Durham County Community Living Programs, Inc.
P.O. Box 51159 Durham, NC 27717-1159
(919) 489-0682

Fax

To: Kimberly Sauls

From: Karyn Stoeckl

Extension #: 30

Fax: 919 - 715 - 8078

Pages: 13 (including cover)

Phone:

Date: 9/23/2021

Re:

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

● Comments:

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

September 14, 2021

Elizabeth Scott, Executive Director
Durham County Community Living Programs, Inc.
P.O. Box 51159
Durham, NC 27717

Re: Annual and Follow up Survey completed September 10, 2021
Carpenter-Fletcher Road Group Home, 1119 Carpenter Fletcher Road, Durham, NC 27713
MHL # 032-264
E-mail Address: ewscott-dcclp@ncrrbiz.com

Dear Ms. Scott:

Thank you for the cooperation and courtesy extended during the Annual and Follow up survey completed September 10, 2021.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 11/9/21.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown at 919-855-3822.

Sincerely.

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:
DHSR@Alliancebhc.org
Pam Pridgen, Administrative Assistant

PRINTED: 09/13/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 and follow up survey was completed on September 10, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600 C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Assistant Director 9/23/202,

PRINTED: 09/13/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 118	Continued From page 1	V 118		

This Rule is not met as evidenced by:
Based on record review and interviews, the facility staff failed to keep the MAR current affecting one of three clients (#2). The findings are:

Review on 9/8/21 of client #2's record revealed:
-Admission date of 8/31/16.
-Diagnoses of Psychosis, Mild Mental Retardation, Fetal Alcohol Syndrome, Asthma and Systolic Heart Murmur.
-Physician's order dated 6/30/20 for Divalproex Sodium ER 500 milligrams (mg), two tablets at bedtime; Cetirizine 10 mg, one tablet daily and Basaglar Insulin Pen, 25 units injected nightly.

Review of MAR for client #2 on 9/8/21 revealed:
-July 2021 had blank boxes for the following medications: Divalproex Sodium ER 500 mg, Cetirizine 10 mg and Basaglar Insulin Pen on 7/20.

"Due to the failure to accurately document medication administration it could no be determined if clients received their medication as ordered by the physician"

Interview with the Division Director on 9/8/21 revealed:
-He thought staff possibly forgot to sign that the medication was administered to client #2 in July 2021.
-There were no issues with clients not getting

PRINTED: 09/13/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 118	Continued From page 2 their prescribed medications. -He confirmed staff failed to keep the July 2021 MAR current for client #2. Interview with the Assistant Director on 7/9/21 confirmed: -Staff failed to keep the July 2021 MAR current for client #2.	V 118		
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. (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	V 500		

PRINTED: 09/13/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 500	Continued From page 4 Review on 9/9/21 of General Statue 122C-62 revealed "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 (QP) 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 records." Review on 9/8/21 of client #3's record revealed: -Admission date 2/1/20. -Diagnoses of Mild Intellectual Disability, Autism, Schizoaffective Disorder, Anxiety Disorder and Depression. -There was no evidence of a written statement for client #3 detailing restrictions of personal possessions or evidence of an evaluation of each restriction reviewed at least every seven days by the Qualified Professional. Review of facility records on 9/8/21 revealed: -Incident report for client #3 dated 6/21/21 had the following: Client #3 told Manager he had burned his nipple and penis. Client #3 told the Manager he used his computer cord. The Manager asked client #3 to bring the computer cord to the office in order to keep client #3 from hurting himself with it again. -A note dated 6/22/21 posted on the wall in staff's office area. The note had the following: "All of [Client #3's] computer and ipod chargers will be kept in the staff office. When his devices need to be charged he will bring them to the office and staff will charge them and return them to [Client #3]."	V 500		

PRINTED: 09/13/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 500	Continued From page 3 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 over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement interventions to address behaviors which did not restrict the rights for one of three clients (#3). The findings are:	V 500		

