PRINTED: 12/22/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL043-075 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE **808 NORTH MCKAY AVENUE** HARMONY HOME **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) It should be noted that the 2 former V 000 V 000 INITIAL COMMENTS clients referenced in the findings were discharged effective 11/19/21, 1/8/22 An annual, complaint, and follow up survey was completed 12/16/21. The complaint (Intake well in advance of the state survey #NC00183246) was substantiated. Deficiencies conducted in early December 2021. were cited. Hence the former clients were not active residents in the care of this This facility is licensed for the following service Provider at the time of the survey. category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. A sister facility was identified in this report. The It should be further noted that 5 of 5 sister facility will be identified as facility A. Staff of the facility's current client and/or clients will be identified using the letter population - at the time of the survey 1/8/22 A and a numerical identifier. were not compromised and there The survey sample consisted of audits of 5 was no evidence cited by the state current clients & 2 former clients from sister of client rights violations impacting facility A. the current population. The Director of Operations/Qualified Professional (QP#1) referenced in this report is the Administrator's wife. V 109 27G .0203 Privileging/Training Professionals V 109 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. DHSR - Mental Health (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills JAN 5 _ 2022 and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, Lic. & Cert. Section

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including:

STATE FORM

(1) technical knowledge;

Director Quality Management 1/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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V 109	 (2) cultural awarene (3) analytical skills; (4) decision-making; (5) interpersonal ski (6) communication s (7) clinical skills. 	ss; ; lls; skills; and	V 109	The facility will ensure that perfunctioning in the capacity of a demonstrates knowledge, skill abilities required to serve the population to include but not I to the following.	a QP, lls,	1/8/22
	(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.			A-The QP will implement the disaster plan and staff will condocumentation of disaster dril quarterly on each shift in the hB-The QP will provide training staff to ensure all medications	nome. I to are	18/22
				administered in accordance we physician's orders and staff we complete documentation on the MAR for all assigned clients. C- The QP will ensure that the environment affords the approper services, care, habilitation to individuals who have mental it and/or developmental disability.	ill ne home priate Iness	
	knowledge, skills and a population served. The A. Cross reference 104 Emergency Plans and on record review and ir	rector of Operations and the Director of DQM)) demonstrated the abilities required by the findings are:		D-The QP will coordinate and monitor in the home to ensure no more than 6 clients are sere. E-The QP will monitor in the hoto ensure the facility is maintain a safe, clean, and attractive m	ved. ome ined in	1/8/22 1/8/22

A. BUILDING: A. BUILDING: R B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MHL043-075 B. WING 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
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HARMONY HOME DUNN, NC 28334	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ETE
V 109 Continued From page 2 V 109 F. QP will ensure that the individuals 1/8/22	2
have access to sleeping quarters	
B. Cross reference 10A NCAC 27G .0209 that are separate from areas used	
Medication Requirements (V118). Based on for habilitative and therapeutic	
observation, record review and interview, the facility failed to ensure that MARs were kept	
current for 3 of 3 audited clients (#1, #3 and G-The Director of Quality	
#4) and failed to assure 3 of 3 staff (#8, #9 and #10) demonstrated competency in medication Management completed the	
administration. investigation timely and uploaded	
the findings to IRIS. The former staff 1/8/22	
C. Cross reference 10A NCAC 27G .5601 was terminated accordingly. Prior to	
Supervised Living for Adults with Mental Illness - Scope (V289). Based on record review and	
interview the facility failed to provide a home were in fact trained on abuse,	
environment where the primary purpose of these neglect in accordance with	
services was the care, habilitation/rehabilitation recommendations from the	
of individuals who have a mental illness and developmental disability affecting 5 of 5 clients	
(#1-#5)	
addressed all issues and corrective	
D. Cross reference 10A NCAC 27G .5603 actions were taken-resulting from	
Supervised Living for Adults with Mental Illness - the abuse. neglect investigation: all Operations (V291). Based on record review and in advance of the survey team exit	
intensions the facility failed to encure that no	
more than six clients were served with mental and in advance of the request for a	
illness or developmental disabilities affecting the plan of protection.	
needs of 5 of 5 current clients (#1-#5) and 2 of 2 former clients (FC #A6 and FC #A7). In the future the Director of Quality	
in the fatale the Bhotol of Quality	
E. Cross reference 10A NCAC 27G .0303 Management will continue to complete investigations timely and	
Location and Exterior Requirements (V736). Based on observation, record review and ensure that all corrective actions are	
Based on observation, record review and interview the facility was not maintained in a addressed in a timely manner to	
safe, clean and attractive manner include but not limited to any	
recommendations for staff training.	
F. Closs reference TOA NCAC 27G .0303	
Location and Exterior Requirements (V784). Based on interview and record review the facility The QP will monitor in the home 2-3	
failed to ensure areas in which therapeutic and times weekly or more often to	
habilitative activities are routinely conducted were ensure continued compliance.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION NG:		(X3) DATE SURVEY COMPLETED		
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		from the Human Resc following dates for Fol Professionals (FQP) e January-July 2021: - FQP #3: Hired-5/2 Terminated-1/8/2021 - FQP #4: Hired-1/2 Terminated-3/3/2021 - FQP #5: Hired-3/2 Terminated-4/28/2021 Review on 12/13/21 or QP #2's record revealed hired: 8/9/21 - job description dat that included but not limbriefed by our count medical and document check status or complete all filted than disafety stands supervised by (DOO)/QP #1 Review on 12/14/21 of personnel record revealed hired: 6/1/05 - job description dat included but not limited orientate and provide active treatment provide direct arrange, coordinate and and provide active treatment and provide direct arrange, coordinate and provide active treatment and provide	f an email dated 12/15/21 curce Manager revealed the rmer Qualified employed between 20/2013 & 23/2020 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021 & 2/2021	V 109			
	1	act as an adv	ocate for consumers	I	1		1

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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V 109	provide Clinic twice a month	cal consultation at least umentation in accordance tions and agency's es I the Director of Quality personnel record revealed: ted 11/1/11 listed duties that d to: sight and work closely with pport of all outcomes empletion of audit fordination and provide I of the facility's dated 12/9/21 for FC #A6 0/11/21 corted 10/13/21 g DOO/QP #1 completed 10/18/21 ngs: [FC #A6] said (former her bedroom and hit her anger on the back, head is in the bed and turn down FC #A6] also reported picked up her blue tennis I hit her with the tennis vas substantiated as staff with a white plastic clothes the member's blue tennis dations: 1. staff [FS #11] at rights violations of	V 109	The QP will monitor in the hotimes weekly and implement tourrent plan of protection to econtinued compliance. It should be noted that the 2 for clients referenced in the state findings were discharged effect 11/19/21, well in advance of the state survey conducted in earth December 2021. Hence the for clients were not active resident the care of this Provider at the of the survey. It should be further noted that of the facility's current client population - at the time of the were not compromised and the was no evidence cited by the sof client rights violations impact the current population.	ormer ctive ne ly ormer nts in e time 5 of 5 survey ere state	1/8/22

