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V 000	INITIAL COMMENTS An annual and complaint survey was completed on August 18, 2021. The complaints were substantiated (intake #NC00180211 and intake #NC00180225). Deficencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000	DHSR - Mental Health SEP 29 2021 Lic. & Cert. Section	
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying,	V 108	All staff will be trained in cardiopulmonary resuscitation (CPR) provided by American Red Cross to include participation in in-person skills sessions. Monarch's Education Department will ensure staff are trained according to 27.G.0202 (F-I) Personnel Requirements. Monarch's Education Department will monitor required trainings by running reports weekly for trainings due in 60 days which will alert staff and managers of upcoming trainings needed to include CPR.	10/19/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Theresa Bechue Director of Regulatory Affairs 09/23/2021

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V 108	Continued From page 1 reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were currently trained in cardiopulmonary resuscitation (CPR) provided by the American Red Cross, the American Heart Association or their equivalence affecting 3 of 3 audited staff (#4, #5 and the Qualified Professional) and 1 of 1 former staff (Former Staff #6). The findings are: Review on 8/18/21 of staff #4's personnel record revealed: -Hire date of 3/29/21. -Training in CPR was dated 4/1/21. Review on 8/18/21 of staff #5's personnel record revealed: -Hire date of 8/28/17 -Training in CPR was dated 10/4/20. Review on 8/18/21 of the QP's personnel record revealed: -Hire date of 12/18/17. -Training in CPR was dated 11/12/19. Review on 8/18/21 of FS #6's personnel record revealed: -Hire date of 2/15/16. -Date of separation was 8/16/21. -Training in CPR was dated 3/3/20.	V 108	Page intentionally left blank	

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V 108	Continued From page 2 Interview on 8/18/21 with staff #1 revealed: -Prior to COVID, trainings were completed online. -CPR training was completed online. -Doing chest compressions using a computer mouse was difficult. Interview on 8/18/21 with the QP revealed: -All trainings were being completed online. -CPR compressions were demonstrated by clicking the computer mouse. -Online training failed to ensure appropriate hand placement.	V 108		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter	V 111	Residential Team Leaders will complete an Admission Assessment on the day of admission to include: Admission Date, 1. Presenting Problems, 2. Needs and Strengths, 3. Diagnosis, 4. Pertinent social, family and medical history Monarch will include in the LTSS Admission Group Forms in the EHR an Admission Assessment that will be completed at admission to services. Director of Program Operations will monitor quarterly during peer review audits to include new admissions for the quarter.	10/19/2021

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V 111	Continued From page 3 referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an assessment was completed prior to the delivery of services affecting 1 of 3 audited clients (#1). The findings are: Review on 8/17/21 of client #1's record revealed the following: -Date of admission 6/15/21. -Diagnoses include Moderate Intellectual Disability, Down Syndrome, Hypothyroidism and Obesity. -There was no assessment or documentation of client #1's needs, strengths and identified presenting problems. Interview on 8/18/21 with the Qualified Professional revealed: -She was not sure why an assessment was not completed. -She gathered the application and psychological evaluation both dated prior to admission. -Neither document identified the presenting problem and current needs of the client.	V 111	Page intentionally left blank	

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V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of three audited clients (client #1) treatment plan received written consent and was signed by their guardian. The findings are:	V 112	Residential Team Leader will follow Monarch's Policy on Person Centered Planning to include obtaining the Legally Responsible Person's signature and date prior to implementing the plan. DPO will monitor plan signatures during quarterly peer reviews	10/19/2021

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V 112	Continued From page 5 Review on 8/17/21 of client #1's record revealed: -Date of admission 6/15/21. -Diagnoses include Moderate Intellectual Disability, Down Syndrome, Hypothyroidism and Obesity. -Treatment plan was developed on 6/15/21. -The guardian signature was dated 8/3/21. Interview on 8/17/21 with the Qualified Professional revealed: -She thought the treatment plan had been signed by the guardian. -She had to reach out to the guardian on 8/3/21 requesting a signature. -She was responsible for ensuring treatments plans were completed and signed. -She confirmed she failed to have the treatment plan signed.	V 112		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.	V 121	In review of the completed 6-month Pharmacy Review form, while done in practice, the form does not indicate the review of psychotropic medication. Monarch's LTSS Nursing Supervisor will request Kerr Drug to include a statement on their Pharmacy Review form to indicate all meds are reviewed including Psychotropic Medications. Manager will continue to review the outcomes of the 6-month Pharmacy Reviews and assure the client's physician is informed of the results when medical intervention is indicated.	10/19/2021

