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	MHL092-866	A. BUILDING: ______ B. WING ______	R 10/07/2021

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HEAVENLY PLACE, LLC	8600 NEUSE HUNTER DRIVE RALEIGH, NC 27616

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed 10/7/21. The complaint was substantiated (Intake #NC00181000). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. A sister facility is identified in this report. The sister facility will be identified as facility A. Sister facility A is licensed for the following service category 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. Staff and/or clients will be identified using the letter A and a numerical identifier.	V 000		
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	V 108		

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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 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 1 of 2 paraprofessional staff (#1) and 1 of 3 Qualified Professionals (QP #2) were trained in first aid and cardiopulmonary resuscitation (CPR). The findings are:

Review on 9/17/21 of staff #1's personnel record revealed:
-Hire date of 12/20/16
-Certificate of course completion from Emergency Medical Services (EMS) Safety dated 8/01/21 by the Administrator/QP

Interview on 9/20/21 staff #1 reported:
-She had previous training as a medical technician and certified nursing technician
-She received CPR/First Aid refresher training provided by the QP #1

Review on 9/17/21 of the QP #2's personnel record revealed:
-Hire date of 9/01/20

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-Certificate of course completion from EMS Safety dated 2/9/21 by the Administrator/QP

Interview on 9/16/21 the QP #2 reported:
-She had to read a brochure on CPR/First Aid, read some information and take a test online
-Did not demonstrate CPR/First Aid competency skills on a mannequin, or perform any other form of skill demonstration

Interview on 9/20/21 EMS Safety CPR/First Aid course staff reported:
-The instructor can choose to teach the course via online or by face to face classroom style instruction
-The online part of the course is taught by watching videos
-The classroom instruction will earn the student a certificate of attendance and course completion, but will not certify them
-They must complete the demonstration piece with the instructor to be certified

Interview on 9/20/21 the QP #1 reported:
-He is not a certified CPR/First Aid instructor

Interview on 9/22/21 the Administrator/QP reported:
-The QP #1 is not a certified CPR/First Aid instructor and should not be certifying staff competencies
-She is the certified CPR/First Aid instructor

This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Developmental Disabilities -Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.

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V 109	Continued From page 3	V 109		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.	V 109		

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This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure 3 of 3 Qualified Professionals (QP #1, QP #2 and Administrator/QP) demonstrated the knowledge, skills and abilities required by the population served. The findings are:

Review on 9/17/21 of the QP #1's personnel records revealed:
-Hired: 9/10/02

Review on 9/17/21 of facility documents submitted by the QP #1 revealed credentials: Bachelor of Science (Business Administration)

Review on 9/17/21 of the QP #2's personnel records revealed:
-Hired: 9/1/20

Review on 9/17/21 of facility documents submitted by the QP #2 revealed credentials: Bachelor of Arts, (Interdisciplinary Studies)

Interview on 9/9/21 the Administrator/QP reported:
-She was the owner of the agency

Interview on 9/9/21 the QP #1 reported:
-He provided supervision to all of the QP's employed by the Administrator/QP

Interviews between 9/16/21 and 10/7/21 the QP #2 reported:
-She provided supervision to the staff of the facility and the sister facility A

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V 109	Continued From page 5 I. Example the QP #1 overseeing skills competencies CPR/First Aid for staff: Review on 9/17/21 of staff #1's personnel record revealed: -Hire date of 12/20/16 -Certificate of course completion from EMS Safety dated 8/01/21 Interview on 9/20/21 staff #1 reported: -She had previous training as a medical technician and certified nursing technician -She received CPR/First Aid refresher training under the QP #1 Interview on 9/22/21 the Administrator/QP reported: -The QP #1 is not a certified CPR/First Aid instructor and should not have certified staff competencies -She is the certified CPR/First Aid instructor II. Example the QP #1 failed to provide coordination of client/staff coverage: Interview on 9/20/21 the QP #2 reported: -Staff #1 and staff #2 submit client appointments to the main office weekly -The QP #1 creates the transportation schedule for the week -The QP #1 creates the facility staffing schedule Interviews between 9/9/21- 9/20/21 staff #1 reported: -Appointments are sent to the main office weekly -The QPs #1 and #2 make out the transportation schedule	V 109		

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-Group home operated 1 staff to 5 clients
-Staff worked alone on the shift

Interview on 9/21/21 the QP #1 reported:
-He and the QP #2 create the transportation schedule together

During interviews on 9/9/21, clients #1, #2, #3, #4 and #5 verified:
-Staff #2 left clients #1-#5, at the sister facility A from Friday morning-Friday evening after dinner
-Client A12 and client A13 went to the day treatment program, client A14 went to the doctor with Staff #2, leaving client A11 and client A15 at the sister facility A with clients #1-#5.
- Staff A22 was on duty.
-Staff A22 worked with all 7 clients.

