STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411124	A. BUILDING: _____ B. WING _____	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES GROUP HOME II, LLC	5788 BETHEL CHURCH ROAD MC LEANSVILLE, NC 27301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 10/25/21. The complaint was unsubstantiated (intake #NC00180898). 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 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a	V 107	DHSR-Mental Health NOV 29 2021 Lic. & Cert. Section	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHANGING LIVES GROUP HOME II, LLC	5788 BETHEL CHURCH ROAD MC LEANSVILLE, NC 27301

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V 107	Continued From page 1 decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a complete personnel record was kept for 1 of 3 audited staff (staff #2). The findings are: Review on 10/21/21 of staff #2's record revealed: - No documentation of a date of hire - No evidence of written and signed job description which specified the minimum level of education, competency, work experience and other qualifications for the position and the duties and responsibilities required of the position - No evidence staff #2 met the minimum level of education for the position Interview on 10/25/21 with the Qualified Professional revealed: - No indication as to why this information was	V 107	The Qualified professional and the Group Home Directors are working together to revise the Employee Records. Upon hire of any new staff, an Orientation Checklist will be completed that includes information that is to be obtained prior to an employee being able to begin working such as copy of diploma, transcripts, signed job description, personnel paperwork, etc. The date of hire and first day of work will be included the checklist and will be filed at the front of the record.	To be completed by 11/22/2021

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	MHL0411124	A. BUILDING: _____ B. WING _____	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES GROUP HOME II, LLC	5788 BETHEL CHURCH ROAD MC LEANSVILLE, NC 27301

(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 107	Continued From page 2 not present in staff #2's record.	V 107		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.	V 108		

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V 108	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a complete personnel file was kept for 1 of 3 audited staff (staff #2). The findings are: Review on 10/21/21 of staff #2's record revealed: - No documentation of a date of hire - No evidence staff #2 had completed training in bloodborne pathogens Interview on 10/25/21 with the Qualified Professional revealed: - No indication as to why this information was not present in staff #2's record.	V 108	The Qualified professional and the Group Home Directors are working together to revise the Employee Records. Upon hire of any new staff, an Orientation Checklist will be completed that includes information that is to be obtained prior to an employee being able to begin working such as copy of diploma, transcripts, signed job description, personnel paperwork, etc. The date of hire and first day of work will be included the checklist and will be filed at the front of the record. There will also be a checklist for all trainings that need to be completed and copies of all training certificates will be filed in each record. The Group Home Director has a spreadsheet for all annual trainings to be able to make sure they are completed in a timely manner.	To be completed by 11/22/2021
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.	V 114		

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(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	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were held at least quarterly and repeated for each shift. The findings are: Review on 10/21/21 of the facility's fire and disaster drill log book revealed: - No evidence any fire drills had been held in the fourth quarter of 2020 (October - December 2020); the first quarter of 2021 (January - March); the second quarter of 2021 (April - June) and the third quarter of 2021 (July - September) - No evidence any disaster drills had been held in the fourth quarter of 2020 (October - December) and first quarter of 2021 (January - March) - One disaster drill was held during the second quarter of 2021 (April - June) with no evidence of any additional drills being held during the same quarter Interview on 10/20/21 with client #1 revealed: - He was not responsive when asked if he participated in fire or disaster drills at the facility. Interview on 10/20/21 with client #2 revealed: - He had only lived at the group home since July of 2021 - When asked about fire drills, he reported staff had shown him where everything was - "We know how to do it basically every day." Interview on 10/20/21 with client #3 revealed: - When asked about fire drills, he stated, "That's the one thing we haven't had yet." - He reported he knew were the exits were and could use them if necessary - When asked about disaster drills, he stated, "We did one not too long ago."	V 114	Staff has been retrained on completion of fire and disaster drills. The newest log has been provided. There is a schedule will be provided as well as reminders of hen to perform drills each month. The Qualified Professional will check at least monthly the fire and disaster drill logs to make sure all have been completed as scheduled.	To be completed by 11/20/2021

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	MHL0411124	A. BUILDING: _____ B. WING _____	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES GROUP HOME II, LLC	5788 BETHEL CHURCH ROAD MC LEANSVILLE, NC 27301

(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	Continued From page 5 Interview on 10/21/21 with staff #1 revealed: - Fire and disaster drills were held monthly and at different times (early morning and at night) - The clients understood they were to go outside and wait by "the pole."	V 114		
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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411124	A. BUILDING _____ B. WING _____	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES GROUP HOME II, LLC	5788 BETHEL CHURCH ROAD MOCKSVILLE, NC 27301

(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 6 report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A 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;	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041124	A. BUILDING _____ B. WING _____	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES GROUP HOME II, LLC	5788 BETHEL CHURCH ROAD MC LEANSVILLE, NC 27301

