STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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, complaint and follow up survey was completed on October 21, 2021. One complaint was substantiated (#NC00181445) and one complaint was unsubstantiated (#NC00182344). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		
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	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 109	Continued From page 1	V 109		

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.

This Rule is not met as evidenced by:
Based on record review, observation and interview the Qualified Professional (QP)/Director (D)/Manager (M) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are:

Refer to V110 regarding ensuring staff competency.
-Deceased Client #4 (DC #4) left the facility on 10/13/21 in the middle of the night and was hit by a vehicle and killed.
-Staff #1 was in contact with the QP/D/M through text messages to inform her of the behaviors of DC #4 after returning from the hospital up until DC #4 went to her room.
-Staff #1 went to bed at approximately 12:00am and did a last bed check at approximately 2:30am and did not do any more bed checks the rest of the evening.
-DC #4 had been in escalating behaviors the entire evening having erratic behaviors that were not normal for DC #4.
-Staff #1 did not know DC #4 had left the facility in the middle of the night.
-The QP/D/M did not respond or assist in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 109	Continued From page 2 de-escalating DC #4's behaviors that continued after she was released from the hospital throughout the evening. Refer to V112 regarding not following DC #4's Crisis Prevention and Intervention Plan. -DC #4's Crisis Prevention and Intervention Plan revealed to call the guardian to assist if DC #4 was in behaviors or crisis. -The QP/D/M made one contact with the guardian earlier in the day to inform her that DC #4 was home from the hospital and that she was unsure if DC #4 would take her medications. -No further contact was made to the guardian about DC #4's escalating behaviors including knocking the television over, threatening staff and clients and urinating on herself. Refer to V118 regarding the medication administration record (MAR) errors, Physician orders and not administering the medication as ordered. -Client #1-#3's October 2021 MARs had numerous blanks. -Medications were not in the home and it was difficult to determine if the clients were receiving the medications as ordered. -Physician orders were not present and the MARs did not match Physician orders. -The QP/D/M was responsible for maintaing the medication and the MARs in the home. Refer to V119 for not properly disposing of medications. -Observation revealed several bags of medication in bubble packs with medication still present in each bubble in a closet that was not locked. -Several of the medications were expired and were from clients that were no longer residing at the facility.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 109	Continued From page 3 -The QP/D/M was responsible for making sure the medications were properly dispensed and removed from the facility. Refer to V120 for the proper storage of medications. -Observation during the walk thru of the facility revealed medication in the refrigerator that was not in a separate container and not locked. -The medication was stored in the same refrigerator of the food the clients ate. Refer to V121 for not completing the drug regimen reviews every 6 months. -Clients #1-3 did not have a drug regimen completed since November of 2020. Refer to V291 for not coordinating with outside professionals for client treatment. -Client #2 and Client #3 both had Department of Social Services (DSS) appointed legal guardians. -The consents for receiving the COVID vaccine were not given by the guardians for the clients to receive the vaccination. -Client #2 and Client #3 did receive the COVID vaccine without guardian consent. Refer to V366 for failing to document their response to a Level III incident. -DC #4 was blind and left the facility in the middle of the night without staff knowledge and was struck by a vehicle and killed. -Staff #1 was unaware DC #4 was not in the facility at the time of the incident. Refer to V367 for not completing a Level III incident report. -DC #4 left the facility on 10/13/21 in the middle of the night and was struck by a vehicle and was killed.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 109	Continued From page 4	V 109		

-The QP/D/M completed an in-house Level I incident report but did not complete a Level III incident report of the death of DC #4.

During interviews on 10/20/21 and 10/21/21 the QP/D/M revealed:
- She contacted DC #4's Guardian on 10/12/21 at 1:07 pm to notify her about DC #4's discharge from the hospital.
- DC #4's behaviors upon her return from the hospital were not typical for her.
- Contacting DC #4's guardian was an intervention in DC #4's Crisis Prevention and Intervention Plan.
- She did not see the need to contact DC #4's Guardian again because DC #4 was having "periods of calming down" on the evening of the incident.
- "We did an incident report," but she did not submit a level III incident report regarding DC #4's elopement and death.
- She was aware of the requirement for medications to be documented on the MAR immediately after being administered, but confirmed there were blanks on the MARs; "If it's not documented, it's not done."
- Storage of discontinued, expired, and discharged clients' medications in the unlocked attic on the stairs was "on me. When they send the new meds (medications) I'm too quick to pull it out. But now I use all of them until all the pills are gone."
- Discontinued, expired, and discharged clients' medications were stored in the unlocked attic on the stairs for "at least 6 months" because the pharmacy would not accept them for disposal."

This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ____ B. WING ____	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 109	Continued From page 5 Neglect or Exploitation (V512) 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; (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.	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 110	Continued From page 6	V 110		

This Rule is not met as evidenced by:
Based on record reviews and interviews 2 of 3 staff (#1 and #2) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:

Review on 10/20/21 of staff #1's record revealed:
-Hire date 11/25/20.
-Residential Care Specialist.

Review on 10/20/21 of staff #2's record revealed:
-Job Description Residential Care Specialist/Transportation with hire date of 12/20/19.
-The DHSR Client/Census form filled out by the Qualified Professional (QP)/Director (D)/Manager(M) had staff #2 listed as "Transportation."

During the entrance of the survey on 10/20/21 at approximately 9:30am staff #2 was not present. The QP/D/M called staff #2 to inform him of the survey. Approximately 1 hour later staff #2 arrived at the facility. During the exit of the survey on 10/21/21 at approximately 4:00pm staff #2 and the QP/D/M were present. During the exit staff #2 revealed the job description that was reviewed was an old job description and he would send the new job description. The new job description was never sent by the end of the survey.

Review on 10/20/21 of Deceased Client (DC) #4's record revealed:
-37 year old female.
-Admission date of 06/18/20.
-Date of death 10/13/21.
-Diagnoses of Schizoaffective Disorder, Bipolar Type, Type II Diabetes Mellitus, Hypertension,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 110	Continued From page 7	V 110		

Asthma, Hypothyroidism, Obesity, and Visual Impairment/ Glaucoma, and Blind.