Review on 9/10/21 of the sister facility A's public file maintained by Division of Health Service Regulation (DHSR) revealed:
-Mental Health License certificate with a December 31, 2021 expiration date and capacity of 6
-Licensed for service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.

III. Example the QP #2 unaware of facility environmental living issues:

Refer to V736 regarding the living environment. Outlined in these citations included the following information:
-Space between floor planks in the laundry room, duct tape holding the floor together at the threshold
-Separated floor planks in the hallway
-Hole in wall of client #1's room covered by duct tape

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Interview on 9/16/21 the QP #2 reported:
-She made weekly house visits
-She was unaware of the above environmental living issues

IV. Example the QP #2 failed to provide supervision to the staff:

Interview on 9/15/21, staff #2 reported:
-She provided transportation for this facility and the sister facility A
- The QP #2 was aware of her taking clients to the sister facility A when transportation was needed
-The QP #2 told her she could take the clients to the sister facility A

Interview on 9/16/21, the QP #2 reported:
-She was aware that staff #2 provided transportation for both facilities
-She was unaware of staff #2 taking clients to the sister facility A
-She was unaware of how often staff #2 has taken clients to the facility to provide transportation for clients
-She did not authorize staff #2 to take the clients to the sister facility A at any time

V. Example the QP #2 failed to develop and implement strategies to address needs and behaviors for client #1 in her treatment plan:

Review on 9/9/21 of client #1's record revealed:
-Admitted: 5/18/21
-Diagnoses: Intellectual Developmental Disability (IDD), seizure disorder, anxiety, history of falls and headaches.
-Age: 73 years old
-Treatment plan dated 5/18/21 revealed

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"What is not working: [client #1]'s Neuropathy, [client #1] uses a walker for stabilization, but [client #1] still has difficulty with stability while getting up and walking without stumbling, not staying focused on a particular task is also not working for [client #1]. GH (Group Home) staff will do hourly checks throughout the day monitoring [client #1]'s stability."
-No goals related to address walker usage or encouraging client #1 to use her walker

Refer to V112 regarding client #1's treatment plan:
-Client #1's treatment plan revealed no strategies or interventions to promote the use of her walker
-The QP #2 was responsible for updating the treatment plan

VI. Example the QP #1 and the QP #2 failed to develop and implement fall prevention strategies:

Review on 10/4/21 of client #1's local hospital records dated 5/31/21 revealed the following:
-Admitted: 5/27/21
-Discharged: 5/31/21
-Reason for admission: "Per EMS (Emergency Management Services), the patient lives at a group home and they received a call earlier this morning for frequent falls. The patient reportedly fell over to her side while trying to pick up a remote yesterday evening, The patient was asymptomatic after the fall and so they picked the patient up and set her back down."
-Discharge recommendations: if client #1 was discharged back to group home then the following were included in the recommendations of Home Health Services Physical Therapy (PT) and Occupational Therapy (OT)
-Hospital staff discussed discharge

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recommendations with the QP #1 prior to client #1's discharge

Interviews between 9/13/21-10/5/21, the QP #1 and the QP #2 reported since client #1's admission:
-Besizes her 8/27/21 fall, she had not been admitted to the hospital or had fallen
-Neither recalled her receiving Home Health Services inclusive of PT or OT at the group home
-Both indicated they would need to refer to her record at the group home to verify if PT or OT services were rendered

Interview on 10/4/21 and 10/5/21, the QP #1 reported he:
-Did not see anything in his records of an Emergency room visit for client #1 in May 2021.
-Tried unsuccessfully to reach QP #2 yesterday (10/4/21).

Continued interview on 10/5/21, the QP #2 reported:
-Client #1's sister/Power of Attorney (POA) took her to most appointments
-She was not informed if client #1's sister/POA took client #1 to PT sessions.
-She advised Division of Health Service Regulation staff to follow up with client #1's sister/POA if more information was needed regarding PT sessions
-Client #1 "may have fallen, called her sister as opposed to informing the group home staff." The sister/POA would have taken client #1 to local appointments. The sister/POA takes care of client #1's appointments.

Interview on 10/5/21, the Home Health Service Provider Supervisor reported the following about client #1:

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V 109	Continued From page 10 -Received Services June 1-21, 2021 -Address on file was for 8600 Neuse Hunter Raleigh, NC -All services were provided in home as the agency did not have a brick and mortar building or office -Physical Therapy completed a total of 5 visits in June (9th, 10th, 14th, 15th and 21st) -Occupation Therapy conducted 1 visit in June (4th) This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Developmental Disabilities -Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness;	V 110		

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(3) analytical skills;
(4) decision-making;
(5) interpersonal skills;
(6) communication skills; and
(7) clinical skills.
(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 1 of 2 staff (#2) demonstrated the knowledge, skills and abilities to meet the needs of the population served. The findings are:

