qualified Professional (QP)/Licensee on 8/19/21. Interviews between 8/17/21 and 8/24/21 the QP/Licensee stated: -She was not aware of any allegation against staff by client #3. "She will lie if she does not get her way." -Now that she was made aware of allegations from client #3 and #4 about Staff #1, she would investigate, but she did not believe it happened because nothing had been said to her by the clients prior to 8/19/21. -(8/24/21) She did not recall any allegations. When reminded about the allegations made during interviews on 8/19/21, stated she had not considered their comments to be allegations because client #3 "lies all the time." -She had not done an investigation of the allegations made against Staff #1 by clients #3 or #4 on 8/19/20, or made a report to the County Department of Social Services. Refer to V366 for additional information about interviews and allegations by clients #3 and #4.	V 500		

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V 513	Continued From page 33	V 513		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to provide services/supports which promoted a safe and respectful environment using the least restrictive and most appropriate methods affecting 3 of 3 audited clients (#1, #2, #3). The findings are: Review on 8/17/21 and 8/19/21 of client #1's	V 513		

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V 513	Continued From page 34 record revealed: -53 year old female admitted 9/17/03. -Diagnoses included Epilepsy, Anemia, Anxiety, Diabetic, Mental Disorder; Mild Seizure Disorder, Mild Intellectual Disability. -Client #3 attended a Psychosocial Rehabilitation program to develop pre-employment skills and adult basic education. Review on 8/17/21 of client #2's record revealed: -52 year old female admitted 12/3/14. -Diagnoses included Mild Intellectual Disorder, Depressive Disorder, Schizoaffective disorder; and Psychotic Disorder. Review on 8/17/21 and 8/19/21 of client #3's record revealed: -47 year old female admitted 9/17/03. -Diagnoses included Schizophrenia, Mild Intellectual Disability, Deafness, and Diabetes. Interview on 8/20/21 Staff #2 stated: -Clients were not allowed to go into the refrigerator. -Clients must ask staff if they want something to eat and staff will get it for them. -One client would not follow the rule (client #4). Interview on 8/20/21 the Residential Supervisor stated the Qualified Professional (QP)/Licensee had said no one can go in the kitchen after 9 pm. Interview on 8/24/21 the QP/Licensee stated: -Clients were allowed to access the refrigerator. -Clients were not allowed to have food in their rooms.	V 513		
V 542	27F .0105(a-c) Client Rights - Client's Personal Funds	V 542		

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V 542	Continued From page 35 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 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.	V 542		

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V 542	Continued From page 36 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide clients with a quarterly accounting of their personal fund account. The findings are: Finding #1: Review on 8/17/21 of client #2's record revealed: -52 year old female admitted 12/3/14. -Diagnoses included Mild Intellectual Disorder, Depressive Disorder, Schizoaffective disorder; and psychotic disorder. Review on 8/19/21 of client #2's "Residential Accounting Fund" log revealed: -She had received 3 stimulus checks for a total of $3200; $250 had been deducted for a balance of $2950. -Stimulus amounts received were dated 9/2/20 ($1200), 1/3/21 ($600), and 4/7/21 ($1400). -There was no recording of $66 a month received or dispersed to the client. -Client #2 had signed by the remaining total amount; no signatures by each entry when checks were received. -There was no date by client #2's signature. Interview on 8/17/21 client #2 stated: -She was her own guardian. -The Qualified Professional (QP)/Licensee received her money and would give her $66. -She paid for part of her medications out of the $66. -No statement was ever given to her about her money. -She asked the QP/Licensee at the beginning of the year and was told she did not get any Stimulus money.	V 542		

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V 542	Continued From page 37 Finding #2: Review on 8/17/21 and 8/19/21 of client #3's record revealed: -47 year old female admitted 9/17/03. -Diagnoses included Schizophrenia, Mild Intellectual Disability, Deafness, and Diabetes. Review on 8/19/21 of client #3's "Residential Accounting Fund" log revealed: -She had received 3 Stimulus checks for a total of $3200; $250 had been deducted for a balance of $2950. -Stimulus amounts received were dated 9/2/20 ($1200), 1/3/21 ($600), and 4/7/21 ($1400). -There was no recording of $66 a month received or dispersed to the client. -Client #3 had signed by the remaining total amount; no signatures by each entry when checks were received. -There was no date by client #3's signature. Interview on 8/19/21 client #3 wrote: -She wanted to purchase a computer tablet but did not have enough money. -She understood what Stimulus money was, but did not receive any. -She had signed the facility "Residential Accounting Fund" log "today." Interview on 8/17/21 and 8/19/21 the QP/Licensee stated: -She was the payee for clients #2 and #3. -Client personal funds were recorded and deposited into a separate bank account. -Clients received $66 a month minus their medication costs. -The money ($66 a month minus their medication costs) was given to the clients. -Some clients received stimulus money and some did not.	V 542		