Review on 10/19/21 of the Division of Motor Vehicles report (police report) dated 10/13/2021 at 4:52am revealed:
"-Narrative: Unit 1 (DC #4) was traveling west on [Road]. Vehicle 2 was traveling east on [Road]. The front left of vehicle 2 struck unit 1 due to unit 1 being in the travel lane of vehicle 2. Unit 1 came to rest on the west bound shoulder after impact. Vehicle 2 moved to the shoulder after impact and reported collision.
-Note: Unit 1 was blind."

Review on 10/19/21 of the facility's incident/accident report dated 10/17/21 sent to Division of Health Service Regulation (DHSR) revealed:
"-[QP/D/M] Preparing
[Staff #1] Staff First person to learn of Death and received report from Highway Patrol
Time of report 6:00am
[Deceased Client #4]...
Circumstances of death
Place: [Address of accident]
Date and time death was discovered: 10/13/21 before 5am
Physical location and cause: On roadside of [Address] hit by a truck. No restraints were used at or prior to death. Walked out into ongoing traffic."

Review on 10/19/21 of the facility's Accident/Incident report dated 10/13/21 and completed by the QP/D/M revealed:
"-Name of Resident: [DC #4]
Date/Time of Accident/Incident: 10/13/21
Date/Time of Notification of Responsible Person:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 110	Continued From page 8	V 110		

10/13/21 6:00am
Date Report Filed: 11/17/21
Person Filing Report: [QP/D/M]
Describe in detail the accident/incident, degree of injury, and plan of treatment:
Resident was picked up at [Local Hospital] around 12 noon on 10/12/21 after being admitted for behavior issues. Hospital removed all prior medications both medical and mental with alternate changes. Upon returning resident was having outburst of vocal threatening toward staff and housemates. Physician called both medical and mental appts (appointments) scheduled for the following week. Resident was experiencing times of calm down after outburst and went to her room around 1:30am on 10/13/21. Round made on residents at 3:30am and she was in room. Resident left without noise before next round ending in vehicle fatality."

Review on 10/20/21 of the facility's "Resident Census Check" for October 2021 revealed:
-Client #1-Client #3 and DC #4's names were written on separate lines.
-Each client had a check mark by each day of the month from 10/1/21-10/14/21 except for DC #4.
-DC #4 had a H (hospital) with a circle around the dates from 10/01/21-10/11/21.
-On October 12, 2021 a staff had written the times 1:30 and 3:30 in the block to indicate that was when DC #4 had a bed check completed.
-On October 13, 2021 deceased was hand written.

During interview on 10/21/21 staff #1 revealed:
-She had worked at the facility for approximately a year.
-She worked 7 days on and 7 days off.
-DC #4 was her favorite client.
-DC #4 was blind.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 110	Continued From page 9 -DC #4 had never left the house or tried to walk outside by herself due to her blindness. -DC #4 had just returned from the hospital and staff #2 was at the facility because he had brought her back from the hospital. -She told DC #4 welcome home and DC #4 did not respond to her. -DC #4 gave the middle finger to client #1. -She told staff #2 to take DC #4 back to the hospital. -Staff #2 explained that all of DC #4's medications had been discontinued at the hospital. -DC #4 cursed at her when asked if she wanted to eat dinner. -DC #4 stood up and "came at" her aggressively. -Staff #2 was able to calm DC #4 down and he left. -DC #4 urinated on herself, knocked the television off of the table and threatened her. -DC #4 "acted like we were poison to her." -DC #4 kept opening and closing the front door, but she never went out. -She sent text messages to the Qualified Professional/Director/Manager(QP/D/M) and Staff #2 about DC #4's atypical behaviors. -At approximately 10:30 pm DC #4 opened the door; she asked DC #4 where she was going and DC #4 responded "Anywhere I want to go." - DC #4 slammed the back door but did not go outside; she went to her room at about 11:30 pm. - Staff #1 did bed checks, locked the front and back doors and went to bed at about midnight; at 2:30 am she did another bed check and found DC #4 asleep. - She did not do another bed check until approximately 5:30 am. - At approximately 4:30 am she saw flashing lights from emergency vehicles down the road. - She "peeped" in DC #4's bedroom and thought	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 110	Continued From page 10	V 110		

she saw her in bed.
- At around 6:15 am she heard someone talking outside; when she went out the front door to investigate, she saw Law Enforcement Officers.
- She told the Officers that "all my people were here."
- The Officers showed her a photo of DC #4.
- She went into DC #4's bedroom and found that she was not there.
- Both the front and back doors were locked when she went outside to speak with the Officers.
- She texted the QP/D/M and staff #2 "2 or 3 times that night" about DC #4's behaviors.
- She did not complete any reports regarding the incident; the QP/D/M and staff #2 were "getting it (information for the police report) together," then she and staff #2 "sat down to make sure he had it all."
- She had never seen nor filled out a "Resident Census Check" form.

During interview on 10/20/21 the State Highway Patrol officer that arrived at the scene of the incident revealed:
-He and a co-worker did the death notification at the facility an hour after the incident.
-Staff #1 answered the door.
-He asked the staff if they were missing any clients and the staff asked why he was asking.
-He showed the staff a picture of the deceased female and the staff stated the DC #4's name and confirmed she was a resident of the facility.
-The staff told him she was having trouble the day before.
-The staff stated she went to bed and she heard a door slam but thought DC #4 was just slamming doors.
-The staff called someone to inform them of the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 110	Continued From page 11	V 110		

During interview on 10/21/21 staff #2 revealed:
-He picked DC #4 up from the hospital and transported her back to the facility on 10/12/21.
-DC #4 acted happy and stable when they left the hospital.
-When they arrived back to the facility staff #1 said something to her and DC #4 began cursing.
-He was called by staff #1 at approximately 6:00pm that evening about DC #4's behaviors and that DC #4 had knocked over the television.
-He went back to the facility to help her calm down.
-DC #4 did not express why she was angry and he assisted her in changing her clothes.
-He did not think DC #4 was in "crisis" because her "behaviors weren't ongoing" and she "was not in a threatening position."
-He left the facility and was called the next morning at approximately 6:00am when the QP/D/M informed him of the accident.