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V 121	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain drug reviews every six months for one of three audited clients (#2) who received psychotropic drugs. The findings are: Review on 8/18/21 of client #2's record revealed: -Admission date of 6/1/11. -Diagnoses of Mild Intellectual Disability, Down Syndrome, Hypertension, Hyperlipidemia, Diabetes Mellitus, Gastroesophageal Reflux Disease and Vitamin D Deficiency. -There was no evidence of a six-month psychotropic medication review for client #2. Review of physician orders for client #2 on 8/17/21 revealed: -Order dated 10/7/20 for Risperidone 3 milligram (mg), Dissolve one tablet on the tongue at bedtime Review of client #2 Medication Administration Record (MAR) on 8/17/21 revealed: -August 2021- Client was administered the above medication on 8/1 thru 8/16. -July 2021- Client was administered the above medication on 7/1 thru 7/31. -June 2021- Client was administered the above medication on 6/1/ thru 6/30. Interview on 8/18/21 with the Qualified Professional revealed: -She was not aware of what this entailed. -She looked in client chart and saw no documentation from the psychiatrist. -She would contact the pharmacy. -She confirmed the six-month psychotropic drug review was not completed for client #2.	V 121	Page intentionally left blank	

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V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive orderly manner and kept free from offensive odor. The findings are: Observation on 8/18/21 at approximately 11:40am at the facility revealed the following: -Hallway light had a blown lightbulb. -Client #2 bedroom smelled of urine; the mattress cover was heavily discolored and soiled; pillows, totes and personal items blocked the window access if needed to exit due to fire. -Hallway towards backyard exit- missing an electrical socket cover. -Backyard- A black office chair sitting by garbage bin and And broken walker leaning against the exterior of the house by the garbage bin. -Outside office door entrance- Lightbulb blown. Interview on 8/17/21 with staff #1 revealed: -He mentioned to management need for a new mattress cover and possible for client room smelling of urine. -He reminded client daily to move items blocking her window. -Once a maintenance order is requested for	V 736	-The Residential Team Leader had the Hallway lightbulb replaced -Client # 2 was informed that staff will need to assist her with cleaning her room including replacing her mattress cover and pillows and relocating the totes and personal items blocking her window to provide her easy access to exit in case of a fire. The Residential Team Leader followed up on Facility Work Orders to assure they were complete - The missing electrical socket cover has been replaced -Backyard- the black office chair and the broken walker have been removed -Outside office door entrance - lightbulb has been replaced. The Residential Manager or designee will ensure that the facility is maintained in a safe, clean and attractivemanner and free of offensive odor when completing the monthly environmental inspection. Work Orders will be completed immediately after discovering an issue. The Residential Manager will provide the Director of Program Operations monthly Environmental Checklist for the next 3 months.	10/19/2021

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V 736	Continued From page 8 house repairs, maintenance comes to address the identified issues. -Maintenance had been to the home to power wash and did not pick up the items on the back porch or replace lightbulbs. Interview on 8/18/21 with Qualified Professional revealed: -She confirmed there was a maintenance department that comes out to repair things in the home. -She thought maintenance had picked up the items on the back porch. -She confirmed facility staff failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor.	V 736	Page intentionally left blank	

Division of Health Service Regulation

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V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.	V 121	In review of the completed 6-month Pharmacy Review form, while done in practice, the form does not indicate the review of psychotropic medication. Monarch's LTSS Nursing Supervisor will request Kerr Drug to include a statement on their Pharmacy Review form to indicate all meds are reviewed including Psychotropic Medications. Manager will continue to review the outcomes of the 6-month Pharmacy Reviews and assure the client's physician is informed of the results when medical intervention is indicated.	10/19/2021

