SCT

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
	MHL078-229	A. BUILDING: _____ B. WING _____	R 09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST IMAGE INC GRACE COURT	3750 MEADOWVIEW RD BLDG F1 LUMBERTON, NC 28358

(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 3, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .4100 Residential Recovery Programs for Individuals with Substance Abuse Disorders and Their Children.	V 000	To correct this deficient practice Employee will receive the updated training. Employee received updated training on 9-19-21. To prevent the problem from reoccurring All Employee trainings will be monitored at least monthly by Grace Court Director and Facility Manager. Grace Court Director and facility Manager will monitor ALL Employee trainings Monthly. Grace Court Director and facility Manger will coordinate with HR Department every 60 Days with updated, if any new employees, Trainings.	10-1-21
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, reporting, investigating and controlling infectious	V 108		

DHSR - Mental Health
OCT 04 2021
Lic. & Cert. Section

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V 108	Continued From page 1 and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were trained in cardiopulmonary resuscitation (CPR) and First Aid affecting 1 of 3 staff audited (#6). Review on 9/2/21 of staff #6's personnel record revealed: -There was no evidence of a current CPR and First Aid certification. Interview on 9/2/21 staff #6 stated: -She had been employed for 2 years as a Behavioral Health Technician. -She worked 1st shift from 7:30am - 4:30pm. -There were 4 Behavioral Health Technician who worked her shift. -Her main job duty was to provide transportation and she mostly worked alone. -She was trained in CPR and First Aid. Interview between 9/2/21-9/3/21 the Facility Manager stated: -Staff #6 did not have current CPR and First Aid training. -Staff #6's CPR and First Aid certification had expired. -Staff #6 worked alone when she provided transportation to clients. -Staff #6 would attend the next CPR and First Aid training scheduled. -She understood there needed to be a CPR and	V 108		

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V 108	Continued From page 2 First Aid trained staff with clients at all times.	V 108		
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	To correct this deficiency, Facility Manager, along with Director Supervisor will ensure that client are informed within 5 days of low medication supply, and ensure within 3 days the resident has either a refill filled or an appointment with the Prescribing Provider. 10/1-2021 To prevent the problem from occurring again, Residents will be informed during intake about medication refills and low meds protocol, when they are reviewing facility rules with Facility Manager. Facility Director and Director will Supervise Med Books, ensure Med Admin are being completed daily. Facility Director will Monitor Daily	

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V 118	Continued From page 3 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure medications were administered as ordered by a physician and MARs current affecting 2 of 3 audited clients (#1, #3). The findings are: Finding #1 Review on 9/2/21-9/3/21 of client #1's record revealed: -25 year old female. -Admitted on 1/19/21. -Diagnoses of Opiate Use Disorder Severe, Cocaine Use Disorder Severe, Unspecified Bipolar-Mood Disorder and Post Traumatic Stress Disorder. -Self-administration order dated 1/14/21. Review on 9/2/21-9/3/21 of client #1's signed physician orders revealed: -Dated 6/10/21, Lamotrigine 50 mg (milligram) daily. (Bipolar mixed with Depression) -Dated 5/20/21, Trazadone 100 mg nightly. (Depression) Review on 9/2/21-9/3/21 of client #1's MARs revealed: -Lamotrigine 50 mg was not administered on 8/3/21-8/4/21. -Trazadone 100 mg was not administered on 6/13/21. Interview on 9/3/21 client #1 stated: -She received her medications daily. -She had no concerns of getting medication ordered and refilled for consistent administration. -It was her responsibility to make sure her medications were ordered and filled.	V 118		

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V 118	Continued From page 4 -Staff would let her know if she is low on her medications. Finding #2 Review on 9/3/21 of client #3's record revealed: -28 year old female. -Admitted on 4/22/21. -Diagnoses of Cocaine Use Disorder and Opioid Use Disorder. -Self-administration order dated 4/26/21. Review on 9/3/21 of client #3's signed physician orders revealed: -Dated 8/24/21, Gabapentin 600 mg 3 times a day. (Withdrawals) Review on 9/3/21 of client #3's MARs revealed: -Gabapentin 600 mg was not administered 7/2/21, 7/22/21 (3rd dose) -7/25/21. Review on 9/2/21 of a level I incident report for the facility dated 7/22/21 revealed: -Date of incident: 7/22/21. -"Description of what happened:...Missed mourning medication. Had to get a written note from pharmasist to continue Gabapentin. Client ran completely out of meds from 22-26th of July..." -"Supervisors are to complete the following section to detail any action taken in response to the reported incident...[Client #3] agreed to contact her provide before she runs out of meds..." Interview on 9/3/21 client #3 stated: -She received her medications daily. -She was responsible for ordering her medications. -When medication administration is completed she had to call and have more medications	V 118		

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V 118	Continued From page 5 ordered or refilled. -She had completely "ran out of her medication 1 time recently." Interview on 9/3/21 the Facility Manager stated: -Clients administered their own medications. -When a client's medication is missed they had to get a continuity of care from physician to continue medications. -A level I incident report is completed when a client missed their medications. -Client #1 ran out of Lamotrigine and it had to be ordered. -Client #3 ran out of Gabapentin and it had to be ordered. -She was unsure why other medications were missed. -It was the responsibility of the facility manager to make sure the medications are ordered and filled timely. -She understood it was the facility's responsibility to ensure clients medications were available to administer. Interview on 9/3/21 the Program Director stated: -The facility completed level I incident reports when a client missed their medication. -It was the responsibility of program director and the facility manager to ensure medications were available. -She advocated for the clients to make their own appointment when they needed refills or clients were present if appointment was made for them. -She understood it was the facility's responsibility to ensure clients medications were available to administer. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		

