STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL042-073	A. BUILDING: _____ B. WING _____	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERYDAY LIVING	166 RUDD TRAIL ROAD HOLLISTER, NC 27844

(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 Complaint Survey was completed 8/18/21. The complaint was unsubstantiated (Intake #NC00180054). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/Alternative Family Living.	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable:	V 113	Rule V113- is met as evidenced by: Former Client #2 no longer lives in the Home. Current member in the home has all current doctors' orders in member's record. Current orders match MAR that is in member's record. QP will monitor Doctor Orders for all medications Monthly. QP will send out Reminders monthly to turn in all Current orders during staff meeting QP will ensure AFL Provider keeps Records on members that is no Longer in the home as well SCANNED OCT 08 2021 MHL & C Section	8/19/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Angie Barbour AFL provider 10-05-2021

Division of Health Service Regulation

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V 113	Continued From page 1 (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain physician's orders in the records of one of one former client (FC #2). The findings are: Review on 8/13/21 of the facility's records revealed no record for FC #2. Review on 8/18/21 of FC #2's record maintained by the facility's management company revealed: - Admitted: 7/5/20 - Diagnoses: Attention-Deficit Hyperactivity Disorder (ADHD), Moderate Intellectual Developmental Disability, Seizure Disorder, Lennox-Gastaut Syndrome (severe form of Epilepsy), intractable without statuepile epileptics, SLE (Systemic Lupus Erythematosus) and Vitamin D Deficiency - Physician's orders printed 8/18/21 listed the following: Clobazam 2.5 mg (milligram) take 10	V 113		

Angie Ballard AFH provider 10/05/2021

Division of Health Service Regulation

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EVERYDAY LIVING	166 RUDD TRAIL ROAD HOLLISTER, NC 27844

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V 113	Continued From page 2 Milliliters (ml) at bedtime dated 5/28/21 (treat Seizures caused by Lennox-Gastaut Syndrome) Levetiracetam 500 mg two tablets (tabs) twice a day dated 4/29/21 (Seizures) Centrum Multi Gummies Women Therapeutic Multiple Vitamins with Minerals tab, chewable 10000 mg one tab daily dated 4/20/21 Clonidine HCL 0.1 mg one tab in the morning and 2 tabs at 6:00 PM dated 3/9/21 (ADHD) Lamotrigine 100 mg three tablets twice a day dated 6/3/21 (Seizures) Topiramate 50 mg three tabs twice daily dated 5/5/21 (Seizures) Zonisamide 100 mg two tabs twice daily dated 6/18/21 (Seizures) Mycophenolate 750 mg total dosage every 12 hours dated 5/24/21 (Lupus) Concerta 36 mg one tab in the morning dated 6/3/21 (ADHD) Interview on 8/17/21 the Licensee reported: - FC #2 last resided at the group home 07/15/21 - Because of an investigation of alleged abuse that involved the Licensee and FC #2, FC #2 was removed from the home by the guardian/Department of Social Services. - The Management Company requested FC #2's records maintained by the facility. She provided all paperwork regarding FC #2. Interviews between 8/17/21 and 8/18/21 the Qualified Professional reported: - She worked for the management company used by the facility. - Around 07/15/21, the Licensee gave FC #2's paperwork and records to the management company - On 8/18/21, she gathered the physician's	V 113		

Azzie Burbaca AFL provider 10/05/2021

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V 113	Continued From page 3 orders requested by the Division of Health Service Regulation. She noticed the writings on the physician's orders were not easy to read. - Monthly, this Licensee either faxed or emailed copies of the physician's orders to the management company. - Once printed, the emailed or faxed physician's orders were difficult to read. - She was not able to connect with FC #2's current residential provider to obtain the original physician's orders located in the record. - She contacted FC #2's pharmacy to request the physician's orders on 8/18/21.	V 113		
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	V 366	Rule V366-is met as evidenced by: AFL ensures to turn in all incident Reports involving members in the Home. AFL Provider was also In serviced on 7/16/2021 about Incident reporting as soon as Incident happens and turn in Paper copy within 24 hours Please see copy of Training QP Will continue to monitor all Incidents and Remind staff at all Staff meetings About turning in Incident reports On time.	7/16/2021

Angie Bullard AFL provider 10-05-2021

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V 366	Continued From page 4 (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. (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	V 366		

Angie Barbour AFL provider 10/05/2021

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V 366	Continued From page 5 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 catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility	V 366		