I. Review on 9/17/21 of staff #2's personnel record revealed the following:
-Date of hire 12/28/19
-Title: House Manager

Review on 9/9/21 of client #1's record revealed:
-Admitted: 5/18/21
-Diagnoses: Intellectual Developmental Disability (IDD), seizure disorder, anxiety, history of falls, headaches

Review on 9/13/21 of client #1's hospital record revealed:
-Admitted on 8/27/21
-Discharged: 9/3/21
-Hospital impression: Left patella fracture, 3 centimeter laceration to the right eyebrow with hematoma. Surgical consult obtained and

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surgical repair of left patella performed.
-Client #1 discharged from the hospital to a rehabilitative care facility

Interview on 9/15/21 staff #2 reported:
-On 8/27/21, she took all 5 clients to the sister facilty A. Client A14 had a doctor appointment and staff #2 provided transportation to and from the appointment.
-Prior to leaving for sister facilty A, she told client #1 to get her walker to take to the sister facilty.
-Client #1 uses her walker in the morning when she leaves her room, and when she is getting ready for bed. She doesn't use the walker all the time. She will use it when she goes shopping
-Client #1 argued with staff #2 and told her that she did not need her walker
-She did not get the walker and put it on the van, therefore, client #1 did not have access to her walker at the sister facilty A
-She received a call from staff A22, who informed her that client #1 had fallen, on her way across the kitchen floor to argue/fight with client #3. Client #1 was hurt and complaining of her leg hurting
-She told staff A22 to give client #1 tylenol and that once she arrived at the sister facilty A, she observed that staff A22 had put a Band-Aid over her eye along the eyebrow as client #1 had a visible laceration
-She asked client #1 to walk to the van to go to urgent care
-Client #1 refused to walk, and stated that she could not walk on her leg
-She called the Qualified Professional (QP) #1 and discussed client #1's injuries with him, and was told by the QP #1 to call Emergency Medical Services (EMS)

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-She called EMS and they arrived on the scene an hour later

Interview on 9/15/21 client #1 reported:
-On 8/27/21, staff #2 was taking other clients from the sister facilty A to the doctor, so all clients had to go to the sister facilty A
-Before getting on the van, staff #2 told her to leave her walker at home, and use the arms of other clients and staff to assist in walking
-She did not have her walker at the sister facilty A
-While at the sister facilty A, client #3 put something slippery on the floor and when she got up, she fell on the floor, breaking her glasses which cut her eye, and "busted her knee"
-Staff A22 was in her room when the incident happened, and the clients had to yell for her to come help her to the couch
-Staff #2 told her to walk to the van when she arrived at the sister facilty A.
-Client #1 told her she could not walk on her "busted leg"
-Staff #2 called EMS and she was taken to the hospital, where she had surgery on her knee

Interview on 9/16/21 the QP #2 reported:
-She was on vacation when the incident occurred.
-She was contacted by the guardian on her cell phone and she missed the call while on vacation. The guardian told her what happened when she returned to work on 8/30/21
-The guardian told her client #1 was in an accident and was hurt and was in the hospital. She told her that client #1 had called her and told her she was hurt. The guardian was calling the QP #2 on 8/27/21 to find out where client #1 was, as she was unaware that client #1 had been brought to the sister facilty A

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-She was told by the QP #1 that client #1 fell because another client poured water on the floor.
-The agency did an internal investigation. She did not know the outcome
-She did not know where client #1's walker was, according to the guardian, it was not at the sister facilty A
-Staff should have brought the walker to the sister facilty A
-She has been told by staff that sometimes client #1 refuses to get her walker and she would argue with staff about using it

Interview on 9/13/21 client #5 reported:
-They were all "at the other home. [Client #1] fell there."
-Their staff (staff #2) went somewhere to buy something. She didn't take anyone else with her
-Client #1 didn't want to bring her walker to the sister facility A
-Heard staff #2 tell client #1 to bring the walker
-She observed client #1 fall trying to throw away trash. She saw her fall and break her knee. Client #5 and Client #2 helped her up
- Staff A22 was in her room at the time of the fall
-After she fell, client #1's knee was all bruised. Her eyebrow was bleeding. The staff put a bandage on her eyebrow and called the hospital
-Client #1 said she was hurting
-It was a long time before staff #2 came back, close to dinner time

Interview on 9/15/21 the QP #1 stated:
-Client #1 is normally mobile. Due to an unstable gate, she has a walker or cane to ambulate for stability. She is supposed to use those devices but usually refuses
-The walker was not at the sister facilty A due

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to client #1's refusal to bring it. She said she only needed it when she went shopping

-The staff should have brought it to the sister facilty A anyway. He communicated with staff that they should have brought the walker and they should have her using the walker. He specifically told staff #2 that client #1 needed to be using the walker