During interview on 10/20/21 the QP/D/M revealed:
-She became full-time staff at the facility in June 2020.
-Staff #1 called her at approximately 6:24am and informed her DC #4 was hit by a car and she was dead at the scene and the state troopers were still at the facility.
-Bed checks at night are done at 10pm and 6am.
-If a client is sick or having a hard time emotionally then bed checks are done every 2 to 4 hours.
-She was not working on 10/12/21.
-DC #4 was not able to go out any windows.
-DC #4 could not have gone out the front door because the staff bedroom was right beside the front door and staff #1 would have seen her or heard her.
-They only guessed DC #4 went out the back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 110	Continued From page 12 door which was also locked. -DC #4 would have never tried to leave without staff. -DC#4 was always nervous about being outside without staff because she was blind. -DC #4 had never left the facility before without staff. -Staff #1 told her she never heard a door or anything open during the night. -DC #4 was discharged from the hospital on 10/12/21. -When DC #4 arrived back to the facility she "flipped the bird" to client #1. -DC #4 was argumentative verbally threatening to staff and the other residents. -DC #4 would calm down and then she would get upset all over again. -Staff #1 contacted her on and off throughout the evening. -When staff #1 would call she could hear DC #4 in the background yelling. -She completed the police statement because staff #1 was very shaken up. -DC #4 was always pleasant and smiled a lot and spoke in a even tone. -The Resident Census form had times instead of check marks because she was having to be watched so closely because something was going on with her. This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) 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	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 112	Continued From page 13	V 112		

10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN
(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.
(d) The plan shall include:
(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;
(2) strategies;
(3) staff responsible;
(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;
(5) basis for evaluation or assessment of outcome achievement; and
(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to implement strategies based on behaviors affecting 1 of 1 deceased client (DC #4). The findings are:

Review on 10/20/21 of DC #4's record revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 112	Continued From page 14	V 112		

-37 year old female.
-Admission date of 06/18/20.
-Date of death 10/13/21.
-Diagnoses of Schizoaffective Disorder, Bipolar Type, Type II Diabetes Mellitus, Hypertension, Asthma, Hypothyroidism, Obesity, and Visual Impairment/ Glaucoma, and Blind.

Review on 10/20/21 of DC #4's Person-Centered Profile dated 06/05/21 revealed:
-"Crisis Prevention and Intervention Plan:
-Crisis prevention and early intervention strategies that were effective. Staff must encourage her to use her coping skills. It is important to talk to [DC #4] to let her know that she is liked and that she is safe. It is also important for [DC #4] and express her feelings and talk to her family you need to talk to her in a calm manner.
-Describe the systems prevention and intervention back-up protocols to support the individual. The staff on site is especially important because they know [DC #4] Contact her guardian [Guardian] any first responder and local police dept. Therapist [Therapist]."

During interview on 10/19/21 the legal guardian for DC #4 revealed:
-DC #4 had been in and out of the hospital due to her mental status.
-DC #4 had just been released back to the facility from the hospital on the day of the accident.
-She received a text from the Qualified Professional (QP)/Manager (M)/Director (D) at approximately 1pm on 10/12/21 stating DC #4 was back at the facility and she was not sure if DC #4 was going to take her medications.
-She told the staff to contact 911 if she refused her medications.
-She did not hear anything else from the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 112	Continued From page 15	V 112		

that day.
-The next phone call she received was from the police telling her her sister was hit by a vehicle and killed.
-The "owner" (staff #2) of the facility called her the next morning at approximately 9:00am.
-Staff #2 told her DC #4 was argumentative and upset and maybe that was why she left the facility.
-The only thing staff #2 told her was he was sorry and that he was going to get counselors in the facility for the other clients.
-She told staff #2 "that was not going to bring my sister back."

During interview on 10/20/21 and 10/21/21 the QP/M/D revealed:
-Staff #1 contacted her throughout the evening of 10/12/21 due to DC #4's behaviors.
-Each time staff #1 contacted her she could hear DC #4 in the background.
- She texted DC #4's Guardian on 10/12/21 at 1:07 pm to notify her about DC #4's discharge from the hospital and about her behaviors.
- Contacting DC #4's Guardian was an intervention in DC #4's Crisis Prevention and Intervention Plan.
- She did not see the need to contact DC #4's Guardian again because DC #4 was having "periods of calming down" that evening.
-Staff #2 went to the facility to speak with DC #4.
-DC #4 would get upset then calm down and then get upset and then calm down.
-The police contacted the guardian and staff #2 called the guardian after the incident.

This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 112	Continued From page 16 Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: Review on 10/20/21 of the facility's fire and disaster drill documentation October 2020-October 2021 revealed: - No disaster drills documented January - October 2021. - No "2nd shift" fire drills documented for the third quarter (July - September) 2021. - No fire or disaster drills documented for the fourth quarter (October - December) 2020.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 114 | V 114

Continued From page 17

During interview on 10/20/21 client #1 revealed:
-She had lived at the facility since 2016.
-She had done fire and disaster drills but it had been a long time.

During interview on 10/20/21 client #2 revealed:
-She had lived at the facility for 2 years.
-She had not done a fire or disaster drill.

During interview on 10/20/21 client #3 stated:
- She had lived at the facility for "5 or 6 years."
- She participated in one or two fire drills.

During interview on 10/21/21 staff #1 stated:
- She had worked at the facility for about one year.
- She worked seven days on and seven days off at the facility.
- She had done one fire drill during her employment, but "our ladies know how to get out the door."

During interview on 10/21/1 the Qualified Professional/Director/Manager stated she understood the requirement to have fire and disaster drills quarterly and repeated on each shift.

This deficiency has been cited 3 times since the original cite on 2/18/19 and must be corrected within 30 days.

V 118 | V 118

27G .0209 (C) Medication Requirements

10A NCAC 27G .0209 MEDICATION REQUIREMENTS
(c) Medication administration:
(1) Prescription or non-prescription drugs shall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 18	V 118		

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.