AND PLAN OF CORRECTION IDENTIFICATION NOWIGER. A. BUILD	ING:	(X3) DATE SURVEY COMPLETED	
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V109 Continued From page 5 Quality Management will provide additonal refresher training to Harmony Home staff on Abuse, Neglect Prevention" Interview on 12/14/21 the DQM reported: - the DOO/QP#1 was the "QP on paper" - some of his job duties were: incident report management, abuse investigations, accreditation policy monitoring of the facilities, staff training & improvement qualities - improvement qualities included: occasional monitoring of the facility, conduct abuse investigations and addressing plan of provide staff training in abuse - he inserviced staff at Sister Facility A on abuse/neglect prevention Interview on 12/14/21 the DOO/QP (#1) reported: - been the QP for last 19 - 20 years - some of the job duties were: managed the employees, participated in team meetings, developed short range goals & worked with the Local Management Entity/Managed Care Organization Care Coordinator - QP#2 reported to her and the DQM During interview on 12/14/21 the Administrator reported: - was 100% administrative and nothing clinical - he ensured "the bills were paid" - human resources addressed any concerns with the DOO/QP#1 & DQM - the DOO/QP#1 & DQM - the DOO/QP#1 & DQM did not need to be "micromanaged" Review on 12/16/21 of a Plan of Protection written by the DOO/QP #1 dated 12/16/21 revealed: "An investigation was conducted and completed and the staff terminated prior to the survey. An IRIS (incident response improvement			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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V 109	notifications took place Findings were shared the survey was completed to the facility of sister Facility A client speech and FC #A7, and like environment for FC couch at the facility. The facility of sister facility on every care staff with client sp #A6 and FC #A7, and like environment for FC couch at the facility. The facility. The facility. The facility. The facility. The facility of Sister facility on every care staff with client sp #A6 and FC #A7, and like environment for FC couch at the facility. The facility is facility and facility. The facility. The facility.	empleted and appropriate and the investigation. in a timely manner. Before eted the QP provided by Home staff on Abuse of the in-service was survey. The QP will monitor insure that the client are neglect and exploitation. In management will monitor the clients are protected and exploitation. The I meet weekly to discuss insure they are in abuse, neglect or agement team will meet client right violations to steed from any harm, abuse, The QP [day program that the management team is estatus of any corrective poliance." The day to day operations and consistently cognizant of census and the frequency into the day to day operations and toonsistently cognizant of census and the frequency into the completion of sues in the home, ion errors, completion of shift; failed to support direct ecific information for FC failed to facilitate a home in the DOO/QP #1 worked at	V 109	DEFICIENCY)		
		s and provided oversight				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION 5:	(X3) DATE SURVEY COMPLETED		
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V 109	Continued From page	e 7	V 109			
	the facilities as well at DOO/QP #1 and the licensed census at the the needs of FC #A6 direct care staff. Harm medication administra #A6 71 days from Jai 2021 and 20 days for 2021 - November 202 regulatory compliance associated facilities at oversight over QP #2 medication errors well were performed quant that staff were trained substantiated incident these deficiencies conviolation for serious no corrected within 23 days penalty of \$2,000 is in not corrected within 2	s the QP staff. Both the QP #2 failed to maintain the e facility or to communicate and FC #A7 to the facility mony staff signed the ation record (MARs) for FC muary 2021 to November FC #A7 from September 21. The DQM assured e for the agency and all s well as regulatory and failed to ensure that re minimized, safety drills terly and on every shift, and it subsequent to a to fabuse. Systematically, institute a Type A1 rule eglect and must be ays. An administrative inposed. If the violation is 3 days, an additional of \$500.00 per day will be the facility is out of				
V 114	27G .0207 Emergenc	y Plans and Supplies	V 114			
	area-wide disaster pla and shall be approved local authority. (b) The plan shall staff and evacuation shall be posted in the (c)Fire and disaster dri shall be held at least qu	ES lan for each facility and an shall be developed by the appropriate be made available to all procedures and routes facility. lls in a 24-hour facility				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	183	MHL043-075	B. WING		12/1	6/2021
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V114	Continued From page under conditions that emergencies. (d) Eac first aid supplies acce	simulate fire ch facility shall have basic	V 114	The facility will ensure that di and/or evacuation drills are conducted at least quarterly, uvaried conditions for each shift the home.	under	1/8/22
	This Rule is not met as evidenced by: Based on record review and interview the facility failed to complete disaster drills quarterly and on each shift. The findings are: Review on 12/2/21 of the facility's disaster drill log from 4/2021-10/2021 revealed: no disaster drills completed after 6/11/21 on any of the three shifts			The QP will in-service the staf home on the evacuation proce and implementation of the sch The evacuation schedule will I	ess nedule.	1/8/22
				posted for staff review. The Qi track all disaster and fire drills monthly to ensure compliance		1/8/22
	Interview on 12/2/21 s - she was hired in c - she had not comp since she was hired.	Control of the Contro		The Quality Management Dire will review all evacuation drills monthly to ensure compliance		
	disaster drills twice a	pposed to complete month. e as many because				
	(QP) #2 reported: - he started work in - "fire drills is what was	we consider a disaster drill." I any tornado drills since he				
	Interview on 12/14/21 Quality Management - QP #2 informed hi completed at the facili	reported: m disaster drills were being				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PLUE DINC:	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING:		
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HARMONY HOME 808 NORTH MCKAY AVENUE		
DUNN, NC 28334		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	D BE COMPLETE	
V 114 Continued From page 9 This deficiency is cross referenced into 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.		
V118 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications 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; (C) instructions for 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.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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V 118	Continued From page	e 10	V 118	The facility will ensure that		1/8/22
	oonanaaa rom pag	0 10		medications are administered	in	
				compliance with physician's o	rders	
				and documentation is comple	te and	
				accurate on the MAR.		
				For Client #1, #3 and #4 the 0)P will	
	This Rule is not met a			monitor 2 times weekly to ens		
	Based on observation	failed to ensure that MARs		that staff initial the MAR as re		
		3 of 3 audited clients (#1,			1	1/8/22
	#3 and #4) and failed	to assure 3 of 3 staff (#8,		The QP will in-service all staff		00/7/19/20/04/20/07/19/20/09
	#9 and #10) demonst			importance of initialing off on t		
	medication administra	ation. The findings are:		MAR for all clients during med		
	I. Example MARs not	signed immediately after		administration.		
	medications given:	g				
				Staff will be instructed to admi	nister	
	A. Review on 12/2/21 revealed:	of client #1's record		all medications and confirm th	rough	1/8/22
	- admitted: 2/9/21			a crosswalk of the MAR during	each	
		n, Severe Intellectual		medication pass.		
	Developmental Disab			•		
		eflux Disease (GERD)		The QP will monitor the MARs	for all	
	and Colitis	1 MAR entry was blank		clients, 2-3 times weekly in the	9	
	for the following 8am	5 - Table 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		home to ensure compliance.		1/8/22
		ng (milligram) (Sedative				
	and high blood pressu			The Director of Quality Manag	ement	
		am) (cardiovascular		will monitor the MAR weekly ir	ı the	
	disease) Depakote extende	ed release 500mg		home to ensure continued		
	(anticonvulsant)			compliance and consult with the	ne QP	
	Calcium 500mg (d	lietary supplement)		and/or direct care staff accord	ngly.	
	Omeprazole 40mg					
		te 1/2 tablet for 2 mg				
	dosage (irritability cau	R listed Peppermint 50mg				
		ome) blank entries for 12				
	7	11th, 12th, 13th, 15th,				
	18th and 19th					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			D. MANAG			R
MHL043-075			B. WING		12/	16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
HARMONY	/ HOME	808 NOR	TH MCKAY AVE	NUE		
TIAKWOW	TIOME	DUNN, N	C 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	11	V 118			
	B. Review on 12/2/21 revealed: - admitted 2/4/13 - diagnoses of Mod Deafness and Epileps Review on 12/2/21 of 2021 MAR revealed: - no staff signatures on 12/1/21 - medications listed Zoloft 100mg ever Carbamazepine 3 (seizures) Vitamin B12 daily healthy) Triamcinolone 250 conditions) C. Review on 12/2/21 revealed: - admitted 3/7/09 - diagnoses: Major Recurrent Episode-Mod Anxiety Disorder, Deve Expressive/Receptive and Moderate Intellect - December 2021 M that included the follow Fiber Laxativa day (constipation) Multivitamin (nutritional supplement Lisinopril 10r (blood pressure)	of client #3's record derate IDD, Cerebral Palsy, y Unspecified client #3's December s for morning medications I on the MAR: ryday (anxiety) 00mg twice a day (blood & nerve cells % twice a day (skin of client #4's record Depressive Disorder, derate, Unspecified elopmental Language Disorder ual Disability IAR listed medications ving: ve 625 mg, 1 tablet once 1 tablet once a day				
		000 capsule, 1 capsule oplement)				