II. Review between 9/9/21 and 9/23/21 of the facility's records revealed the following client Information:

-Client #1
Admitted: 5/18/21
Diagnoses: Intellectual Developmental Disability (IDD), Seizure Disorder, Anxiety, History of falls and Headaches

-Client #2
Admitted: 6/07/21
Diagnoses: Impulse Control Disorder, Bipolar disorder, Moderate IDD, Seizure Disorder, Overactive Bladder, Breast Cancer Survivor and Osteoarthritis

-Client #3
Admitted: 8/23/21
Diagnoses: Bipolar Disorder unspecified and Mild IDD

-Client #4
Admitted: 12/01/14
Diagnoses: Down Syndrome, Mental Retardation, Hypertension, Hyperlipidemia and Obstructive Sleep Apnea

-Client #5
Admitted: 3/14/19
Diagnoses: Autism Spectrum and IDD

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Interview on 9/16/21 staff A22 reported the following:
-On 8/27/21, staff #2 brought clients #1-#5 to sister facility A in which she worked as the on duty staff
-Staff #2 left clients #1-#5 in her care as staff #2 transported a client from sister facility A to a medical appointment 30 minutes away from the group home
-Prior to 8/27/21, she was not familiar with clients #1-#5
-Staff #2 told her about the behaviors of clients #1-#5. She could not recall specifics of what was shared during the exchange
-Staff #2 did not share that client #1 used a walker. She did not find out about the walker until after client #1 fell
-As of the date of the interview, she only recalled the name of client #1 because she fell

Interview on 10/4/21 staff A22 reported the following:
-Staff #2 did inform her client #1 had a walker and left it in the van on 8/27/21
-Client #1 refused to bring her walker inside of the group home (sister facility A)
-She could not recall specifics staff #2 told her about each client on 8/27/21

Interview on 9/16/21, staff #2 reported she:
-Informed staff A22 of the behaviors of the clients on 8/27/21
-Did not recall specifics she shared regarding each client

III. Interview on 9/9/21, client #5 reported:
-Client #1 was hospitalized because she fell

Interview on 9/9/21, staff #1 reported she:
-Worked for the agency since June 2021

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V 110	Continued From page 17 -Started her shift at this location on 9/1/21 -Had never worked at this location prior to her 9/1/21 shift -Had never met client #1 -Was not aware why client #1 was hospitalized until client #5 disclosed the information during conversation with Division of Health Care Regulation (DHSR) staff -Did a shift exchange of information with staff #2 Interview on 9/15/21, staff #2 reported she: -Did not recall the specifics of information she shared with staff #1 during shift exchange Interviews between 9/16/21 and 9/21/21, the QP #2 reported she: -Visited the group home weekly -Shared client information with oncoming staff as the staff schedule rotation was frequent at each home. -Could not recall specifically what she shared if anything with staff #2 about client #1 -The responsibility of sharing information at shift exchange would be both hers as well as the outgoing staff This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Developmental Disabilities -Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN	V 112		

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V 112	Continued From page 18 (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 develop and implement strategies to address needs and behaviors of 1 of 1 clients (#1) who required an assistive mobility device. The findings are: Review between 9/9/21 and 9/13/21 of client #1's record revealed: -Admitted: 5/18/21 -Diagnoses: Intellectual Developmental	V 112		

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Disability (IDD), seizure disorder, anxiety, history of falls and headaches.
-Age: 73 years old
-Treatment plan dated 5/18/21 revealed "What is not working: [client #1]'s Neuropathy, [client #1] uses a walker for stabilization, but [client #1] still has difficulty with stability while getting up and walking without stumbling, not staying focused on a particular task is also not working for [client #1]. GH (Group Home) staff will do hourly checks throughout the day monitoring [client #1]'s stability." No goals related to address walker usage or encouraging client #1 to use her walker.

Review on 10/4/21 of client #1's local hospital records dated 5/27/21 revealed the following:
-Admitted: 5/27/21
-Discharged: 5/31/21
-Reason for admission: "Per Emergency Management Services (EMS), the patient lives at a group home and they received a call earlier this morning for frequent falls. The patient reportedly fell over to her side while trying to pick up a remote yesterday evening, The patient was asymptomatic after the fall and so they picked the patient up and set her back down. Overnight, she had an additional two falls. The last fall was while she was trying to put her dentures in. She states that she fell into the bathtub. The patient typically ambulates with a walker at baseline and has been using this for several years. The sister states that the patient does have a history of falls but has never been unsteady on her feet like this before."
-Discharge summary listed possible Dilantin toxicity as reason for falls. Physical Therapy (PT) assessment noted client used roller walker for ambulation but required reinforcement to use. "Evidence of education: No evidence of learning,

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needs reinforcement" noted in assessment. Client mobiity and gait listed as unsteady. Client "refused to use RW (Rollator Walker) for support." Comments regarding her gait included client cued for posture awareness when use of RW (tends to walk too far out)" and at times pushed walker aside to walk without it despite unsteady. Poor safety awareness, high risks of falls

-Discharge recommendations: if client #1 was discharged back to group home then the following were included in the recommendations of Home Health Services PT and Occupation Therapy (OT)

-Hospital staff discussed discharge recommendations with the Qualified Professional (QP) #1 prior to client #1's discharge

Interview on 10/5/21 with client #1's Home Health Service Provider Supervisor revealed the following per their notes:

-Client #1 was rendered services June 1-21, 2021

-Her Discharge summary dated 6/21/21 noted she ambulated with "modified independence." Modified independence was a clinical term that described independence "with some type of assistance device or adaptation. In her case, the modified adaptation is the rollator walker. Independent is with no device."