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V 736	Continued From page 6	V 736		
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 clean, safe and attractive manner. The findings are: Observation of the facility on 9/3/21 between 11:25am-12:45pm revealed: -In client apartment G3 there was a smoke detector that beeped about every minute. The hallway and master bedroom's smoke detectors battery compartments were pull out and there were no batteries in the smoke detectors. -The bathroom sinks in client apartments G4 and F4 drained water slowly. -In client apartment F3 the hallway bathroom had 4 floor tiles that were a different color between the bathtub and the toilet, the shower curtain rod was next to the bathtub against the wall, the floor around the toilet was wet, and the laundry closet door's hinge with door stopper was detached from door and caused a quarter size hole in the door. -The bathroom vanity light in client apartment G4 blinked off and on repeatedly. -The bathroom vanity light in client apartment F1	V 736	To Correct the deficient area, The smoke detector's Batteries were replaced that day. To Correct and Prevent this problem, Grace Court staff will include Battery Check in their list of Daily Apartment Checks. Staff will test the battery to assess the devices operation. This will be Monitored by Daily Checksheets, Facility Manager and Site Director.	10-1-2021

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V 736	Continued From page 7 had 2 blown light bulbs. Interview on 9/3/21 -She lived in G3. -The smoke detectors were sensitive and she had removed the batteries the night before while she was cleaning so the alarm would not sound and wake up her child/children. -The batteries needed to be replaced in one smoke detector. Interview in 9/3/21 the facility manager stated: -Clients resided in apartment buildings F and G. -She would have maintenance replace the batteries in the smoke detectors. -She was not sure why the client who lived in G3 removed the batteries from 2 of the 3 smoke detectors. -Clients were not supposed to tamper with the smoke detectors. -She would ensure maintenance resolved all issues.	V 736	To correct the lighting, sink drains, hole in door, and bathroom fixtures out of place (curtain rod), wet floor and faulty light bulbs - Maintence replaced light Bulbs, patched hole in door with Door Cover, redirected residents about safety with fixtures that should be in place such as the curtain rod, cleaned sink drain and placed curtain rod in proper order. Water was mopped up. To prevent the problem(s) from occurring again, Maintence staff will walk through apartments with facility Director at least Monthly for repairs. Behavioral Health Staff will look for needed repairs daily and report to facility manger. Residents will be provided safety education on apartment safety to explain why water cannot be on the floor by Behavioral Staff and facility Director to ensure safety At least Monthly	
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, the facility	V 752		

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V 752	Continued From page 8 water temperatures were not maintained between 100-116 degrees Fahrenheit in areas where clients were exposed to hot water. The findings are: Observation of the facility on 9/3/21 between 11:25am-12:45pm revealed: -The hot water temperature in the client bathroom used for drug screenings was 120 degrees Fahrenheit. -In client apartment G2 the hot water temperature in the hallway bathroom and kitchen sink was 117 degrees Fahrenheit. -In client apartment G4 the hall bathroom and master bathroom hot water temperature were 118 degrees Fahrenheit. -In client apartment F4 the hall bathroom hot water temperature was 119 degrees Fahrenheit. Interview on 9/3/21 the facility manager stated: -Water temperature checks were completed daily by maintenance staff. -Water temperatures in client areas ranged from 116-122 degrees Fahrenheit. -She understood hot water temperatures were to maintained between 100-116 degrees Fahrenheit. -She would have maintenance staff adjust hot water temperatures and maintain between 100-116 degrees Fahrenheit.	V 752	All needed repairs will be completed within 24 hours. All needed repairs and light bulb changes will be documented and a Work Order completed - facility Manager and Director will monitor. To Correct the deficiency of Water Temperatures, Maintenance reduced the temperature with adjustments to Hot Water Tanks to 100-116 degrees. To Prevent said deficiencies, daily temps will continue to be checked Daily. Behavioral Health Staff will check, report any problems in work order, Maintenance will repair or attempt to repair within 24 hrs - Facility Director will Monitor Behavioral Health Staff	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL078-229 Y1	A. Building B. Wing Y2	9/3/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST IMAGE INC GRACE COURT	3750 MEADOWVIEW RD BLDG F1 LUMBERTON, NC 28358

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 V0112 Reg. # 27G .0205 (C-D) LSC	Correction Completed 09/03/2021	ID Prefix V0366 Reg. # 27G .0603 LSC	Correction Completed 09/03/2021	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
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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
			Tareva Jones	9-3-21
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
1/31/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: VUV112

STATE FORM: REVISIT REPORT (11/06)

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

Copy

Mary Locklear, Program Director
Robeson Health Care Corporation (RHCC)
3750 Meadowview Rd. Apt A-1
Lumberton, NC 28358

Re: Annual and Follow Up Survey completed September 3, 2021
First Image Inc. Grace Court, 3750 Meadowview Rd. Bldg. F1 Lumberton, NC, 28358
MHL # 078-229
E-mail Address: mary_locklear@rhcc1.com; iola_woodell@rhcc1.com

Dear Ms. Locklear:

Thank you for the cooperation and courtesy extended during the Annual and Follow Up survey completed September 3, 2021.

As a result of the follow up survey, it was determined that some 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

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is October 3, 2021.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is November 2, 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 Gloria Locklear, Team Leader at 910-214-0350.

Sincerely,

Tareva Jones, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSRreports@eastpointe.net
Pam Pridgen, Administrative Assistant