Division of Health Service Regulation

STATE FORM C31R11 If continuation sheet 12 of 58

Division	of Health Service Regu	ilation				
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
		MHL043-075	B. WING			R 6/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE		
			RTH MCKAY AVEN			
HARMONY	HOME	DUNN, N	IC 28334			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From pag	e 12	V 118			
	every morning (overa Denta 5000 application for daily u Polyethylene 2 capfuls in 8 ounces mouth twice daily (conceprazole twice a day Montelukast evening (chronic alle Ondansetror mouth every eight hon Trazodone 5 at bedtime only if need no initials for morning medications on the lateral part of the late	plus 1.1 % cream, use one se (tooth decay prevention) e glycol 3350 17/grams, Mix sof water and drink by onstipation) 20 mg, 1 capsule by mouth Sodium 10mg, 1 tablet in the rgies) 1 4mg, dissolve one tablet in ours as needed (nausea) 0mg, take 1/2 tablet eded (insomnia) 1 the 12/1/21				

Interview on 12/3/21 staff #8 reported:

- staff #10 had not completed the MAR sheet on more than one occasion.
- she notified the Qualified Professional (QP #2) of the medication error when it occurred.

- she had forgotten to sign the MAR sheet for

Interview on 12/3/21 the QP #2 reported:

- hired: 8/9/21

of 12/1/21.

12/1/21.

- duties included weekly monitoring MARs and medications
- reviewed the MARs last week
- not aware of any concerns with a medication called Peppermint for client #1

Interview on 12/14/21 the Director of Operations

Division of Health Service Regulation

C31R11 STATE FORM If continuation sheet 13 of 58 6899

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
						R
		MHL043-075	B. WING	3970	12/	16/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, S TH MCKAY AVE IC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 118	(DOO)/QP #1 reported - QP #2 ensured th - DOO/QP #1 checd - she (DOO/QP #1 medications were transmissing staff initials	d: e MARs were current ked the MARs quarterly checked to see how the scribed on the MARs and	V 118	For Client #1 the peppermint medication was discontinued supported by a copy of the physician's orders. The QP will coordinate with the Pharmacist for appropriate transcribing on the MAR to recurrent physician's orders.	as e	1/8/22 1/8/22
	Management (DQM) in - checked the MAR - when he visited the clients MARs - there were few or - last reviewed MAR III. Example MAR initial medication discontinuemedication and appearance of the permitted discontinuemedication and 4pm double permitted discontinuemedication and	eported: s more than quarterly se facility, would check the no missing staff initials Rs in November 2021 led after ed: client #1 s record revealed: dated 6/15/21 Peppermint times a day dated 10/28/21 for share 2021 MARs listed had been es a day 1 MAR entry listed initials besages were administered MAR entry listed initials disages were administered MAR entry listed initials disages were administered I between lient #1 s meds revealed: mg tablet		The QP will monitor the MAR times weekly in the home to e continued compliance. The Director of Quality Maang will monitor the MAR weekly a crosswalk current physician's to ensure continued compliance.	nsure lemnt and orders	1/8/22