Interviews between 9/9/21-9/24/21, staff #2, the QP #1 and the QP #2 reported client #1 had not fallen prior to the 8/27/21 fall at this group home.

Interview on 9/15/21, staff #2 reported the following:

- When client #1 used her walker, she primarily used it in the mornings to ambulate from her bedroom to the living room. "She would sit

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down, walk out and leave the walker. She need the walker to be going around, but she don't."

-Without using the walker, client #1 walked "fast anytime she walks." She felt client #1 "walked well" without her walker around the home.

-Client #1 preferred only to use her walker when she was out in the mall or major department stores.

-Client #1 did not always want to take her walker on community outings. "I take it (walker) out. I put it in the trunk and she would say she would not use it. She would say she needed it when she was out...She was up and down" with her consistent use of the walker.

-Client #1 needed the walker to help walk

Interviews between 9/16/21 and 9/30/21, the QP #2 reported:

-She visited the group home at least weekly.

-During her visits, she observed client #1 did not always use or have her walker.

-"I would redirect her to retrieve her walker. She would sometimes get upset and remain in her bedroom" opposed to returning to the area with the walker.

-She reminded staff that client #1 needed her walker.

-The home rotated staff often. She was not sure if she trained all staff specifically on client #1's need for walker.

-During her visit at the home, she would redirect staff to promote the usage of the walker. She felt some staff did not want to have conflict with client #1 so they did not redirect or encourage the use of the walker.

-On 8/27/21, client #1 fell and broke her patella while at sister facility A. When she fell, she did not have access to her walker at sister facility A.

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Interview on 10/5/21, the QP #2 reported
-She was not aware client #1 had been hospitalized for three days, received OT or PT services at the group home.
-If she was aware of the requirement for PT/OT, she would have addressed it in client #1's treatment plan.
-Usually an incident report would have been documented if she fell. "I'm not sure if it (fall) actually happened."

Interview on 9/25/21, the Administrator/QP reported the following:
-The agency's normal process was to monitor the clients and make adjustments to the treatment plan.

This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Developmental Disabilities -Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.

V 289 | V 289

27G .5601 Supervised Living - Scope

10A NCAC 27G .5601 SCOPE
(a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.
(b) A supervised living facility shall be licensed if the facility serves either:
(1) one or more minor clients; or
(2) two or more adult clients.

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V 289	Continued From page 23 Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC	V 289		

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27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to operate within its scope for 5 of 5 clients (#1-#5). The findings are:

A. Cross reference 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108). Based on record review and interview the facility failed to ensure 1 of 2 paraprofessional staff (#1) and 1 of 3 Qualified Professionals (QP #2) were trained in first aid and cardiopulmonary resuscitation (CPR).

B. Cross reference 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record review and interview the facility failed to ensure 3 of 3 Qualified Professionals (QP #1, QP #2 and Administrator/QP) demonstrated the knowledge, skills and abilities required by the population served.

C. Cross reference 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (V110). Based on record review and interview, the facility failed to ensure 1 of 2 staff (#2) demonstrated the knowledge, skills and abilities to meet the needs of the population served.

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D. Cross reference 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112). Based on record review and interview, the facility failed to develop and implement strategies to address needs and behaviors of 1 of 1 clients (#1) who required an assistive mobility device.

E. Cross reference 10A NCAC 27G .5602 SUPERVISED LIVING FOR ADULTS WITH MENTAL ILLNESS-STAFF (V290). Based on record review and interview, the facility failed to have minimum staff-client ratios to meet the needs for 5 of 5 clients (#1-#5).

F. Cross reference 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (V736). Based on record review, interview and observation, the facility failed to ensure the home was maintained in a clean, safe, orderly and attractive manner.

G. Cross reference 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record review and interview the facility failed to develop and implement written policies governing their response to incidents as required.

H. Cross reference 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record review and interview the facility failed to report Level II incidents within 72 hours of becoming aware of the incident affecting one of five clients (#1).