This Rule is not met as evidenced by:
Based on record reviews, interviews and observations, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting 3 of 3 clients (#1, #2, and #3) and 1 of 1 deceased client (DC #4). The findings are:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 19 Cross Reference: 10A NCAC 27G .0209(d) Medication Requirements (V119). Based on observation and interview the facility failed to dispose of prescription medications in a manner that guards against diversion or accidental ingestion affecting 3 of 3 clients (#1, #2, and #3) and 1 of 1 deceased client (DC) (DC #4). Cross Reference: 10A NCAC 27G .0209(e) Medication Requirements (V120). Based on observations and interviews the facility failed to store medications in a refrigerator used for food items in a separate locked container. Cross Reference: 10A NCAC 27G .0209(f) Medication Requirements (V121). Based on record reviews, observations, and interviews the facility failed to obtain drug regimen reviews for 3 of 3 clients (#1, #2, and #3) who received psychotropic medications. Finding #1 Review on 10/20/21 of client #1's record revealed: -48 year old female. -Admission date of 02/16/16. -Diagnoses of Schizoaffective Disorder, Borderline Personality Disorder, Crohn's Disease, and Restless Leg Syndrome. Review on 10/20/21 of client #1's Physician orders revealed: 01/20/21 -Metoprolol Succinate ER 25mg (milligrams) (angina (chest pain) and hypertension) Take 1 tablet by mouth daily. -Atorvastatin 20mg (high cholesterol) Take 1 tablet by mouth at bedtime.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 20 -Baclofen 20mg (muscle pain, spasms, and stiffness) Take 1 tablet by mouth at bedtime. -Humira Pen 40mg/0.8 Kit (inflammatory conditions) Inject 0.8ml subcutaneously every two weeks. 09/18/20 -Levothyroxine 50mcg (hypothyroidism) Take 1 tablet by mouth daily. 10/06/20 -Vitamin C 500mg (supplement) Take 1 tablet by mouth every day. 07/06/20 -Pantoprazole Sodium Dr 40mg (erosive esophagitis) Take 1 tablet by mouth daily. -Famotidine 20mg (ulcers in the stomach) Take 1 tablet by mouth twice a day. 02/03/21 -Quetiapine Fumarate 100mg (schizophrenia) Take 2 tablets by mouth at bedtime. 11/04/20 -Buspirone Hcl 15mg (anxiety) Take 1 tablet by mouth twice daily. 05/31/21 -Nystatin 100000 cream (skin infections) Apply to affected area topically twice a day. -No Physician orders for furosemide 40mg (fluid retention) Take 1 tablet by mouth daily, potassium chloride ER 10 Meq (milliequivalent) (supplement) Take 1 capsule by mouth daily, ferrous sulfate 325mg (iron deficiency anemia) Take 1 tablet by mouth daily, stool softener (constipation) Take 1 tablet by mouth every day for 20 days, paroxetine HCL 10mg (antidepressant) Take 1 tablet by mouth every morning, doxepin 10mg (antidepressant) Take 1 capsule by mouth at bedtime, clozapine 200mg (schizophrenia) Take 1 tablet by mouth every morning and take 3 tablets by mouth at bedtime as documented on the MAR.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ____ B. WING ____	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	**1335 LASSISTER ROAD FOUR OAKS, NC 27524**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 21	V 118		

Review on 10/20/21 of client #1's August-October 2021 MARs revealed the following blanks, indicating the medications were not administered:
-Furosemide 40mg-10/09/21-10/20/21, 09/01/21-09/10/21, 09/25/21-09/30/21.
-Humira Pen 40mg-10/15/21.
-Levothyroxine 50mcg- 10/01/21-10/20/21.
-Potassium Cl Er 10 Meq-10/01/21-10/20/21, 09/01/21-09/10/21, 09/25/21-09/30/21.
-Vitamin D2 1.25mg-10/11/21, 10/14/21, 10/18/21.
-Vitamin C 500mg-10/09/21-10/20/21.
-Ferrous Sulfate 325mg-10/09/21-10/20/21.
-Stool Softner-10/01/21-10/20/21.
-Metoprolol Succ Er 25mg-10/01/21-10/20/21.
-Pantoprazole SOD Dr 40mg-10/01/21-10/20/21.
-Paroxetine HCL 10mg-10/01/21-10/20/21.
-Ropinirole 0.5mg-10/01/21-10/20/21.
-Melatonin 5mg-10/01/21-10/19/21.
-Atorvastatin 20mg-10/01/21-10/19/21.
-Baclofen 20mg-10/01/21-10/19/21.
-Doxepin 10mg-10/01/21-10/19/21.
-Quetiapine Fumarate 100mg-10/01/21-10/19/21.
-Buspirone Hcl 15mg-10/01/21-10/20/21.
-Clozapine 200mg-10/01/21-10/20/21.
-Famotidine 20mg-10/01/21-10/20/21, 08/01/21-08/05/21.
-Nystatin 100000 cream-10/01/21-10/20/21.

Observation on 10/20/21 at 10:37 am of client #1's medications on hand and review of client #1's August - October 2021 MARs and Physician's orders revealed:
-Label and MAR for Vitamin D2 1.25mg Take 1 capsule by mouth twice daily. The Physician order dated 01/20/21 revealed Take 1 capsule by mouth twice a week.
-Label and MAR for ropinirole 0.5mg Take 1 tablet by mouth every morning. The Physician order dated 05/21/21 revealed 0.25 Take 1 tablet by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 22	V 118		

Continued From page 22

mouth at bedtime.
-Label and MAR for Melatonin 5mg Take 2 by mouth every day at bedtime. The Physician order dated 01/20/21 revealed Take 1 by mouth at bedtime.

During interview on 10/20/21 client #1 revealed:
-She had lived at the group home since 2016.
-She took her medications every day.

Finding #2
Review on 10/20/21 of client #2's record revealed:
- 48 year old admitted 6/29/20.
- Diagnoses included Major Depressive Disorder, Seizure Disorder, and Neurological Disorder.