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V 121	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain drug reviews every six months for one of three audited clients (#2) who received psychotropic drugs. The findings are: Review on 8/18/21 of client #2's record revealed: -Admission date of 6/1/11. -Diagnoses of Mild Intellectual Disability, Down Syndrome, Hypertension, Hyperlipidemia, Diabetes Mellitus, Gastroesophageal Reflux Disease and Vitamin D Deficiency. -There was no evidence of a six-month psychotropic medication review for client #2. Review of physician orders for client #2 on 8/17/21 revealed: -Order dated 10/7/20 for Risperidone 3 milligram (mg), Dissolve one tablet on the tongue at bedtime Review of client #2 Medication Administration Record (MAR) on 8/17/21 revealed: -August 2021- Client was administered the above medication on 8/1 thru 8/16. -July 2021- Client was administered the above medication on 7/1 thru 7/31. -June 2021- Client was administered the above medication on 6/1/ thru 6/30. Interview on 8/18/21 with the Qualified Professional revealed: -She was not aware of what this entailed. -She looked in client chart and saw no documentation from the psychiatrist. -She would contact the pharmacy. -She confirmed the six-month psychotropic drug review was not completed for client #2.	V 121	Page intentionally left blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL063-091	A. BUILDING: _____ B. WING _____	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDDLETON STREET	340 MIDDLETON STREET ROBBINS, NC 27325

(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 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive orderly manner and kept free from offensive odor. The findings are: Observation on 8/18/21 at approximately 11:40am at the facility revealed the following: -Hallway light had a blown lightbulb. -Client #2 bedroom smelled of urine; the mattress cover was heavily discolored and soiled; pillows, totes and personal items blocked the window access if needed to exit due to fire. -Hallway towards backyard exit- missing an electrical socket cover. -Backyard- A black office chair sitting by garbage bin and And broken walker leaning against the exterior of the house by the garbage bin. -Outside office door entrance- Lightbulb blown. Interview on 8/17/21 with staff #1 revealed: -He mentioned to management need for a new mattress cover and possible for client room smelling of urine. -He reminded client daily to move items blocking her window. -Once a maintenance order is requested for	V 736	-The Residential Team Leader had the Hallway lightbulb replaced -Client # 2 was informed that staff will need to assist her with cleaning her room including replacing her mattress cover and pillows and relocating the totes and personal items blocking her window to provide her easy access to exit in case of a fire. The Residential Team Leader followed up on Facility Work Orders to assure they were complete - The missing electrical socket cover has been replaced -Backyard- the black office chair and the broken walker have been removed -Outside office door entrance - lightbulb has been replaced. The Residential Manager or designee will ensure that the facility is maintained in a safe, clean and attractive manner and free of offensive odor when completing the monthly environmental inspection. Work Orders will be completed immediately after discovering an issue. The Residential Manager will provide the Director of Program Operations monthly Environmental Checklist for the next 3 months.	10/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL063-091	A. BUILDING: _____ B. WING _____	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 736	Continued From page 8 house repairs, maintenance comes to address the identified issues. -Maintenance had been to the home to power wash and did not pick up the items on the back porch or replace lightbulbs. Interview on 8/18/21 with Qualified Professional revealed: -She confirmed there was a maintenance department that comes out to repair things in the home. -She thought maintenance had picked up the items on the back porch. -She confirmed facility staff failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor.	V 736	Page intentionally left blank	

Monarch
Helping Dreams Take Flight

September 23, 2021

Tamara Gathers, Facility Compliance Consultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

DHSR - Mental Health
SEP 29 2021
Lic. & Cert. Section

RE: Green Street/Annual & Complaint/8-20-21
Middleton/Annual & Complaint/8-18-21

Hello,

Please find enclosed the Plan of Correction for deficiencies cited during the survey referenced above.

If you need additional information or have questions, please contact me directly at the number below.

Sincerely,

Theresa Brechue

Theresa Brechue
Director of Regulatory Affairs
Theresa.Brechue@monarchnc.org
585 406-7440