Review on 10/7/21 of the facility's Plan of Protection dated 10/7/21 submitted and written by

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the Administrator/Qualified Professional revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals /v109: All Qualified Professionals were retrained on population served, documentation, and incident reporting. This will be supervised monthly by an Administrative QP.
10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals /v110: All Paraprofessionals were retrained on population served, documentation, and CPR/First Aid; and monthly supervision will be maintained by an Administrative Qualified Professional.
10A NCAC 27G .0205 Assessment/Treatment/Habilitative Plan/v112: All QP's will be retrained on Person Centered Plan; and quarterly training will follow accordingly.
10A NCAC 27G .0202 Personnel Requirements/v108: All staffs were retrained on CPR & First Aid.
10A NCAC 27G .5602 Supervised Living for Alternative Family Living -Staff /v290: All staffs and Administrative Qualified Professionals were re-retrained on staff-client ratio.
10A NCAC 27G .0303 Location and Exterior Requirements /v736: A contractor is currently repairing all environmental needs; the Administrative QP will monitor and observe the environmental needs monthly.
10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366): The QP's were retrained on incident response requirement and proper investigation that incorporates causes, triggers, and interventions accordingly.
10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers

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(V367): the QP's were retrained on IRIS incident reporting requirement for behavioral and medical (Emergency Department visits that requires Physician treatment) incidents.
-Describe your plans to make sure the above happens.
All the aforementioned will be monitored monthly by an Administrative Qualified Professional."

Five clients (#1-#5) resided at the group home. The clients diagnoses ranged from Down's Syndrome, Intellectual Developmental Disability, Bipolar, Impulse Control Disorder and Autism Spectrum. Client #1 had a history of neuropathy in her feet, along with a history of falls.

Client #1 fell on four occasions between 5/27/21-8/27/21. The QPs were unaware of three falls that occurred in May, and consequently, did not develop or implement any interventions or strategies for the house staff to support client #1's use of the walker to prevent further falls. The QPs failure resulted in a fourth fall and significant physical injury to client #1.

The QP #2 worked at the agency for 1 year and was responsible for the direct supervision of the house management staff. She was not knowlegeable of process regarding staffing to provide clients' transportation to appointments, environmental living issues in the home, treatment planning and service delivery to facilitate a home like environment for clients #1-#5. The QP #1 worked at the agency for thirteen years and provided oversight and supervision over all the QP staff. Both the QP #1 and the QP #2 failed to maintain the client/staff ratio at the sister facility A or to communicate the needs of clients #1-#5 to the sister facility A staff.

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V 289	Continued From page 28 Systematically, these deficiencies constitute a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with	V 290		

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one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.
(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:
(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and
(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to have minimum staff-client ratios to meet the needs for 5 of 5 clients (#1-#5). The findings are:

Review between 9/9/21 and 9/23/21 of this facility's records revealed:

-Client #1
Admitted: 5/18/21
Diagnoses: Intellectual Developmental Disability (IDD), seizure disorder, anxiety, history of falls and headaches.

-Client #2
Admitted: 6/7/21
Diagnoses: Impulse Control Disorder, Bipolar disorder, moderate IDD, seizure disorder, overactive bladder, breast cancer survivor and

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V 290	Continued From page 30 osteoarthritis -Client #3 Admitted: 8/23/21 Diagnoses: Bipolar Disorder unspecified, and Mild IDD -Client #4 Admitted: 12/1/14 Diagnoses: Down Syndrome, Mental Retardation, Hypertension, Hyperlipidemia and Obstructive Sleep Apnea -Client #5 Admitted: 3/14/19 Diagnoses: Autism Spectrum and IDD Review on 9/10/21 of the sister facility A's client record revealed: -Client A11 Admitted: 7/2/15 Diagnoses: Schizophrenia, Obesity, Hypothyroidism Interview on 9/16/21, the Qualified Professional (QP) #2 reported the following about client A15 Admitted: 6/15/21 Diagnosis: Bipolar During interview on 9/9/21, staff #1 reported: -Group home operated 1 staff to 5 clients. -Staff worked alone on the shift. During interview on 9/9/21, clients #1, #2, #3, #4 and #5 verified: -Staff #2 left clients #1-#5, at the sister facility A from Friday morning-Friday evening after dinner -Client A12 and client A13 went to the day treatment program, client A14 went to the doctor	V 290		

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with Staff #2, leaving client A11 and client A15 at the sister facility A with clients #1-#5.
- Staff A22 was on duty. Staff A22 worked with all 7 clients.

During interview on 9/15/21, staff #2 reported:
-She provided transportation for clients at the the sister facility A
- The QP #2 was aware of her taking clients to the sister facility A and dropping them off there while she transported the sister facility A client to a doctor appointment

During interview on 9/14/21 staff A22 reported:
-Staff #1 brought clients #1-#5 to the sister facility while Staff #1 transported client A14 to a doctor appointment
-Management makes out the schedule for transportation for the clients

During interview on 9/16/21 the QP #2 reported:
-She supervised the staff of this facility and the sister facility
- She was not aware of clients #1-#5 being taken to the sister facility while staff #2 provided transportation for the sister facility clients
-She did not authorize staff #2 to take clients #1-#5 to the sister facility

During interviews between 9/22/21-10/5/21 the Administrator/QP reported:
-She was not aware that the sister facility was over census on 8/27/21
-She thought client A11 was at the day program on 8/27/21

*This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Developmental Disabilities -Scope (V289) for a Type A1 rule violation and must be corrected

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within 23 days.