Division of Health Service Regulation

STATE FORM

C31R11

6899

	OVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S	SURVEY
	MHL043-075	B. WING			R 6/2021
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, ST	ATE ZIP CODE	12/1	0/2021
		MCKAY AVE			
HARMONY HOME	DUNN, NC 2	28334			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
interview as well as 12/1/21 - did not recall a medication for client #1 - worked with client #1 at the date of the interview - if she signed the MAR, the medication was administered interview on 12/3/21 staff #8 - not aware of a medication "Peppermint" for client #1 Interview on 12/2/21 the DQ - thought the medication for taken to the day program indicate medication was not there an administered - he would follow up on the medication Interview on 12/3/21 the Perfor the DOO/QP #1 reported - she did whatever the DO her to do - when medications came pharmacy, she reviewed and the MARs - if there were concerns such medications, she would contaled in the medication in the medicati	the day program then the Peppermint d. B reported: on called M reported: or Peppermint was be administered ad Peppermint d was not e status of the sonal Assistant : OO/QP #1 instructed in from the d compared with ch as missing act the pharmacy is but never noticed mint medication for DO/QP #1 reported: or accuracy. ARS would have reself and DQM.	V 118			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S	SURVEY
	MHL043-075	B. WING		1	R 1 6/2021
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S'	TATE, ZIP CODE	127	10/2021
HARMONY HOME		MCKAY AVE			
TARTON E	DUNN, NC 2	28334			
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
missed signatures. not aware of staff she last reviewed September/October 2 This deficiency is cross NCAC 27G .0203 Corprofessionals and Ass (V109) for a Type A1 is be corrected within 23 V289 27G .5601 Supervised 10A NCAC 27G .5601 (a) Supervised living is provides residential set home environment whoef these services is the rehabilitation of individiallness, a development or a substance abuse require supervision whoef the facility serves eit (1) one or more in (2) two or more in (2) two or more in (3) two or more in (4) Each supervised living if the facility. (5) Each supervised living if we licensed to serve a population as designation serves adults whose prillness but may also have	not initialing the MARs. the MARs in 021. Its referenced into 10A inpetencies of Qualified sociate Professionals rule violation and must days. I Living - Scope SCOPE Sa 24-hour facility which ervices to individuals in a ere the primary purpose care, habilitation or fuals who have a mental fall disability or disabilities, disorder, and who ere in the residence. facility shall be licensed her: minor clients; or adult clients. shall not reside in the ring facility shall specific ficed below: for means a facility which firmary diagnosis is mental for other diagnoses; for means a facility which		It should be noted that the 2 for clients referenced in the state findings were discharged effect 11/19/21, well in advance of the state survey conducted in early December 2021. Hence the for clients were not active resident the care of this Provider at the of the survey. It should be further noted that of the facility's current client population - at the time of the were not compromised and the was no evidence cited by the sof client rights violations impact the current population.	ctive ne ly prmer nts in e time 5 of 5 survey ere state	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	SURVEY PLETED
			71. 001201110			Б
		MHL043-075	B. WING			R 16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	127	10/2021
HARMONY	HOME	808 NORT	H MCKAY AVE	ENUE		
HARMON	HOIVIE	DUNN, NO	28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 289	serves adults whose developmental disable other diagnoses; (4) "D" designar serves minors whose substance abuse dephave other diagnoses (5) "E" designar serves adults whose substance abuse dephave other diagnoses (6) "F" designat private residence, whithree adult clients who mental illness but mandisabilities, or three actions whose primary developmental disabilities who family provides the seexempt from the follow 27G .0201 (a)(1),(2),(1),(18), and (b); 10A NCA (ii); 10A NCAC 27G .0208 (b), .0209[(c)(1) - non-presid)(2),(4); (e) (1)(A),(E),(E),(E),(E),(E),(E),(E),(E),(E),(E	tion means a facility which primary diagnosis is a sility but may also have tion means a facility which primary diagnosis is bendency but may also so be primary diagnoses is y also have other dult clients or three minor of diagnoses is lities but may also have live with a family and the envice. This facility shall be wing rules: 10A NCAC 33,(4),(5)(A)&(B); (6); (7); (8); (11); (13); (15); (16); (16); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10); (10);	V 289	The facility will ensure coordine efforts with qualified profession and management to address to a home environment where primary purpose would be to support the care, habilitation individuals served with mental health and developmental disabilities. The QP will maintain contact residential facilities daily to eneach client is afforded access home environment. The QP will serve as back-up should a staff call out abruptly. The Director of Operations will notified immediately to help such the coordination of staff resource individual access to a environment. The Director of Operations, Cand Director of Quality Manage will discuss the occupancy state weekly to ensure continued compliance.	onals access e the of all with all asure s to a staff	1/8/22
	This Rule is not met a Based on record revie	s evidenced by: w and interview the facility				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	ECONSTRUCTION	(X3) DATE :	SURVEY PLETED
		MHL043-075	B. WING		12/	R 16/2021
NAMEOFO	ROVIDER OR SUPPLIER		DDDECC CITY CT	ATE 7/D CODE	121	16/2021
			ODRESS, CITY, ST. T H MCKAY AVEI			
HARMONY	HOME	DUNN, NO	28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 289	failed to provide a hor primary purpose of the habilitation/rehabilitati a mental illness and d affecting 5 of 5 clients Review on 12/3/21 of revealed the facility was revealed to the had resided a control of the Division of Health of the Division of Health of the Division of Deration of Qualified Professi the Director of Quality Manager of the Director of Quality	me environment where the ese services was the care, on of individuals who have evelopmental disability (#1-#5). The findings are: the facility's public file as licensed for 6 clients (21 and 12/16/21 of servealed: at the facility between 2009 of Former Client (FC): on date to Sister Facility A ister Facility A on 11/19/21 olar Disorder with a Disorder, Mild Intellectual er, Hyperlipidemia, sis & Chronic Obstructive f a faxed behavioral plan to Service Regulation (DHSR) with no signatures onals (QP) listed were ons (DOO)/QP#1 & the	V 289	DEFICIENCY)		
	other object as a weap behaviorelopement w leave any facility withou	a Harmony Home incident				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE	SURVEY IPLETED
			D. MAINIC			R
		MHL043-075	B. WING	77.55	12/	16/2021
NAME OF P	ROVIDER OR SUPPLIER	808 NOF	ADDRESS, CITY, STA RTH MCKAY AVEN IC 28334			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORR	PECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 289	Continued From pag	e 18	V 289			
V 289	- "[FC #A6] was up screaming and cursin Review on 12/13/21 administration record 2021 through Novem - Harmony Home stapproximately 71 day Attempted interviews Harmony Home reveror did not comprehent Interview on 12/2/21 - began work in June she worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the worked 3rd sless was familiar very proper to the work	from 12am - 2:23am g until 2:30 am" of FC #A6's medication (MARs) from January ber 2021 revealed: taff initials appeared s. on 12/2/21 with clients of aled they were nonverbal id the questions staff #10 reported: ne 2021. nift 11pm to 8 am. with FC #A6. It the facility multiple times gust 2021 and September vernight at the facility by A did not have advance notice that a new g at the facility from the I (QP) or management. Seat the facility asleep ther shift.	V 289			
	Sister Facility A. - FC #A6 would cor Harmony Home and S - came to work one in the bedroom	with FC #A6 who resided at ne back and forth between				

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Division of	of Health Service Regu	ılation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE S	SURVEY PLETED
		MHL043-075	B. WING			R 16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE ZIP CODE		
			RTH MCKAY AVEN			
HARMONY	HOME	DUNN, N	IC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 289	Continued From pag	e 19	V 289			
	about FC #A6 her record came she called the offi FC #A6 would be with the short period with FC #A6 spent 2 the staff with her due to a gardensive and verbar first time she saw in February 2021 or Months of the DOO/QP #1 the DOO/QP #1 the at the facility tempon through November Interview on 12/7/21 worked at the facility tempon through November at the facility tempon through November Interview on 12/7/21 worked at the facility's their appointments ar FC #A6 started to February 2021 or Man was a client of Sis FC #A6's behavior	over later ice and the DOO/QP #1 said in them for a short period was from February - o 3 days each week at the couldn't keep consistent FC #A6's combative, al behaviors (cursing). FC #A6 at the facility was March 2021 of this year. See times during the end of in mid November 2021. old her FC #A6 would only corarily, but stayed off and for 2021. staff #9 reported: illity since 2015. 4pm - 9pm or 4pm - 11pm for van to transport clients to find to the day program for come to the facility in firch 2021 of this year. ster Facility A. for consisted of: would fut your family, yell at staff				
	#11 reported:	(

Division of Health Service Regulation

day was 11/2/21

home was short of staff.

- started at the facility 10/2020 and last

- the DOO/QP #1 brought clients from other homes to the facility, if the client's

- "the [DOO/QP #1] would not tell us they (Sister Facility A clients) were coming over