Review on 10/20/21 of client #2's Physician orders revealed:
6/09/21
- Citalopram (anti-depressant) 2 mg 1 tablet every morning.
- Magnesium oxide (dietary supplement to treat constipation) 400 mg 1 tablet daily.
- Famotidine (antacid) 20 mg 1 tablet daily,
- Pantoprazole (gastroesophageal reflux disease) 40 mg 1 tablet 30 minutes before breakfast.
- Vitamin B-12 (dietary supplement) 100 micrograms (mcg) 1 tablet daily.
- Vitamin D3 (dietary supplement) 1000 units 1 capsule daily.
- Atorvastatin (high cholesterol) 20 mg 1 table daily.
- Melatonin (promotes sleep) 5 mg 1 tablet nightly 30 minutes before bedtime.
- Levetiracetam (anti-convulsant) 750 mg 2 tablets twice daily.
- Mirtazapine (anti-depressant) 15 mg 1 tablet twice daily.
- Vimpat (anti-convulsant) 100 mg 1 tablet twice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	**1335 LASSISTER ROAD FOUR OAKS, NC 27524**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 23 daily. - Divalproex (anti-convulsant) 250 mg 2 tablets twice daily. - LDR-vitamin B1 (dietary supplement) 100 mg 1 tablet daily. 8/24/21 - Meloxicam (anti-inflammatory) 7.5 mg 1 tablet twice daily. Review on 10/20/21 of client #2's August - October 2021 MARs revealed the following blanks indicating the medications were not administered: - Citalopram 2 mg 10/09/21 - 10/20/21. - Magnesium Oxide 400 mg 10/09/21 - 10/20/21. - Famotidine 20 mg 10/09/21 - 10/20/21. - Pantoprazole 40 mg 10/09/21 - 10/20/21. - Vitamin B12 100 mcg 10/09/21 - 10/20/21. - Vitamin D3 1000 units 10/09/21 - 10/20/21. - Atorvastatin 20 mg 10/09/21 - 10/20/21. - Melatonin 5 mg 10/09/21 - 10/20/21. - Levetiracetam 750 mg 10/09/21 - 10/20/21. - Mirtazapine 15 mg 10/09/21 - 10/20/21. - Vimpat 100 mg 10/09/21 - 10/20/21. - Divalproex 250 mg 10/09/21 - 10/20/21. - LDR-vitamin B1 100 mg 10/09/21 - 10/20/21. - Meloxicam 7.5 mg 10/09/21 - 10/20/21. Observation on 10/20/21 at 12:00 pm of client #2's medications on hand revealed: - No citalopram was available. - No mirtazapine was available. During interview on 10/20/21 client #2 revealed: -She took her medications every day twice a day. -She had never missed her medications. Finding #3 Review on 10/20/21 of client #3's record revealed:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 24	V 118		

- 32 year old admitted 1/01/16.
- Diagnoses included Depression, Bi-Polar Disorder, and Generalized Anxiety.

Review on 10/20/21 of client #3's Physician orders revealed:
9/22/21
- Benztropine (side effects of other drugs) 0.5 mg 1 tablet every evening.
8/18/21
- Paliperidone (anti-psychotic) 6 mg 1 tablet nightly.
4/13/21
- Quetiapine (anti-psychotic) 25 mg 1 tablet daily.
2/08/21
- Calcium D (dietary supplement) 600 mg 1 tablet daily.
12/03/20
- Quetiapine 100 mg 1 tablet daily.
8/31/20
- Lisinopril (high blood pressure) 20 mg 1 tablet twice daily.
- Fluoxetine (anti-depressant) 40 mg 1 capsule daily.
- Tri-Lo-Sprintec (birth control) 1 tablet daily.
- Cetirizine (antihistamine) 10 mg 1 tablet at bedtime.
1/20/20
- Vitamin D3 (dietary supplement) 5000 units 1 tablet daily.

Review on 10/20/21 of client #3's August - October 2021 MARs revealed the following blanks:
- Benztropine 0.5 mg 10/01/21 - 10/20/21.
- Paliperidone 6 mg 10/01/21 - 10/20/21.
- Quetiapine 25 mg 10/01/21 - 10/20/21.
- Calcium D 600 mg 10/01/21 - 10/20/21.
- Quetiapine 100 mg 10/01/21 - 10/20/21.
- Lisinopril 20 mg 10/01/21 - 10/20/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 25	V 118		

- Fluoxetine 40 mg 10/01/21 - 10/20/21.
- Tri-Lo-Sprintec 10/01/21 - 10/20/21.
- Cetirizine 10 mg 10/01/21 - 10/20/21.
- Vitamin D3 5000 units 10/01/21 - 10/20/21.

Observation on 10/20/21 at 12:20 pm of client #3's medications on hand revealed no paliperidone was available.

During interview on 10/20/21 client #3 revealed:
-She took her medications daily with staff assistance.

Finding #4
Review on 10/20/21 of DC #4's record revealed:
-37 year old female.
-Admission date of 06/18/20.
-Date of death 10/13/21.
-Diagnoses of Schizoaffective Disorder, Bipolar Type, Type II Diabetes Mellitus, Hypertension, Asthma, Hypothyroidism, Obesity, and Visual Impairment/ Glaucoma, Blind.

Review on 10/21/21 of DC #4's FL2 dated and signed by Physician on 08/31/20 revealed:
-Perphenazine 16mg (anti-psychotic) Take 1 tablet by mouth nightly.
-Ferrous Fumarate 324mg(iron deficiency anemia) Take 1 tablet by mouth twice daily.
-Meloxicam 7.5mg (anti-inflammatory) Take 1 tablet by mouth twice daily.
-Simbrinza 0.2-1% 8ml (open-angle glaucoma or ocular hypertension) Instill one drop three times daily in each eye.