V 366 27G .0603 Incident Response Requirments — V 366

10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS
(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:
(1) attending to the health and safety needs of individuals involved in the incident;
(2) determining the cause of the incident;
(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;
(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;
(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;
(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(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

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V 366	Continued From page 33 or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose 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	V 366		

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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 failed to develop and implement written policies governing their response to incidents as required.
The findings are:

Review of email responses between 9/13/21-9/30/21 from Division of Health Service Regulation (DHSR) staff to the Qualified Professional (QP) #1 and the Administrator/QP included but not limited to the following:
-9/17/21 at 10:38 AM DHSR request of information- "Client specific...Both addresses- Documentation of any investigations conducted

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between June 2021-present date if applicable." The QP #1 and the Administrator/QP were included on the email

- 9/23/21 at 7:18 AM DHSR response- Thanks for submitting the Plan of Protection on 9/22/21 at 11:35 PM.. "Any updates on when we should be anticipating the information you wanted us to look over. We will be looking for this information prior to 1:00 PM today....your internal investigation to include statements, notes, conclusion regarding the 8/27 fall" at Sister Facility A. Only the Administrator/QP was included on this email.

Review on 9/17/21 of a fax submitted on 9/17/21 revealed a handwritten "none" response to the request of any investigations between June 2021-present

Review on 9/30/21 of a fax submitted by the Administrator/(QP) of a narrative of client #1's 8/27/21 fall revealed:

-"Due to the current pandemic, treatment clinics are not allowing patients to be accompanied by more than one care giver. On Friday August 27, 2021, [staff #2] needed to assist another client with a scheduled treatment appointment.

It became necessary for staff to keep her other clients in another home owned and managed by the agency under the care of a equally trained staff who was familiar with the clients.

While at the other home, [staff A22], the staff at the other home reported that [client #1] was restless, verbally and physically aggressive towards her house mates. She refused to bring her walker into the house knowing very well that she has a tendency to fall. She refused to follow redirections by the supervising staff. In the

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process, she missed her steps, lost her balance and fell.

[Staff A22] notified [staff #2] immediately. [Staff #2], in turn called me and reported the incident/accident. I asked the following pertinent questions: Was she okay? Did she hit her head? Did the staff there have to call EMS (Emergency Management System). Responses from [staff #2] to these questions were negative.

Not long after that time, I received photos of injury that [client #1] had sustained as a result of the fall. They were sent to me by [name] (Sister/Legal Guardian to [client #1]). She had a laceration on her right eyebrow and broke her left knee.

I notified the staff to call EMS immediately, so [client #1] could be transported to the nearest emergency room for treatment.

She did as directed and client was transported to [Local satellite hospital].

I visited client at the hospital same day and several times before she was transferred to a rehabilitation facility on [road name], Raleigh for continuity of treatment and physical therapy.

In order to clarify some of the statements presented by [client #1] to her Sister/Legal Guardian. I visited the homes and interviewed staff and other clients.

[Client #3] stated that she did not pour water on the floor as claimed by [client #1]. That she maintained her distance and composure even when [client #1] was provoking her and constantly getting in her personal space.

Staff [A22] stated she went into her room to pick up the phone when the fall occurred and struggled to assist [client #1] with applying First Aid to the wounds on her as she refused to let her assess the extent of her injury to know what to do next.

[Client #1] informed staff that Morning, she

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only needs her walker when going for shopping. Reason why she refused to take her walker from the van into the other home.

It was an unfortunate accident and we hope that she recovers and get back on her feet soon."

-The QP #1's name was typed at the end of the Narrative

-Narrative was not dated.

-The above narrative did not provide the following required information of the fall nor staff A22's delay in attending to the health and safety needs of the client involved in the incident:

-determining the cause of the incident;

-developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;

-developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;

-assigning person(s) to be responsible for implementation of the corrections and preventive measures;

- maintaining documentation regarding the items referenced above.

Interviews between 10/4/21 and 10/5/21, the QP #1 reported he:

-Completed the above narrative/summary of events from client #1's fall on 8/27/21

-Completed the narrative/summary on 9/7/21. "I missed the date on the report."

-"wrote a report for the company. I wrote it up a week after the incident, about a week after I spoke with everyone."

- Concluded client #1 missed a step and fell, was not abused by anyone to cause the fall, no fluid on the floor. Client #1 refused to take the walker inside the group home. Client #1 said she only used the walker for outings. Client #1 was

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aggressive and missed step moving towards another client who had not done anything to her.