(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 7 (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure report a Level II incident that occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident affecting 1 of 4 audited clients (client #1). The findings are: Review on 10/21/21 of client #1's record revealed: - An admission date of 2/1/21 - Diagnoses of Schizoaffective Bipolar Type and Intellectual Disability, Moderate Review on 10/21/21 of Staff #3's record revealed: - A hire date of 1/28/17 as a Paraprofessional Review on 10/21/21 of an in-house incident report revealed: - An in-house incident report had been completed by the Qualified Professional (QP) and	V 367	The Qualified Professional is responsible for IRIS reports. The staff is being re-trained on incident reporting so that staff can complete the in-house reports. Protocol is that once completed (within 24 hours of incident occurring, a copy is sent to the Qualified Professional so that an IRIS can be completed and the original is kept in the book at the home.	To be completed by 11/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	M[illegible]L041124	A. BUILDING _____ B. WING _____	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES GROUP HOME II, LLC	5788 BETHEL CHURCH ROAD MOCKSVILLE, NC 27301

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V 367	Continued From page 8 documented "...Consumer (client #1) was to become aggressive towards staff (staff #3) when redirected for trying to obtain a cigarette from the ashtray. Law enforcement was contacted and he (client #1) was taken into custody and charged with simple affray..." Review on 10/21/21 of the North Carolina Department of Health and Human Services' Incident Response Improvement System (IRIS) revealed: - No evidence an incident report had been submitted to IRIS regarding the events of 8/27/21 Interview on 10/25/21 with the CP revealed: - Although she had completed an in-house incident report; she had failed to submit an incident report to IRIS regarding the events of 8/27/21 - She realized she was "going to get dinged" on this.	V 367		
V 369	G.S. 122C-6 Smoking Prohibited § 122C-6 SMOKING PROHIBITED; PENALTY (a) Smoking is prohibited inside facilities licensed under this Chapter. As used in this section, "smoking" means the use or possession of any lighted cigar, cigarette, pipe or other lighted smoking product. As used in this section, "inside" means a fully enclosed area. (b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall: (1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in	V 369		

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	M[illegible]_041[illegible]4	A. BUILDING _____ B. WING _____	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES GROUP HOME II, LLC	5788 BETHEL CHURCH ROAD MC LEANSVILLE, NC [illegible]301

(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 369	Continued From page 9 a red circle with a red bar across it. (2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product. (3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice. (c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section. A violation of this section constitutes a civil offense only and is not a crime. (d) This section does not apply to State psychiatric hospitals. (2010-159, s. 1.) This Rule is not met as evidenced by: Based on observation and interview the facility failed to prohibit smoking within the facility. The findings are: Observation on 10/20/21 at 1 pm revealed: - No smoking signs posted in the facility - A sign posted on the side of office door which read "You can smoke every two hours" Observations on 10/21/21 between 11:50 am and 12:15 pm of client #5 and #6's bedroom and bathroom revealed: - The clients' bedroom smelled of cigarette smoke - Dark flecks of what appeared to be cigarette ashes were in the bathroom sink	V 369	Members are permitted to only smoke in designated areas on the outside of the home. The Group home staff is responsible of keeping cigarettes and lighters and only providing them at times in which the group home members are smoking. The policy of the home is that members smoke every 2 hours when at the home beginning at 8am each morning and ending at 8pm each night. Group home staff will monitor members while smoking and observe each member place their cigarette butt in the permitted ash tray. Members will not place any any items in their personal pockets.	11/18/02021

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	M[illegible]041112[illegible]4	A. BUILDING _____ B. WING _____	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES GROUP HO[illegible], LLC	5788 BETHEL CHURCH ROAD MC LEANSVILLE, N[illegible] 301

(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 369	Continued From page 10 - A cigarette butt on the second shelf of a shelving unit in the bathroom - A cigarette butt and two handheld lighters (red in color) on top of client #5's dresser - A cigarette butt and a hand held lighter (blue in color) on the floor beneath client #6's bed Interview on 10/21/[illegible] with staff #1 revealed: - Clients were allowed to smoke every two hours - He had told the clients they were to never smoke in their room or anywhere else inside the facility - Clients have a designated smoking area outside of the facility to use when they wanted to smoke. Observation at 3:51 [illegible] of the interaction between staff #1 and client #[illegible] revealed: - Staff #1 asked client #[illegible] if either he or client #6 had been smoking in the room and why there was a cigarette butt in the bathroom he and client #6 shared - Client #5 denied smoking had occurred in his bedroom or bathroom - Client #5 reported client #6 must have left the cigarette butt in the bathroom - Staff #1 reiterated to client #5 that it was dangerous to smoke in the facility. Interview on 10/25/2[illegible] with the QP revealed: - Client #6 had been asked to not be a resident of their facilities on more than one occasion and knew he should not smoke in the facility - The clients were told where they were not to smoke inside the facility however, they sometimes "want to smoke where they want to smoke."	V 369		