Angie Buchanan AFL provider 10/05/2021

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V 366	Continued From page 6 failed to ensure a Level I incident was completed effecting one of one former clients (FC #2). The findings are: Record review on 8/18/21 of FC #2's record revealed: - Admitted: 12/2020 - Diagnoses: Attention-Deficit Hyperactivity Disorder, Moderate Intellectual Disabilities, Seizure Disorder, Lennox-Gastaut Syndrome, intractable without statuepile epilepticus, SLE (Systemic Lupus Erythematosus) and Vitamin D Deficiency - No documentation of level 1 incident reports regarding falls or bruises Interview on 8/13/21 the Licensee reported: - Department of Social Services (DSS) conducted an investigation into bruises on FC #2 which she could explain. - In May and June FC #2 was seen by her primary care physician and her rheumatologist. During both physician visits, blood work was taken which caused FC #2 to bruise. It was difficult to draw blood for labs from FC #2 so medical providers used various places on the body. The Licensee was not able to provide the dates of these appointments. She did make FC #2's day program aware of these bruised areas - A few weeks prior to 07/15/21, FC #2 was in the bathroom. The Licensee went to obtain an item from the linen closet. She told FC #2 to "stand right here." Water was on the bathroom floor. Before the Licensee could return, FC #2 had slipped and fell on the floor. FC #2 "must have fallen when she attempted to put a pamper on" herself. FC #2 was not hurt. Initially, a red bruise appeared on FC #2's buttocks. FC #2 was pale in color and was easy to bruise. The Licensee thought the fall and bruise were	V 366		

Angie Bulhan AFL provider 10/05/2021

Division of Health Service Regulation

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V 366	Continued From page 7 superficial. "I didn't document it because I didn't feel like it was major..." - She was aware she should have documented both incidents. Interview on 8/13/21 DSS Social Worker reported: - Per medical records, FC #2 was seen in May and June 2021 in which blood work was obtained. Interview on 8/17/212 the Qualified Professional reported: - She reviewed the incident reporting requirements with the Licensee after 07/15/21.	V 366		
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 the home was maintained in a safe manner. The findings are: Observation and tour of the facility on 8/17/21 between 3:00 PM and 4:00 PM revealed the following: - Hall bathroom electrical outlet near the sink was missing the outlet cover	V 736	Rule V736-is met as evidenced by: Hall bathroom electrical outlet Near sink outlet cover has been Replaced by AFL Provider Qualified Professional has Went out to home to ensure Cover has been replaced QP will complete monthly Visits to ensure Facility is maintained in a safe manner and check all outlets to ensure they are covered	8/19/2021

Angie Buchanan AFL provider 10-05-2021

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V 736	Continued From page 8 Interview on 8/17/21 and 8/18/21 the Licensee reported: - The bathroom had been renovated and the cover was removed during the renovation - Renovations occurred over a month ago. Staff #2 initiated the renovations but due to a change in health status, was not able to complete the project. - She was aware the cover needed to be placed on the outlet	V 736		

Angie Barbour AFL provider 10/05/2021

Community Alternatives – North Carolina
Inservice/Training Signature Sheet

TITLE OF TRAINING: Incident Reporting

DATE: 7/16/2021 LOCATION: Roanoke Rapids Office DURATION: 3 hours

SIGNATURE OF FACILITATOR: Carmita Alston BSW QP

PRINTED NAME OF FACILITATOR: Carmita Alston BSW QP; Senior Program Coordinator

Incident reporting as soon as it is safe to do so and turn in paper copy within 24 hours. Carmita Alston went over Tools of Support Training on Incident reporting

Participant's Signature	Printed Name	Title	Service Site
Angie Richardson	Angie Richardson	AFL Provider	166 Rudd Trail Road

Community Alternatives – North Carolina
Inservice/Training Signature Sheet

BRIEF DESCRIPTION OF TRAINING: _____

- Complete Incident Report for:
  1. Any type of injury (including SIB, vehicle accidents, trip/fall/bump, etc.)
     - Observed
     - Discovered (Injury of Unknown Origin) as soon as safe to do /right away
  2. Dangerous Behaviors (Suicide attempt, property destruction, theft, etc.)
  3. Other Incidents (death, AWOL, illness or Medical Emergency, etc.)
  4. Use of a restrictive intervention
  5. Allegation of Abuse or Neglect
  6. Med Errors
- For all incidents/injuries document: who/what/when/why/how
- When describing injury:
- Be specific where located
- Be specific about size and color
- relate to size of known objects, golf ball, dime, quarter, etc.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

September 8, 2021

Mrs. Angie Richardson, Licensee
166 Rudd Trail Road
Hollister, NC 27844

Re: Annual and Complaint Survey completed August 18, 2021
Everyday Living, 166 Rudd Trail Road, Hollister, NC 27844
MHL #042-073
E-mail Address: angierichardson411@yahoo.com
Intake #NC00180054

Dear Mrs. Angie Richardson:

Thank you for the cooperation and courtesy extended during the Annual and Complaint Survey completed August 18, 2021. The complaint was unsubstantiated.

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 October 17, 2021.

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 Renee Kowalski at 919-552-6847.

Sincerely,

India Vaughn-Rhodes
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Roanna Newton, MS

Roanna Newton
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: qmemail@cardinalinnovations.org
Pam Pridgen, Administrative Assistant