Interviews between 9/9/21 and 9/30/21 the Administrator/QP reported:
-The QP #1 or the QP #2 would have completed incident reports in IRIS (incident reporting improvement system) regarding the 8/27/21 fall that involved client #1 at sister facility A.
-The narrative of client #1's fall was an "investigation" conducted by QP #1
-The QP #1 must have misunderstood and thought the term "investigation: meant police involvement"
-She submitted the narrative on 9/22/21 or 9/23/21 via fax to DHSR. She was not aware until 9/30/21 the narrative and a few other documents were not received.

This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Developmental Disabilities -Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.

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27G .0604 Incident Reporting Requirements

10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS
(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where

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V 367	Continued From page 39 services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-866	A. BUILDING: ______ B. WING ______	R 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 367	Continued From page 40 providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to report Level II incidents within 72 hours	V 367		

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V 367	Continued From page 41 of becoming aware of the incident affecting one of five clients (#1). The findings are: Review on 9/9/21 of Client #1's record revealed: -Admitted: 5/18/21 -Diagnoses: Intellectual Developmental Disability (IDD), Seizure Disorder, Anxiety, History of falls and Headaches Review on 10/4/21 of local hospital records dated 5/27/21-5/31/21 revealed: -Admitted: 5/27/21 -Discharged: 5/31/21 -Client #1 was seen in the Emergency Room (ER) for assessment after 3 falls -Client #1 reported to ER staff that she had fallen twice the night before on 5/26/21 and once the morning of 5/27/21 Review on 10/4/21 of the Incident Reporting Information System revealed: -No entries submitted for the 5/26/21 or 5/27/21 falls Interview on 10/05/21 the Qualified Professional #2 reported: -She was not aware of the incident, and did not complete an incident report This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Developmental Disabilities -Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 736	Continued From page 42	V 736		

(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 record review, interview and observation, the facility failed to ensure the home was maintained in a clean, safe, orderly and attractive manner. The findings are:

Review on 9/9/21 of the facility's public file maintained by the Division of Health Service Regulation revealed the following:
-2/12/20 Statement of deficiency report listed environmental citations that included
Third Bedroom: door damaged, light switch broken
Fourth Bedroom: hole in the door
Hallway bathroom: ceiling peeling

Review on 9/30/21 of a fax dated 9/30/21 submitted by the Administrator/Qualified Professional (QP) revealed the following:
-An invoice for the 8600 Neuse Hunter Drive address. Pricing to repaint interior of home and repairing/changing of flooring noted.
-No date or signature noted on the invoice

Observation on 9/9/21 between 6:00 PM -6:40 PM revealed:
-Hardwood flooring tiles separated leaving gaps and tiles peeling throughout the home (living room, hallway near client bedrooms, client #5's bedroom)
-Living room:

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V 736	Continued From page 43	V 736		

piece of duct tape an estimated 2 cm in length noted in the middle of the floor
-Main Hallway:
several scratches on the wall estimated 1-2 feet in length
-Client #2's Bedroom:
cluttered lots of items packed throughout
scratch on the wall estimated 1 foot in length
-Laundry room/hallway:
6 pieces of duct tape noted where hardwood flooring and laminate flooring for laundry room meet
-Client #5's Bedroom that include master bathroom:
bathroom (sink cabinet door paint peeling, 2 vanity light bulbs blown, paint peeling near shower)
-Hallway Bathroom shared by all clients
vent rusted
paint peeling near overhead shower
-Client #3's bedroom
cut in door extended from the door knob to midway the door
clothes, trash noted throughout room on floor
paint peeling on wall
-Client #1's bedroom/Fourth bedroom:
hole in door covered by white piece of tape
-Client #4's bedroom/Third bedroom:
door damaged, light switch cracked

Interview on 9/9/21 clients #2-#5 reported they were not sure how long the flooring had been separated, duct tape had been on the floor, paint had been peeling, light bulb had been blown.

Interview on 9/16/21, the QP #2 reported:
-She visited at the home at least weekly

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V 736	Continued From page 44	V 736		

-She was aware of client #2's bedroom clutter. Staff would assist with straightening it up, and client #2 would mess it back up the next or same day.
-Prior to this interview, she had not noticed nor was she aware of the environmental issues noted

Interview on 9/22/21, the Administrator/QP reported:
-Prior to 9/9/21, she had been in the process of purchasing the home. Initially, she negotiated with the previous owner of repairs needed. She did not want to have items repaired if the clients would have been required to move. As of 9/14/21, she had purchased the home.
-As part of the purchase process, she had secured an estimate to make repairs to the home. She indicated she would provide Division of Health Service Regulation the required documents by 12 noon on 9/23/21.

This deficiency constitutes a re-cited deficiency.

This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Developmental Disabilities -Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.