PRINTED: 09/13/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 500	Continued From page 5 Interview on 9/8/21 with client #3 revealed: -He had an incident a few months ago. -He used his power cord to masturbate. -He would plug the power cord into the wall and stick the other end of the power cord into the hole of his penis. -A few months ago he used the power cord in his genital area and on his nipples. -He felt a little burning sensation after doing that. -He told staff he thought he burned himself and staff took away his power cord. -He was not allowed to keep the power cords and/or chargers in his room anymore. -These were his personal power cords and chargers to his phone and other devices. Interview on 9/8/21 with the Division Director revealed: -Client #3 had an incident on June 21, 2021. -Client #3 told staff he put a power cord onto his nipples and was burned. -It came to staff attention in June 2021 after that incident that client #3 had been using his power cord to masturbate. -He told staff he was plugging the cord into the wall socket and putting the other end of the cord into the hole of his penis. -When that came to their attention client #3's power cords were taken away. -Staff now keep client #3's power cords in the staff office. -If client #3 needs anything charged he has to bring those items to the office. -They were not aware of client #3 was using the power cord in this way until the incident occurred in June 2021 when he said he burned his nipples. -Staff were not aware that he had been using a power cord to masturbate. -They talked to the guardian and she agreed to	V 500		

PRINTED: 09/13/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 500	Continued From page 6 staff keeping his power cords in the staff's office. -The power cords are client #3's, these are items that belong to him. -There is a note posted in the staff office area that indicates client #3 must keep all of his power cords in staff's office. -He confirmed client #3's rights were being restricted. Interview on 9/9/21 with the Assistant Director revealed: -She was aware of the incident with client #3 burning his nipples using a power cord. -Client #3's one on one staff brought that incident to her attention. -Client #3 also informed them he had been using the power cord in his genital area and plugging it into the wall. -Staff did take the power cord away in June 2021 once it came to their attention. -The agency did not meet with the human rights committee prior to taking the power cord away from client #3. -She confirmed client #3's rights were being restricted. Interview on 9/9/21 with the Executive Director revealed: -She was aware of the issue with client #3 using the power cord on his nipples and genital area. -The team did meet to discuss that issue. The team agreed that all power cords should be removed from client #3's bedroom. -The Assistant Director failed to submit the required information to the Human Rights Committee. -She confirmed client #3's rights were being restricted.	V 500		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL032-264 Y1	A. Building B. Wing Y2	9/10/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0114	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 27G .0207	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/10/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Profix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE 9/14/21
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
7/18/2019	

EVENT ID: 0C2E12

Durham County Community Living Programs, Inc.

Post Office Box 51159
Durham, N.C. 27717-1159
(919) 489-0682

Carpenter Fletcher Road Group Home
MHL # 032-264
Plan of Correction to Survey Completed 9/10/2021

***V 118 27G .0209 (C) Medication Requirements*:**

To Correct the Deficiency: This rule is not met as evidenced by the facility failing to keep one MAR current by staff signing on one client at specific administration times. To correct the deficiency, we have met with the staff member involved in this failure to document on the MAR and reviewed the procedures for correct documentation. The staff reported that she knew she was supposed to document on the MAR and that it was an oversight. The staff is receiving disciplinary write-ups in her personnel files for this documentation error. In addition, refresher training has been scheduled to prevent this deficiency from occurring again. Proper policies and procedures are already in place regarding these requirements.

To Prevent the Deficiency from Occurring Again: To prevent the deficiency from occurring again, we are having the involved staff go through an additional refresher on Medication Administration, and focusing particularly on the six rights of Medication Administration and proper documentation. The training time has not been confirmed with the nurse who will do the training.

Who will Monitor: The QP for this program has responsibility to monitor the MAR's to make sure that all documentation procedures are being followed.

How Often the Monitoring will Take Place: Monitoring of the MAR's will take place at least monthly, with unscheduled monitoring to take place at a variety of times throughout the month.