MHL043-075 S. WING S. WING R. 1/16/2021 MARKONY HOME STREET ADDRESS, CITY, STATE, ZIP CODE S08 NORTH MCKAY AVENUE DUNN, N. C. 28334 D. PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST SE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DREETING (EACH DEFICIENCY MUST SE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V.289 Continued From page 20 (Harmony Home)." - F. C. #A6 and F. C. #A7 were the clients the DOC/QP #1 would bring over to the facility. - "the two of them [FC #A6 and F. C. #A7] were there lots of time, [FC #A6] was there every other weekend at the facility. - "twe never knew when they were coming that day." - "it was weekly for as far back as the summer time." Interview on 12/9/21 FC #A6's Local Management Entity/Managed Care Organization Care Coordinator (LME/MCO/CC) reported: - F. C. #A6 liked to be alone - management kept placing her with other clients - she told the DQM if they kept placing her in facilities with other clients "things would go downhill for staff or other clients" - downhill meant she would have a behavior of cursing or racial slurs - the guardian made her aware of the overnight stays at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she would go down Harmony Home - FC #A6 informed the guardian she would go down Harmony Home - FC #A6 informed the guardian she would go down Harmony Home - FC #A6 informed t	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S	BURVEY
MHL043-075 STREET ADDRESS CITY, STATE, ZIP CODE				A. BOILDING			
NAME OF PROVIDER OR SUPPLIER BOB NORTH MCKAY AVENUE DUNN, NC 28334 (X4) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 289 Continued From page 20 (Harmony Home). - FC #A6 and FC #A7 were the clients the DOO/Q/D #1 would bring over to the facility "the two of them [FC #A6] was there every other weekend at the facility." - "we never knew when they were coming that day." - "it was weekly for as far back as the summer time." Interview on 12/9/21 FC #A6's Local Management Entity/Managed Care Organization Care Coordinator (LME/MCO/CC) reported: - FC #A6 liked to be alone - management kept placing her with other clients - she told the DQM if they kept placing her in facilities with other clients - downhill for staff or other clients." - downhill meant she would have a behavior of cursing or racial slurs - the guardian made her aware of the overnight stays at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home			MHL043-075	B. WING			
ARRIMONY HOME DUNN, NC 28334	AME OF PROVIDER OR SUPPLIER	ME OF PROVID	R SUPPLIER STREE	TADDRESS, CITY, S	TATE, ZIP CODE		-
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES FREEIX SUMMARY STATEMENT OF DEFICIENCIES (EACH OEPICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG CROSS-REPERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 289	A DRIONLY LIGHT	DINONIV LION					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 289 Continued From page 20 (Harmony Home)." F C #A6 and F C #A7 were the clients the DOO/QP #1 would bring over to the facility. "the two of them [FC #A6 and FC #A7] were there lots of time, [FC #A6] was there every other weekend at the facility." "we never knew when they were coming that day." "it was weekly for as far back as the summer time." Interview on 12/9/21 FC #A6's Local Management Entity/Managed Care Organization Care Coordinator (LME/MCO/CC) reported: F C #A6 liked to be alone management kept placing her with other clients she told the DQM if they kept placing her in facilities with other clients "things would go downhill for staff or other clients" downhill meant she would have a behavior of cursing or racial slurs the guardian made her aware of the overnight stays at Harmony Home F C #A6 informed the guardian she stayed at Harmony Home F C #A6 informed the guardian she stayed at Harmony Home Harmo	ARMONY HOME	ARMONY HOM	DUNN	NC 28334			
(Harmony Home)." - FC #A6 and FC #A7 were the clients the DOO/QP #1 would bring over to the facility. - "the two of them [FC #A6 and FC #A7] were there lots of time, [FC #A6] was there every other weekend at the facility." - "we never knew when they were coming that day." - "it was weekly for as far back as the summer time." Interview on 12/9/21 FC #A6's Local Management Entity/Managed Care Organization Care Coordinator (LME/MCO/CC) reported: - FC #A6 liked to be alone - management kept placing her with other clients - she told the DQM if they kept placing her in facilities with other clients "things would go downhill for staff or other clients" - downhill meant she would have a behavior of cursing or racial slurs - the guardian made her aware of the overnight stays at Harmony Home - FC #A6 informed the guardian she stayed at Harmony Home	PREFIX (EACH DEFIC	REFIX	EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
- guardian said FC #A6 stayed a few times a month prior to her discharge from Sister Facility A - The DOO/QP#1 was her main contact - the DQM contacted her at times to make her aware of an overnight stay at the facility due to staff shortage - a meeting was held with the guardian, DOO/QP#1 and the DQM on 10/5/21 - part of the meeting was to discuss staffing issues at Sister facility A - The DOO/QP#1 & the DQM said FC #A6 stayed a couple nights a week at Harmony Home Interview on 12/14/21 the DOO/QP #1 reported:	(Harmony Home) - FC #A6 and FDOO/QP #1 woul - "the two of the there lots of time, other weekend at "we never kne day." - "it was weekly time." Interview on 12/9, Management Enticare Coordinator - FC #A6 liked to management clients - she told the Dfacilities with other downhill for staff to downhill mear cursing or racial set the guardian matays at Harmony - FC #A6 inform Harmony Home - guardian said month prior to her guardian said month prior to her the DOO/QP# - the DQM contraware of an overnataff shortage - a meeting was DOO/QP#1 and the part of the meastaffing issues at the DOO/QP# stayed a couple night	(Har-DO) - the oth - day - time Man Car - clie - faci dow - curs - stay - Har - mor - awa staf - stay	my Home)." #A6 and FC #A7 were the clients the P #1 would bring over to the facility. two of them [FC #A6 and FC #A7] were ts of time, [FC #A6] was there every eekend at the facility." never knew when they were coming that was weekly for as far back as the summer w on 12/9/21 FC #A6's Local ement Entity/Managed Care Organization cordinator (LME/MCO/CC) reported: #A6 liked to be alone tagement kept placing her with other told the DQM if they kept placing her in with other clients "things would go I for staff or other clients" nhill meant she would have a behavior of or racial slurs guardian made her aware of the overnight Harmony Home #A6 informed the guardian she stayed at y Home dian said FC #A6 stayed a few times a rior to her discharge from Sister Facility A DOO/QP#1 was her main contact DQM contacted her at times to make her f an overnight stay at the facility due to ortage eleting was held with the guardian, P#1 and the DQM on 10/5/21 of the meeting was to discuss issues at Sister facility A DOO/QP#1 & the DQM said FC #A6 couple nights a week at Harmony Home	V 289	DELINITY		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION .	(X3) DATE S	SURVEY PLETED
					1	R
		MHL043-075	B. WING		1	16/2021
NAME OF PROVIDER OR SUPPL	ER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
HARMONY HOME		808 NORT	H MCKAY AVE	NUE		
HARMONY HOME		DUNN, NC	28334	,		
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
- she was at the facility a fe how many time - staffing she Facility A woul FC #A6 spent - "sometime minutes prior to the was unit the facility - he did not clients from Sis - decisions to would be performed by the facility - he did not clients from Sis - decisions to would be performed by the facility - he did not clients from Sis - decisions to would be performed by the facility - unknown at and discharged - diagnoses: Unspecified, Al Bipolar Disorder intellectual Disorder, and L - 9/2/20 behind behavior, sever aggression, prospit and scratco discovered by the facility of the form September 2021 revealed: - Harmony Happroximately 2021 revealed: - Harmony Happroximately 2021 revealed: - Harmony Happroximately 2021 revealed: - Interview on 12/10 from September 2021 revealed: - Harmony Happroximately 2021 revealed: - Harmony Happroxima	as not a ware so relocate the night of the so relocate the solution of the sol	a resident of the facility. he had spent the night at es, but was unsure exactly s or "call outs" at Sister been the reason that ght at the facility. would call out only 10 shift." 1 the DQM reported: FC #A6 stayed overnight at rize for staff to relocate cility A to another facility. at clients to a sister facility by the QP #2 or DOO/QP #1. I of FC #A7's record on date to Sister Facility A Sister Facility A on 11/19/21 sive Development Disorder, Disorder Unspecified, Moderate s, Hearing Loss, Seizure Communication Skills. lan included self injurious uptive behaviors, destructionwill hit, bite, of FC #A7's MARs I through November	V 289			

1	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE	SURVEY MPLETED
		MHL043-075	B. WING		12	R /16/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATETH MCKAY AVENU		, .=	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 289	was a staffing issue - FC #A7 slept ove 2021-November 2022 Interview on 12/6/21 - FC #A7 came to there was no staff at Interview on 12/10/21 reported: - she was aware thovernight at the facili not the Care Coordin Interview on 12/10/21 supervisor for FC #A7 - the guardian was to Harmony Home ar - on 10/19/21 a corthe Administrator, DO - she was informed stay at Harmony Hom - would be concern several overnight star - concerned about the moved FC #A7 with be another facility, no stafe FC #A7 was placed in clients & why manage aware there were several overnight star - "she (FC #A7) was there a month. (Sister - "I don't know whe women's side of the full interview on 12/7/21 starterview on 12/7/21 startervi	er at the facility when there at Sister Facility A. r 3-4 times from September 1. FC #A7's guardian reported: the facility with FC #A6 as Sister Facility A. FC #A6's LME/MCO/CC nat FC #A7 was staying ty even though she was ator for FC #A7. the LME/MCO/CC's reported: supset FC #A7 had visits nd slept on a couch afference call was held with O/QP#1 and the DQM FC #A7 had one overnight are due to staffing and if she had and ys at the facility he following: why they a facility with unfamiliar ament did not make them are long. She was a facility)" re she slept but on the acility."	V 289			