Review on 10/20/21 of DC #4's After Visit Summary from the behavioral health unit at the hospital revealed DC #4 was in the hospital from 09/14/21-10/12/21 "Worsening psychosis and agitation."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 26	V 118		

Review on 10/20/21 of DC #4's September 2021 MAR revealed:
-Perphenazine 16mg, Ferrous Fumarate 324mg, Meloxicam 7.5mg and Simbrinza 0.2-1% had initials from 9/23/21-09/30/21 to indicate the medications were administered.
-DC #4 was in the hospital at the time the initials were transcribed on the MAR.

During interview on 10/20/21 the Qualified Professional/Director/Manager (QP/D/M) stated:
- Client #2 took the last of her citalopram and mirtazapine on 10/19/21 and the bubble cards were thrown away.
- Client #3 took the last of her paliperidone on 10/19/21 and the bubble card was thrown away.
- "If it's not documented, it's not done."
- She understood the requirement for medication administration to be documented immediately.

Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the Physician.

Review on 10/21/21 of the Plan of Protection completed by the QP/D/M dated 10/21/21 revealed:
"-What immediate action will the facility take to ensure the safety of the consumers in your care? Drugs that were still in the home has already been disposed of on 10/20/21. Further meds will be completed before opening new meds. MAR's will be signed and checked from shift to shift and med reviews will be monitored every 6 months for guidelines.
-Describe your plans to make sure the above happens. Meds will remain in the medication room under lock and key. Also a lock box to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 27	V 118		

properly store refrid (refrigerated) meds."

Clients #1, #2, #3, and deceased client #4 had diagnoses that included Schizoaffective Disorder, Borderline Personality Disorder, Major Depressive Disorder, Neurological Disorder, Bi-Polar Disorder, Generalized Anxiety, Crohn's Disease, Seizure Disorder, Type II Diabetes, Hypertension, Hypothyroidism, and visual impairment/blindness. Each client was prescribed psychotropic medications and medications for their physical diagnoses. Reviews of each clients' MARs revealed significant periods of time, ranging from 1 day to 20 days, during which medication administration was not documented. The QP/D/M could not provide Physicians' orders for seven medications documented on client #1's MARs. The pharmacy label and the MAR transcriptions did not match the Physicians' orders for three of client #1's medications. Two of client #2's medications and one of client #3's medications were not available at the facility. The facility stored discontinued and expired medications, as well as medications prescribed to discharged clients, in approximately 20 bags on the unsecured attic stairway. Medication used to treat client #1's Crohn's Disease was stored, unsecured, in the kitchen refrigerator. Drug regimen reviews had not been completed for any client since November 2020. The failures of the facility to accurately document the administration of medications, maintain copies of Physicians' orders, to properly dispose of medications in a manner to prevent diversion, to securely store refrigerated medications and to obtain drug regimen reviews every six months constitutes serious neglect. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ____ B. WING ____	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 28 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 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 119	Continued From page 29 This Rule is not met as evidenced by: Based on observation and interview the facility failed to dispose of prescription medications in a manner that guards against diversion or accidental ingestion affecting 3 of 3 clients (#1, #2, and #3) and 1 of 1 deceased client (DC) (DC #4). The findings are: Observation on 10/20/21 at approximately 1:15 pm revealed: - An unlocked attic door beside the staff bedroom in the foyer. - Approximately 20 paper and plastic bags stacked on the attic stairs. - The bags included white paper bags labeled "Seizure Meds (Medications)," "Stomach," "Clozapine," "Melatonin," and "Seroquel," a large tied black plastic garbage bag, a large tied white plastic garbage bag, and various plastic shopping bags. - Each bag contained medication bubble cards with pharmacy labels. - The bubble cards were labeled by the pharmacy for use by each of the current clients, former clients, and DC #4. - Each bubble card observed contained unused medication. - The unsecured bubble cards included lorazepam (a controlled sedative); Vimpat (a controlled anti-convulsant); antipsychotic medications clozapine, Trilafon, and Seroquel; anti-depressant medications mirtazapine, citalopram, fluoxetine and sertraline; diuretics furosemide and hydrodiuril; levetiracetam (anti-convulsant); anti-hypertensive medications valsartan and lisinopril, and other medications. During interview on 10/20/21 the Qualified Professional/Director/Manager stated:	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ____ B. WING ____	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 119	Continued From page 30	V 119		

- The medications stored on the attic stairs were either expired, prescribed for discharged clients, or were discontinued by the physician.
- When new bubble cards were received from the pharmacy, she put the bubble cards being used into the stairs for disposal and began using the new bubble cards immediately.
- Some of the medications had been stored on the stairs for "the last 6 months."
- The pharmacy refused to accept the medications for disposal; the bags were to be taken to the local Sheriff's Department for disposal.

During interview on 10/21/21 staff #2 stated he had disposed of the medications stored on the attic stairs.

This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.

V 120 — 27G .0209 (E) Medication Requirements — V 120

10A NCAC 27G .0209 MEDICATION REQUIREMENTS
(e) Medication Storage:
(1) All medication shall be stored:
(A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit;
(B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container;
(C) separately for each client;
(D) separately for external and internal use;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 120	Continued From page 31	V 120		

(E) in a secure manner if approved by a physician for a client to self-medicate.
(2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.

This Rule is not met as evidenced by:
Based on observations, record review and interviews the facility failed to store medications in a refrigerator used for food items in a separate locked container. The findings are:

Review on 10/20/21 of client #1's record revealed:
-48 year old female.
-Admission date of 02/16/16.
-Diagnoses of Schizoaffective Disorder, Borderline Personality Disorder, Crohn's Disease, and Restless Leg Syndrome.

Observation on 10/20/21 at approximately 12:20pm revealed:
-The refrigerator in the kitchen contained multiple food items for the clients' use.
-In the bottom drawer of the refrigerator in the kitchen were 3 boxes of Humira Pens labeled with client #1's name and not in an individual locked container.