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V 542	Continued From page 38 -She would give those that received the stimulus funds "so much at a time, not all at one time." -Clients signed a form when they were given money. -She did not provide clients with a quarterly accounting of their personal fund account. -Prior to the stimulus money the clients always had a balance of "zero." -She was not aware there was a requirement to provide quarterly reporting of personal funds to clients.	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 was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 8/17/21 between 10:15 am and 10:34 am revealed: -Client bathroom: sink separated from the wall and surface of wall torn away; painted surface of the walls were smudged/discolored; paint worn from a painted light switch plate; painted surface worn with black build up in corners of the wooden floor boards along the front of the shower. -Client #3's room: 5 drawer dresser was missing	V 736		

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V 736	Continued From page 39 both knobs on 2 drawers and 1 of 2 knobs on 1 drawer. -Client #1's room: Paint worn on closet doors; carpet stained and wrinkled. -Carpet in hallways stained dark gray and wrinkled. -Dining room chair upholstery stained dark gray with circle patterns of discoloration. -Kitchen floor covering repaired with duct tape. -Baseboards throughout facility were scuffed and had build up of dust on the horizontal surfaces. -Entry door facing damaged and surfaces of door and facing stained/smudged a gray discoloration. -Medication room: curtain rod sagging; unpainted wall repair below the window.	V 736		
V 738	27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on interviews the facility did not keep the facility free of insects. The findings are: Interview on 7/29/21 Staff #3 stated: -The facility had bed bugs that had been treated by a professional and by the staff. -Staff sprayed for bed bugs weekly. -The staff had not seen any bed bugs "in a while." Interview on 7/30/21 the Exterminator stated: -He had treated the facility for bed bugs in the	V 738		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl026-655	A. BUILDING: _____ B. WING _____	R 08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND MANOR DDA #3	408 PELT DRIVE FAYETTEVILLE, NC 28301

(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 738	Continued From page 40 past; last time was more than a year ago in 2020. -He sprayed using chemicals he purchased on line and from a hardware store. -He never provided documentation that the facility was free of bed bugs. Interviews on 7/29/21, 7/30/21, and 8/19/21 the Qualified Professional(QP)/Licensee stated: -7/29/21:A professional had treated the facility for bed bugs. Her documentation of services was at the office and she would call the surveyor when she located the paperwork. -7/30/21: She could not find her paperwork from the exterminator. -She last used the services of the exterminator in 2020. -After that she had been treating for bed bugs using chemicals she had purchased locally. -She was not aware that it was not recommended to treat bed bugs yourself using these chemicals that could be purchased locally, or that a professional licensed exterminator was required for treating bed bugs. -On 8/19/21 she stated the construction surveyor told her to get an exterminator "If I wanted one;" he did not recommend she have a licensed exterminator treat for bed bugs. (Division of Health Service Regulation (DHSR) Construction Survey completed 8/11/21.)	V 738		
V 784	27G .0304(d)(12) Therapeutic and Habilitative Areas 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,	V 784		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl026-655	A. BUILDING: _____ B. WING _____	R 08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND MANOR DDA #3	408 PELT DRIVE FAYETTEVILLE, NC 28301

(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 784	Continued From page 41 residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (12) The area in which therapeutic and habilitative activities are routinely conducted shall be separate from sleeping area(s). This Rule is not met as evidenced by: Based on interviews and observation, the facility failed to maintain a sleeping area for over night staff separate from areas used for therapeutic and habilitative activities. The findings are: Observation on 8/17/21 between 10:15 am ad 10:34 am revealed no sleeping area for staff. Interview on 8/17/21 client #1 stated: -Staff #1 was the night and day staff when she worked and slept on a fold out couch. -All staff slept on the couch. Interview on 8/17/21 Staff #1 stated she worked overnight shifts and was allowed to sleep on the sofa. Interview on 8/17/21 the Qualified Professional/Licensee stated she could convert the medication room into a sleep room for staff.	V 784		