MHL043-075 B. WING	R 12/16/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH MCKAY AVENUE DUNN, NC 28334 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 289 Continued From page 23 V 289	
HARMONY HOME SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
DUNN, NC 28334 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 289 Continued From page 23 CX4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BY TAG CROSS-REFERENCED TO THE APPROPRIATION) V 289 V 289	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) V 289 Continued From page 23 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATION) V 289	
	BE COMPLETE
she arrived to the day program to pick	
up Harmony Home clients, FC #A6 & FC #A7 needed to go Harmony Home - there would not be staff at sister facility A to care for FC #A6 & FC #A7	
Interview on 12/10/21 FS #11 reported: - "the two of them [FC #A6 and FC #A7] were there (Harmony Home) lots of time, [FC #A6] was there every other weekend at the facility." - "we never knew when they were coming." - "it was weekly for as far back as the summer time."	
Interview on 12/6/21 FC #A6 & FC #A7's guardian reported: - when short of staff at Sister Facility A, they would go to Harmony Home - did not know how often - sometime this year and possibly last year for FC #A6 - the DOO/QP #1 & the DQM contacted her "every now and then" when FC #A6 & FC #A7 went to Harmony Home	
- FC #A6 made her aware most of the time when she stayed at Harmony Home - "the [DOO/QP #1] gave the authorization when the clients went to Harmony Home"	
Interview on 12/14/21 the DOO/QP #1 reported: - FC #A7 was not a resident of the facility. - was aware she (FC#A7) had stayed overnight at the facility a few times, but was unsure exactly how many times. - "she and the [DQM] would approve for [FC #A6] & [FC #A7] to come to the facility" - was not aware if staff knew about FC #A6 & FC #A7's behaviors - QP #2 did not feel comfortable staying	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION .	(X3) DATE COM	SURVEY
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		MHL043-075	B. WING		12/	16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
HARMONY	HOME	808 NORTI DUNN, NC	H MCKAY AVE	NUE		
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	DATE
V 289	Continued From pag	e 24	V 289			
	A because he was a	male				
	facility to stay overnig the QP #2 or the authorization he and DOO/QP: with FC #A7's LME/N in her medications or did not recall whee Interview on 12/14/27 was not apart of a pertaining to FC #A7 was not aware FC had overnight stays a prior to any clients sister facility, QP #2 w #2 would notify the DC This deficiency is cross NCAC 27G .0203 Col Professionals and As	orize a client from a sister of that at another facility DOO/QP #1 would give the #1 had a conference call MCO/CC about a change only en the conference call was 11 the Administrator reported: any conference calls C #A6 & FC #A7 at the facility being moved from the could be contacted and QP QM or the DOO/QP #1 ss referenced into 10A mpetencies of Qualified sociate Professionals rule violation and must				
V 291	27G .5603 Supervise	d Living - Operations	V 291			
	six clients when the cl developmental disabili on June 15, 2001, and more than six clients a to provide services at licensed capacity. (b) Service Coordinati	shall serve no more than ients have mental illness or ities. Any facility licensed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S	SURVEY PLETED
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		MHL043-075	3. 7111.0		12/1	16/2021
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		DUNN, N	C 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
	qualified professionals treatment/habilitation of (c) Participation of the Responsible Person. E provided the opportunit relationship with her or means as visits to the fithe facility. Reports sha annually to the parent of legally responsible perseports may be in writic conference and shall for progress toward meetin (d) Program Activities activity opportunities be needs and the treatment Activities shall be designiclusion. Choices may or legal system is involved as a second of the program activity of the program activities shall be designed by the program activities of the program a	who are responsible for or case management. Family or Legally each client shall be try to maintain an ongoing his family through such facility and visits outside all be submitted at least of a minor resident, or the son of an adult resident. In gor take the form of a locus on the client's high individual goals. Each client shall have assed on her/his choices, ant/habilitation plan. In gned to foster community or be limited when the court lived or when health or a primary concern. Exercise evidenced by: In and interview, the facility of more than six clients all illness or lies affecting the needs of each of the court lived or when health or a primary concern. Exercise evidenced by: In and 2 of 2 former lies affecting the needs of each of the court lived of the court lived of the court lived of the court lived or when health or a primary concern.	V 291	The facility will ensure coord efforts with qualified profession and management to ensure the more than 6 clients are served the home to support individual mental health and developmed disabilities. The QP will maintain contact residential facilities daily to eneach home does not serve an number of clients beyond the licensed occupancy capacity. The Director of Operations will notified immediately to help so the coordination of staff resource ensure the home does not serve any number of clients beyond current occupancy capacity. The Director of Operations, Cand Director of Quality Manage will discuss the occupancy state weekly to ensure continued compliance. The facility contends that at no did it serve clients beyond the capacity of 6 individuals at any given time or date.	onals nat no d at als with all with all asure by	
	- DOA: 12/15/09					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE	MPLETED
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		MHL043-075	B. WING	A STATE OF THE STA	12	/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	808 NOF	ADDRESS, CITY, STAT RTH MCKAY AVENU IC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 291	Review on 12/2/21 of - DOA: 2/4/13 - diagnoses: Mode Disabilities, Cerebral Repilepsy Unspecified Review on 12/2/21 of - DOA: 3/07/09 - diagnoses: Major Recurrent Episode-Mc Anxiety Disorder, Dev Expressive/Receptive Moderate Intellectual IReview on 12/2/21 clies - DOA: 2017 - diagnosis: Moderate Intellectual IReview on 12/2/21 of - Unknown admission and discharged from Series of Bipo Personality Disorder, Myperlipidemia, Asthm Chronic Obstructive Purchasel Chronic Obstructive Pur	Disorder and Profound client #3's record revealed: rate Intellectual Palsy, Deafness and client #4's record revealed: Depressive Disorder, Oderate, Unspecified elopmental Language Disorder and Disability ent #5's record revealed: ate IDD FC #A6's record revealed: on date to Sister Facility A ister Facility A on 11/19/21 lar Disorder with dependent fild Intellectual Disorder, a, Spinal Stenosis and allmonary Disorder FC #A7's record revealed: on date to Sister Facility A ister Facility A on 11/19/21 sive Development Disorder, isorder Unspecified, ecified, Moderate Hearing Loss, Seizure communication Skills.	V 291			
1	 sne would be the 	only staff at the facility with				1

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		MHL043-075	B. WING		12/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	FATE, ZIP CODE	
HARMONY	HOME		TH MCKAY AVE	NUE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	28334 ID	PROVIDER'S PLAN OF CORRECTION	N (VE)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 291	Continued From page	e 27	V 291		
	Harmony Home's 5 c	lients, FC #A6 & FC #A7			
	- the bus from the country and FC #A7 to the solid type of the facility only how times a week." Refer to V289 regarding this citation included the facility.	ility since October 2020. day program would bring FC ne facility. eld 6 clients. One staff on			
V 512	NCAC 27G .0203 Col Professionals and As (V109) for a Type A1 be corrected within 23 27D .0304 Client Right 10A NCAC 27D .0304	rule violation and must 3 days. hts - Harm, Abuse, Neglect	V 512		
	abuse, neglect and exwith G.S. 122C-66. (b) Employees shall most of abuse or negle NCAC 27C .0102 of the comparison of purchased from a comparison of the co	his Chapter. shall not be sold to client except through body policy. se only that degree of force			