During interview on 10/21/21 the Qualified Professional/Director/Manager revealed:
-She would ensure client #1's medication was stored in a separate, locked container.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 120	Continued From page 32 This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 120		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews the facility failed to obtain drug regimen reviews for 3 of 3 clients (#1, #2, and #3) who received psychotropic medications. The findings are: Finding #1 Review on 10/20/21 of client #1's record revealed: -48 year old female. -Admission date of 02/16/16. -Diagnoses of Schizoaffective Disorder,	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ___ B. WING ___	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 121	Continued From page 33 Borderline Personality Disorder, Crohn's Disease, and Restless Leg Syndrome. -The following Physician orders: 01/20/21 -Quetiapine Fumarate 100mg (anti-psychotic). 11/04/20 -Buspirone Hcl 15mg (anxiety). -No Physician orders for paroxetine HCL (antidepressant), doxepin (antidepressant) clozapine (anti-psychotic) as documented on the MARs. -No documented six month drug regimen reviews completed by a pharmacist or physician. Finding #2 Review on 10/20/21 of client #2's record revealed: - 48 year old admitted 6/29/20. - Diagnoses included Major Depressive Disorder, Seizure Disorder, and Neurological Disorder. - The following Physician's orders: 6/09/21 Citalopram (anti-depressant), trazodone (anti-depressant and sedative) and mirtazapine (anti-depressant). - No documented six month drug regimen reviews completed by a pharmacist or physician. Finding #3 Review on 10/20/21 of client #3's record revealed: - 32 year old admitted 1/01/16. - Diagnoses included Depression, Bi-Polar Disorder, and Generalized Anxiety. - The following Physician's orders: 8/18/21 - Paliperidone (anti-psychotic). 4/13/21 - Quetiapine (anti-psychotic) 25 mg 1 tablet daily. 3/09/21	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 121 | V 121

Continued From page 34

- Lorazepam (sedative, used to treat anxiety).
12/03/20
- Quetiapine 100 mg 1 tablet daily.
8/31/20
- Fluoxetine (anti-depressant).
- No documented six month drug regimen reviews completed by a pharmacist or physician.

During interview on 10/21/21 staff #2 stated the pharmacy "dropped the ball" in regard to the drug regimen reviews. The pharmacy "had a change of management." He would request six month drug regimen reviews to be completed as required.

This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.

V 291 | V 291

27G .5603 Supervised Living - Operations

10A NCAC 27G .5603 OPERATIONS
(a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.
(b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.
(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	**1335 LASSISTER ROAD FOUR OAKS, NC 27524**

(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 291	Continued From page 35 the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the clients' treatment affecting 2 of 3 clients (#2 and #3). The findings are: Review on 10/20/21 of client #2's record revealed: - 48 year old admitted 6/29/20. - Diagnoses included Major Depressive Disorder, Seizure Disorder, and Neurological Disorder. - Client #2's home county Department of Social Services served as Guardian. - Documentation of administration of 2-part COVID-19 vaccination on 4/26/21 and 5/26/21. - Consent for COVID-19 vaccine dated 5/26/21 signed by client #2. - No consent for COVID-19 vaccine signed by the Guardian. During interview on 10/20/21 client #2 stated she could not remember if she received the COVID-19 vaccine.	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 291	Continued From page 36 Review on 10/20/21 of client #3's record revealed: - 32 year old admitted 1/01/16. - Diagnoses included Depression, Bi-Polar Disorder, and Generalized Anxiety. - Client #3's home county Department of Social Services served as Guardian. - Documentation of administration of 2-part COVID-19 vaccination on 4/26/21 and 5/26/21. - No consent for COVID-19 vaccine signed by the Guardian. During interview on 10/20/21 client #3 stated she received "both shots" of the COVID-19 vaccination in the spring (2021). During interview on 10/21/21 staff #2 revealed: - All clients received the COVID-19 vaccination. - "So basically they had the vaccine but I guess the guardians gave verbal consent." - The consent forms were being "faxed over from the pharmacy so we can get their signature on the consent." - He would contact the Department of Social Services Guardian Representatives and request consent for the COVID-19 vaccinations. This deficiency is cross referenced into 10A NCAC 27D .0304 Protection From Harm, Abuse, Neglect, or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 291		
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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 366	Continued From page 37	V 366		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 366	Continued From page 38 (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 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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 366	Continued From page 39 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 reviews and interviews the facility failed to document their response to level III incident. The findings are: Review on 10/19/21 of facility records from August-October 2021 revealed no documented incident reports. Review on 10/20/21 of Deceased Client (DC) #4's record revealed: -37 year old female. -Admission date of 06/18/20. -Date of death 10/13/21. -Diagnoses of Schizoaffective Disorder, Bipolar Type, Type II Diabetes Mellitus, Hypertension, Asthma, Hypothyroidism, Obesity, Visual Impairment/ Glaucoma, and Blind. Review on 10/19/21 of the facility's incident/accident report sent to Division of Health Service Regulation revealed:	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ___ B. WING ___	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 366	Continued From page 40 "-[Qualified Professional] Preparing [Staff #1] Staff First person to learn of Death and received report from Highway Patrol Time of report 6:00am [Deceased Client #4]... Circumstances of death Place: [Address of accident] Date and time death was discovered: 10/13/21 before 5am Physical location and cause: On roadside of [Address] hit by a truck. No restraints were used at or prior to death. Walked out into ongoing traffic." During interview on 10/20/21 the Qualified Professional(QP)/Director(D)/Manager(M) revealed: -The facility had not had to do any incident reports. -She did not do a report in the Incident Response Improvement System for the incident for DC #4. This deficiency is cross referenced into 10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 366		
V 367	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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ___ B. WING ___	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 367	Continued From page 41	V 367		

responsible for the catchment area where 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	**1335 LASSISTER ROAD FOUR OAKS, NC 27524**

(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 367	Continued From page 42 becoming aware of the incident. Category A 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 reviews and interviews the	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 367	Continued From page 43	V 367		

facility failed to report a critical incident to the home and host Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are:

Review on 10/19/21 of the North Carolina Incident Response Improvement System (IRIS) website revealed no level III incident report had been submitted to the LME by the facility.