Karyn Stoeckl, BSW, QDDP
Assistant Director
September 23, 2021

Durham County Community Living Programs, Inc.
Post Office Box 51159
Durham, N.C. 27717-1159
(919) 489-0682

Carpenter Fletcher Road Group Home
MHL # 032-264
Plan of Correction to Survey Completed September 10, 2021

V 500 27D Client Rights:

To Correct the Deficiency:
A written statement was developed and signed by the guardian and was posted in the staff office. The statement of restriction will also be placed in the client's record.

On 9/16/2021 the statement of restriction was submitted to the Human Rights Committee, all members agreed due to the health and safety issues involved, to restrict client #3 from having his power cords in his possession. The deficiency has been corrected.

Who will Monitor:
The QP will at least every 7 days evaluate the restriction to determine if it can be removed. The QP will meet with client #3 each time to review why the restriction was put in place and to assess his understanding of the possible harm to himself when using the power cords for anything other than charging his devices. Each evaluation will be documented in the client's record, and reported to the team, including administration, guardian, and therapist (monthly).

All issues that arise that need to be presented to the Human Rights Committee will be presented by the Assistant Director, either at a regularly scheduled meeting, or a specially called meeting. Such presentation will be documented.

How Often the Monitoring will Take Place:
The monitoring for this client will take place every 7 days, with a report to the team at least monthly.

Human Rights Committee meetings are normally held quarterly (exception during COVID), so monitoring of any needed approval needed for any human rights restrictions will be verified/monitored prior to each Human Rights Committee meeting.

To Prevent the Deficiency from Occurring Again:
When the QP feels the client appears to have a clear understanding of using the power cords for charging his devices only, the team will be meet regarding the restriction possibly being removed. If the client does not have a clear understanding of the possible harm to himself by using the power cords to masturbate, then the Team will continue the restriction. This process will be ongoing until the client has proven to staff and the Team that he clearly understands the appropriate use of his charger cords.

Human rights restrictions will be presented to the Committee in a timely manner as they arise.

Karyn Stoeckl, BSW, QDDP
Assistant Director
September 23, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 and follow up survey was completed on September 10, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600 C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118	DHSR - Mental Health SEP 27 2021 Lic. & Cert. Section	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 118	Continued From page 1	V 118		

This Rule is not met as evidenced by:
Based on record review and interviews, the facility staff failed to keep the MAR current affecting one of three clients (#2). The findings are:

Review on 9/8/21 of client #2's record revealed:
-Admission date of 8/31/16.
-Diagnoses of Psychosis, Mild Mental Retardation, Fetal Alcohol Syndrome, Asthma and Systolic Heart Murmur.
-Physician's order dated 6/30/20 for Divalproex Sodium ER 500 milligrams (mg), two tablets at bedtime; Cetirizine 10 mg, one tablet daily and Basaglar Insulin Pen, 25 units injected nightly.

Review of MAR for client #2 on 9/8/21 revealed:
-July 2021 had blank boxes for the following medications: Divalproex Sodium ER 500 mg, Cetirizine 10 mg and Basaglar Insulin Pen on 7/20.

"Due to the failure to accurately document medication administration it could no be determined if clients received their medication as ordered by the physician"