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		MHL043-075	B. WING		R 12/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE ZIP CODE	
Paris Control Property Control			RTH MCKAY AV		
HARMONY	HOME	DUNN, N	NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
	governing body polic is necessary depend characteristics of the and physical and me of aggressiveness dis of intervention proces with Subchapter 10A (e) Any violation by a	y. The degree of force that s upon the individual client (such as age, size ntal health) and the degree splayed by the client. Use dures shall be compliance NCAC 27E of this Chapter. In employee of Paragraphs Rule shall be grounds for		actions and terminated the for staff who abused the client in question. The Director of Quality Manage completed the investigation tir and uploaded the findings to I Again, the former staff was terminated accordingly. Prior to survey exit on 12/16/21, all staff.	gement nely RIS. 1/8/22 o the
	This Rule is not met a on record review and i staff (FS #11) subjects (FC #A6) to abuse. The Review on 12/14/21 or hired 10/2020 rerminated 11/2/2 Abuse and Neglet 9/9/21	s evidenced by: Based interview 1 of 1 former ed 1 of 2 former clients are findings are: of FS #11's record revealed:		were in fact re-trained on abuse neglect in accordance with recommendations from the investigation summary report. Therefore, the facility had addressed all issues and correactions were taken-resulting from the abuse. neglect investigation in advance of the survey team and in advance of the request plan of protection.	ective com on: all exit
	9/9/21	revealed training certificate dated		In the future the Director of Que Management Director will cont to complete investigations time and ensure that all corrective	inue 1/8/22
	12/14/21 revealed: - signatures of staff Abuse, Neglect, Explo - Qualified Profession	onal (QP) #2 noted as the		actions are addressed in a time manner to include but not limit any recommendations for staff training.	ed to 1/8/22
	- unknown admissio	FC #A6's record revealed: on date to Sister Facility A ister Facility A on 11/19/21		The QP will monitor in the hom times weekly or more often to ensure continued compliance.	e 2-3

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S	SURVEY PLETED
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		MHL043-075	B. WING			R 16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
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HARMONY	HOME	DUNN, NC	28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	- diagnoses of Bipi dependent Personalit Developmental Disord Asthma, Spinal Stend Pulmonary Disorder Review on 12/15/21 of the Division of Health for FC #A6 - dated 11/27/2020 - QP's listed were for (DOO)/QP#1 & the Division of Health for FC #A6 - dated 11/27/2020 - QP's listed were for (DOO)/QP#1 & the Division of Health for FC #A6 - dated 11/27/2020 - Dehaviors consists threats to harm others yelling, profanity, use of other object as a weap behaviorelopement will be deadle and for incident 10 date and for incident 10 date of incident 10 date allegation rereported to DQM - Investigator: DQM - date investigation date findings report 10/18/21 - date of investigation date findings report 10/18/21	olar Disorder with y Disorder, Mild Intellectual der, Hyperlipidemia, sis & Chronic Obstructive of a faxed behavioral plan to Service Regulation (DHSR) with no signatures the Director of Operations rector of Quality ed of: "aggression including hitting and spitting at staff, of either the body or any conphysically assaultive will include any attempt to ut staff supervision" of the facility's investigation of for FC #A6 revealed: 0/11/21 ported 10/13/21 & DOO/QP #1 completed 10/18/21 ed to Administrator: on summary: 12/9/21 ngs: [FS #11] indicated ded that approval was given no 10/11/21 during early gement report that they had is #11] had come in to gave approvalclient [FC aggression and severe is client was yelling and	V 512	DEPICIENCY		
	cursing in her bedroon confirmed the behavio	n and client and staff rs. The behaviors occurred				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE S	URVEY LETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING		CONF	LETED
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		MHL043-075			12/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST			
HARMONY	HOME		H MCKAY AVE	NUE		
		DUNN, NC	28334			
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V 512	Continued From page	30	V 512			
	on 10/11/21 during the 12am to 2:30am. [FC her bedroom and hit I hanger on the back, hwas in the bed and tu face. [FC #A6] also reher blue tennis shoe fwith the tennis shoe. [injuries on [FC #A6] a assisted her during the reported it to her co-we 10/13/21. [Staff #13] In [day program] and cal (DOO/QP #1) Conclusubstantiated as staff implement less intrusion Intervention) technique interventions to address disruptive behaviors. In substantiated as staff a white plastic clothes the member's blue ten Disposition/Recomme was terminated for clie physical abuse and ne Quality Management we refresher training to Habuse, Neglect Prevention 10/15/21 at app (2:48pm) was given inforegarding the incident assaulted [FC #A6]. [FS by striking her on her her stricts and the substriking her on her her substriking her substr	e early morning hours from #A6] said [FS #11] came in her with a plastic clothes head and legs while she rn down on her side and aported [FS #11] picked up from the floor and hit her astaff #A14] discovered the tall [Sister facility] while he wake-up routine and forker [staff #A13] on hoticed the injuries at the led her supervisor asion: neglect was [FS #11] failed to to the worker [FC #A6] Physical Abuse was [FS #11] hit [FC #A6] with hanger and hit her with hanger and hit her with hanger and hit her with in shoe as well. Final hotations: 1. staff [FS #11] ent rights violations of eglect 2. The Director of will provide additional armony Home staff on hotion"	V 512			
	#A6] does not reside at was just there because					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE	SURVEY IPLETED
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		WITE043-075			12/	16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
HARMON	Y HOME	808 NOR	TH MCKAY AVENU	JE		
		DUNN, N	C 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 512	Continued From page	31	V 512			
	permeant room at the [DQM] also confirmed sound mind and was a with clarity" Review on 12/13/21 of FC #A6's primary phys appointment date "patient reported different facility and re was physically abusive bruisingshe reports thand that she has bruis clothes hanger was us	[Sister Facility A] location that [FC #A6] was of able to recall the incident f a medical summary from sician revealed: 10/14/21 d that she had to stay at a ported that the staff there e. She reported hat an employee hit her ingreports a shoe and edskin inspection and ymosis in various areas) rior scale 3. left upper per thigh (2) 5. right inner upper anPhysical abuse of d in a patient with				
	concise HPI (history of Interview on 12/13/21 I confirmed she was by FS #11 while at Har happened one tim it was at night and bruises on her legative tried to walk away incident FS #11 requested the 10/11/21 incide Interview on 12/10/21 F received a call fror staff #10 cried and had behaviors	FC #A6 reported: s hit with a clothes hanger mony Home e there were no witnesses s "and everywhere" from the facility after the she return to the facility ent made her "feel bad" FS #11 reported: m staff #10 reported FC #A6 ust left the facility and				