Review on 10/19/21 of the facility's incident/accident report sent to Division of Health Service Regulation revealed:
"-[Qualified Professional] Preparing
[Staff #1] Staff First person to learn of Death and received report from Highway Patrol
Time of report 6:00am
[Deceased Client #4]...
Circumstances of death
Place: [Address of accident]
Date and time death was discovered: 10/13/21 before 5am
Physica location and cause: On roadside of [Address] hit by a truck. No restraints were used at or prior to death. Walked out into ongoing traffic."

During interview on 10/20/21 the Qualified Professional(QP)/Director(D)/Manager(M) revealed:
-The facility had not had to do any incident reports.
-She did not do a report in the Incident Response Improvement System for the incident for DC #4.

This deficiency is cross referenced into 10A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 367	Continued From page 44 NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews the facility staff (staff #1, staff #2 and the Qualified Professional (QP)/Director (D)/Manager (M)) failed to protect 2 of 3 clients (#2 and #3) and 1 of 1 deceased clients (DC #4) from harm and	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 512	Continued From page 45	V 512		

neglect The findings are:

Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record review and interview the Qualified Professional (QP)/Director (D)/Manager(M) failed to demonstrate knowledge, skills and abilities required by the population served.

Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). Based on record reviews and interviews 2 of 3 staff (#1 and #2) failed to demonstrate the knowledge, skills and abilities required by the population served.

Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record reviews and interviews the facility failed to implement strategies based on behaviors affecting 1 of 1 deceased client (DC #4).

Cross Reference: 10A NCAC 27G .5603 Operations (V291). Based on record reviews and interview the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the clients' treatment affecting 2 of 3 clients (#2 and #3).

Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record reviews and interviews the facility failed to document their response to a level III incident.

Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record reviews and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 512	Continued From page 46	V 512		

interviews the facility failed to report a critical incident to the home and host Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required.

Review on 10/21/21 of the Plan of Protection completed by the QP/D/M dated 10/21/21 revealed:
"-What immediate action will the facility take to ensure the safety of the consumers in your care? A communication book will be utilized to have a written record of client behavior and actions taken to resolve present issues. Alarms will be placed on doors and window for client safety.
-Describe your plans to make sure the above happens. Alarms will be placed. Better communication. Refresher on compliance for incident reporting. Compliance on QP accuracy in med management."

Clients #2, #3, and Deceased Client (DC) #4 had diagnoses that included Schizoaffective Disorder, Borderline Personality Disorder, Major Depressive Disorder, Neurological Disorder, Bi-Polar Disorder, Generalized Anxiety, Seizure Disorder, Type II Diabetes, Hypertension, Hypothyroidism, and visual impairment/blindness. Client #2 and client #3 received a COVID-19 vaccination on 04/26/21 and 05/26/21 without consent from their Guardians. On October 12, 2021, DC #4 was released back to the facility from the hospital. DC #4 was agitated and verbally aggressive throughout the evening. Staff #1 called the QP/D/M and staff #2 to inform them of DC #4's increased agitation, informing them DC #4 needed to go back to the hospital. The guardian of DC #4 was informed through text by the QP/D/M that DC #4 had returned to the facility from the hospital. Staff #1 went to bed at approximately 11:30pm on October 12, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(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 512	Continued From page 47 Staff #1 did a bed check at 2:30am and DC #4 was in her bed. At approximately 6:15am State Troopers arrived at the facility informing staff #1 of the fatal accident which involved DC #4. The State Troopers showed staff #1 a picture and staff #1 identified the picture as DC #4. DC #4 had left the facility in the middle of the night without staff knowledge and was hit by a vehicle and was killed upon impact. The QP/D/M and staff #2 were aware of the increased agitation following the hospital discharge. The QP/D/M did not complete a Level III incident report after the death or document their response to the Level III. Staff #1, staff #2 and the QP/D/M failed to respond to the increased agitation and destructive behaviors of DC #4 and implement treatment strategies for DC #4 by contacting the guardian of DC #4 about her behaviors and agitation as identified to do so in the Crisis/Prevention plan. Subsequently DC #4 was able to walk away from the facility in the middle of the night and was struck and killed on a nearby road. This deficiency constitutes a Type A1 rule violation for serious neglect and harm and must be corrected within 23 days. An administrative penalty of $8000.00 is imposed. If the violation is not corrected within 23 days, and 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 512		
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.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 48	V 736		

This Rule is not met as evidenced by:
Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:

Observations of the facility between 9:30 am and 1:00 pm on 10/20/21 revealed:
- Kitchen cabinet surfaces were sticky to touch and had a brown substance on all the surfaces.
- The cabinet door under the kitchen sink was held onto the cabinet with a piece of clear packing tape.
- Particles consistent with rodent droppings were found under the kitchen sink, in the lower cabinet bedside the refrigerator, and in the silverware tray.
- Food crumbs and dried food splatter inside the microwave.
- Heavy coating of dust on dining room ceiling fan blades; the dining room walls had stains and the paint was scuffed.
- A very heavy coat of black matter on the kitchen wall and ceiling by the laundry room and at top of cabinet door above the oven,
- Particulate matter on the floors throughout the facility.
- The vinyl floor covering in the kitchen and dining area was worn and scuffed.
- The upholstery on the dining room chairs was stained.
-Client #1 and client #2's shared bathroom tub had an exposed hole and a shower head and tubing were laying in the tub.
-A light bulb was missing in the light fixture.
-The vanity next to the closet was missing a light

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 49	V 736		

bulb.
-The doors throughout the facility had worn paint.
-The carpet at the entrance of client #3's bedroom was soiled and bubbled and not secure.
- Client #3's mattress was leaned against her bedroom wall, there was no bed frame in the room.
-The carpet was soiled and had scattered debris.
-The walls had plastered areas that were not painted and the blind was broken.
-The vacant room had a broken bed frame leaning against the wall and the carpet was soiled.
-The hall bathroom had an exposed wire from the ceiling to the window and the cabinets were soiled and dirty.

During interview on 10/20/21 client #3 stated she did not know why her mattress was propped against the wall; her window blind was broken "a long time ago."

During interview on 10/21/21 staff #2 stated the property owner refused to make repairs to the facility. He was aware the cabinet door was held on to the cabinet with a piece of tape.