Interview with the Division Director on 9/8/21 revealed:
-He thought staff possibly forgot to sign that the medication was administered to client #2 in July 2021.
-There were no issues with clients not getting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 118	Continued From page 2 their prescribed medications. -He confirmed staff failed to keep the July 2021 MAR current for client #2. Interview with the Assistant Director on 7/9/21 confirmed: -Staff failed to keep the July 2021 MAR current for client #2.	V 118		
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. (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	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 500	Continued From page 4 Review on 9/9/21 of General Statue 122C-62 revealed "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 (QP) 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 records." Review on 9/8/21 of client #3's record revealed: -Admission date 2/1/20. -Diagnoses of Mild Intellectual Disability, Autism, Schizoaffective Disorder, Anxiety Disorder and Depression. -There was no evidence of a written statement for client #3 detailing restrictions of personal possessions or evidence of an evaluation of each restriction reviewed at least every seven days by the Qualified Professional. Review of facility records on 9/8/21 revealed: -Incident report for client #3 dated 6/21/21 had the following: Client #3 told Manager he had burned his nipple and penis. Client #3 told the Manager he used his computer cord. The Manager asked client #3 to bring the computer cord to the office in order to keep client #3 from hurting himself with it again. -A note dated 6/22/21 posted on the wall in staff's office area. The note had the following: "All of [Client #3's] computer and ipod chargers will be kept in the staff office. When his devices need to be charged he will bring them to the office and staff will charge them and return them to [Client #3]."	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 500	Continued From page 3 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 over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement interventions to address behaviors which did not restrict the rights for one of three clients (#3). The findings are:	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 500	Continued From page 5 Interview on 9/8/21 with client #3 revealed: -He had an incident a few months ago. -He used his power cord to masturbate. -He would plug the power cord into the wall and stick the other end of the power cord into the hole of his penis. -A few months ago he used the power cord in his genital area and on his nipples. -He felt a little burning sensation after doing that. -He told staff he thought he burned himself and staff took away his power cord. -He was not allowed to keep the power cords and/or chargers in his room anymore. -These were his personal power cords and chargers to his phone and other devices. Interview on 9/8/21 with the Division Director revealed: -Client #3 had an incident on June 21, 2021. -Client #3 told staff he put a power cord onto his nipples and was burned. -It came to staff attention in June 2021 after that incident that client #3 had been using his power cord to masturbate. -He told staff he was plugging the cord into the wall socket and putting the other end of the cord into the hole of his penis. -When that came to their attention client #3's power cords were taken away. -Staff now keep client #3's power cords in the staff office. -If client #3 needs anything charged he has to bring those items to the office. -They were not aware of client #3 was using the power cord in this way until the incident occurred in June 2021 when he said he burned his nipples. -Staff were not aware that he had been using a power cord to masturbate. -They talked to the guardian and she agreed to	V 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-264	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

(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 500	Continued From page 6 staff keeping his power cords in the staff's office. -The power cords are client #3's, these are items that belong to him. -There is a note posted in the staff office area that indicates client #3 must keep all of his power cords in staff's office. -He confirmed client #3's rights were being restricted. Interview on 9/9/21 with the Assistant Director revealed: -She was aware of the incident with client #3 burning his nipples using a power cord. -Client #3's one on one staff brought that incident to her attention. -Client #3 also informed them he had been using the power cord in his genital area and plugging it into the wall. -Staff did take the power cord away in June 2021 once it came to their attention. -The agency did not meet with the human rights committee prior to taking the power cord away from client #3. -She confirmed client #3's rights were being restricted. Interview on 9/9/21 with the Executive Director revealed: -She was aware of the issue with client #3 using the power cord on his nipples and genital area. -The team did meet to discuss that issue. The team agreed that all power cords should be removed from client #3's bedroom. -The Assistant Director failed to submit the required information to the Human Rights Committee. -She confirmed client #3's rights were being restricted.	V 500		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL032-264 Y1	A. Building B. Wing Y2	9/10/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARPENTER-FLETCHER ROAD GROUP HOME	1119 CARPENTER FLETCHER ROAD DURHAM, NC 27713

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0114 Reg. # 27G .0207 LSC	Correction Completed 09/10/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE 9/14/21
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/18/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: 0C2E12

STATE FORM: REVISIT REPORT (11/06)

Durham County Community Living Programs, Inc.

Post Office Box 51159
Durham, N.C. 27717-1159
(919) 489-0682

Carpenter Fletcher Road Group Home
MHL # 032-264
Plan of Correction to Survey Completed 9/10/2021

***V 118 27G .0209 (C) Medication Requirements*:**

To Correct the Deficiency: This rule is not met as evidenced by the facility failing to keep one MAR current by staff signing on one client at specific administration times. To correct the deficiency, we have met with the staff member involved in this failure to document on the MAR and reviewed the procedures for correct documentation. The staff reported that she knew she was supposed to document on the MAR and that it was an oversight. The staff is receiving disciplinary write-ups in her personnel files for this documentation error. In addition, refresher training has been scheduled to prevent this deficiency from occurring again. Proper policies and procedures are already in place regarding these requirements.

To Prevent the Deficiency from Occurring Again: To prevent the deficiency from occurring again, we are having the involved staff go through an additional refresher on Medication Administration, and focusing particularly on the six rights of Medication Administration and proper documentation. The training time has not been confirmed with the nurse who will do the training.

Who will Monitor: The QP for this program has responsibility to monitor the MAR's to make sure that all documentation procedures are being followed.

How Often the Monitoring will Take Place: Monitoring of the MAR's will take place at least monthly, with unscheduled monitoring to take place at a variety of times throughout the month.

Karyn Stoeckl, BSW, QDDP
Assistant Director
September 23, 2021

Durham County Community Living Programs, Inc.
Post Office Box 51159
Durham, N.C. 27717-1159
(919) 489-0682

Carpenter Fletcher Road Group Home
MHL # 032-264
Plan of Correction to Survey Completed September 10, 2021

***V 500 27D Client Rights*:**

To Correct the Deficiency:
A written statement was developed and signed by the guardian and was posted in the staff office. The statement of restriction will also be placed in the client's record.

On 9/16/2021 the statement of restriction was submitted to the Human Rights Committee, all members agreed due to the health and safety issues involved, to restrict client #3 from having his power cords in his possession. The deficiency has been corrected.

Who will Monitor:
The QP will at least every 7 days evaluate the restriction to determine if it can be removed. The QP will meet with client #3 each time to review why the restriction was put in place and to assess his understanding of the possible harm to himself when using the power cords for anything other than charging his devices. Each evaluation will be documented in the client's record, and reported to the team, including administration, guardian, and therapist (monthly).

All issues that arise that need to be presented to the Human Rights Committee will be presented by the Assistant Director, either at a regularly scheduled meeting, or a specially called meeting. Such presentation will be documented.

How Often the Monitoring will Take Place:
The monitoring for this client will take place every 7 days, with a report to the team at least monthly.

Human Rights Committee meetings are normally held quarterly (exception during COVID), so monitoring of any needed approval needed for any human rights restrictions will be verified/monitored prior to each Human Rights Committee meeting.

To Prevent the Deficiency from Occurring Again:
When the QP feels the client appears to have a clear understanding of using the power cords for charging his devices only, the team will be meet regarding the restriction possibly being removed. If the client does not have a clear understanding of the possible harm to himself by using the power cords to masturbate, then the Team will continue the restriction. This process will be ongoing until the client has proven to staff and the Team that he clearly understands the appropriate use of his charger cords.

Human rights restrictions will be presented to the Committee in a timely manner as they arise.

Karyn Stoeckl, BSW, QDDP
Assistant Director
September 23, 2021

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

September 14, 2021

Elizabeth Scott, Executive Director
Durham County Community Living Programs, Inc.
P.O. Box 51159
Durham, NC 27717

Re: Annual and Follow up Survey completed September 10, 2021
Carpenter-Fletcher Road Group Home, 1119 Carpenter Fletcher Road, Durham, NC 27713
MHL # 032-264
E-mail Address: ewscott-dcclp@ncrrbiz.com

Dear Ms. Scott:

Thank you for the cooperation and courtesy extended during the Annual and Follow up survey completed September 10, 2021.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 11/9/21.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown at 919-855-3822.

Sincerely,

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:
DHSR@Alliancebhc.org
Pam Pridgen, Administrative Assistant