Division of Health Service Regulation

100000000000000000000000000000000000000	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION	(X3) DATE COM	SURVEY IPLETED
		MHL043-075	B. WING		12/	R 16/2021
					12/	10/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT			
HARMONY	HOME		RTH MCKAY AVENU	JE .		
		DUNN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT: (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 512	return to work - FC #A6 was in he arrived and was cuss - tried to ignore wh - she heard a loud - had a clothes han dresser, threatened to threatened to set facilicients & threatened to - tried to spit on he - kicked the furnitur with her arms, threw fell backwards - stayed with her in she calmed down - later, heard the down - later, heard the down - did not call anyon because she could not she redirected he - did not call anyon because she could not she helped her ge morning and there we linterview on 12/14/21 - he inserviced staff on abuse/neglect - QP #2 will provide Harmony Home staff - he reviewed the a curriculum with QP #2	er bedroom when she sing en she cussed bang ger hitting a glass on the obreak her car windows, ity on fire and burn up the okill her mother rand hit her (FS #11) re and kicked "wildly" herself on the floor and the bedroom until for alarm, when she (FS #A6) was not far ratoreturn to the facility e about the behaviors of find her phone of dressed the next ere no bruises the DQM reported: fat Sister Facility A e abuse/neglect training for buse/neglect 2 an inservice abuse/neglect	V 512			
	Review on 12/16/21 of Protection dated 12/ the DOO/QP #1 reveal	16/21 submitted by				
		action will the facility take to ne consumers in your care?				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE S	SURVEY PLETED
			B MING		1	R
		MHL043-075	B. WING		12/1	16/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
HARMON	Y HOME	808 NOR	TH MCKAY AVEN	IUE		
		DUNN, N	C 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 512	An investigation we completed and staff to An IRIS (Incident System) report was contifications took place findings were shared. Before the survey provided training to habuse neglect prever was presented during. The QP will monitensure that the client abuse Neglect and earthe Director of Quemonitor weekly to ensure the management discuss any client right are protected from Abuse. The management discuss any client right are protected from an exploitation. Describe your plathappens. The QP [name from the with the management with the management determine the status ensure compliance." FC #A6 had diagnosed dependent Personality Developmental Disord plan with behaviors the aggression, making the and biting. She was at of staff at Sister Facility facility's investigation of documented FC #A6 shedroom and hit her were surveyed.	ras conducted and erminated prior to the survey Response Improvement completed and appropriate e and the investigation in a timely manner was completed the QP darmony Home staff on a timent on and the in-service go the survey to rin the home daily to a are protected from exploitation unality management will ure that clients are neglect and exploitation team will meet weekly to at violations to ensure they by harm, abuse, neglect or and any program, PhD will ement team weekly to of any Corrective actions to so of Bipolar Disorder with a Disorder & Mild Intellectual tear. There was a treatment at consisted of verbal reats to harm others, kicking tharmony Home due to lack by A, where she resided at. A completed by the DQM said FS #11 came in her with a plastic clothes hanger legs while she was in the	V 512			

PRINTED: 12/22/2021 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 12/16/2021 MHL043-075 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 808 NORTH MCKAY AVENUE HARMONY HOME **DUNN, NC 28334** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 512 V 512 Continued From page 34 A medical summary documented elderly abuse due to bruises to the legs, neck and back of FC #A6. FS #11 was terminated & the DQM recommended additional refresher training on abuse & neglect prevention. The DQM provided Sister Facility A's staff with the refresher training, however, Harmony Home's staff was provided the abuse & prevention training 2 months after the incident happened. The training was provided during the course of the survey on 12/14/21 by QP#2. This deficiency constitutes a Type A1 rule violation for serious abuse and

27E .0107 Client Rights - Training on Alt to Rest. V 536 Int.

must be corrected within 23 days. An

administrative penalty of \$1,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.

10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS

- (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.
- (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.
- (c) Provider agencies shall establish training based on state competencies, monitor for internal

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V 536

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: R B. WING MHL043-075 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH MCKAY AVENUE HARMONY HOME **DUNN, NC 28334** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE. REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) The facility will review its policy and 2/14/22 Continued From page 35 V 536 procedures on training relative to compliance and demonstrate they acted on alternatives to restrictive data gathered. interventions and provide updates (d) The training shall be competency-based, accordingly. The Quality include measurable learning objectives, measurable testing (written and by observation Management Director will of behavior) on those objectives and measurable coordinate with the EBPI instructor methods to determine passing or failing the towards the modifications to the policy. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). The facility reserves the right as (f) Content of the training that the service outlined in the rules to have staff provider wishes to employ must be approved trained in either and to implement 2/14/22 by the Division of MH/DD/SAS pursuant to training for EBPI and/or NCI Plus. Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: The staff will be in-service by the QP (1) knowledge and understanding of and/or EBPI Instructor on updates to the people being served; the policy to reflect the use of (2)recognizing and interpreting alternatives to restrictive human behavior: (3)recognizing the effect of internal interventions. 2/14/22 and external stressors that may affect people with disabilities; The Director of Quality Management (4) strategies for building positive will consult with EBPI Instructor relationships with persons with disabilities; quarterly should there be a need to recognizing cultural, environmental and organizational factors that may affect people update the policy to reflect the use 2/14/22 with disabilities; of alternatives to restrictive recognizing the importance of and interventions. As changes occur to assisting in the person's involvement in the policy, staff will be in-service making decisions about their life; accordingly on any updates. (7)skills in assessing individual risk for escalating behavior: communication strategies for defusing (8)and de-escalating potentially dangerous behavior; and (9)positive behavioral supports (providing means for people with disabilities to choose

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
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	MHL043-075	B. WING		12/1	16/2021
ME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RMONY HOME	808 NOR	TH MCKAY AVE	:NUE		
	DUNN, N	C 28334			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
behaviors which are (h) Service providers documentation of init at least three years. (1) Documenta (A) who partici outcomes (pass/fail); (B) when and v (C) instructor's (2) The Div review/request this d (i) Instructor Qualificat Requirements: (1) Trainers sh by scoring 100% on to aimed at preventing, in need for restrictive int (2) Trainers sh competence by scorin testing in an instructo (3) The training competency-based, in objectives, measurabl observation of behavior measurable methods failing the course. (4) The content the service provider p approved by the Divis pursuant to Subparag (5) Acceptable shall include but are n (A) understandi (B) methods for course; (C) methods for performance; and	tly oppose or replace unsafe). shall maintain ial and refresher training for ation shall include: pated in the training and the where they attended; and name; ision of MH/DD/SAS made to the maintain at any time. ations and Training all demonstrate competence esting in a training program reducing and eliminating the erventions. all demonstrate and a passing grade on retraining program. It is shall be include measurable learning e testing (written and by or) on those objectives and to determine passing or the of the instructor training lans to employ shall be	v 536			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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HARMONY	HOME	808 NORTH	MCKAY AVE	NUE		
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V 536	experience teaching a preventing, reducing a restrictive intervention positive review by the (7) Trainers sha aimed at preventing, rneed for restrictive intrannually. (8) Trainers sha instructor training at le (j) Service providers sha documentation of initial training for at least thr (1) Docume (A) who particip outcomes (pass/fail); (B) when and who instructor's request and review this (k) Qualifications of Co (1) Coaches sha requirements as a train (2) Coaches sha competence by completrain-the-trainer instruction (I) Documentation sha as for trainers.	all have coached a training program aimed at and eliminating the need for as at least one time, with coach. all teach a training program reducing and eliminating the erventions at least once all complete a refresher ast every two years. hall maintain all and refresher instructor ee years. Intation shall include: atted in the training and the here attended; and name. If of MH/DD/SAS may a documentation any time. Daches: all meet all preparation ner. all teach at least three times being coached. all demonstrate etion of coaching or cotion. If be the same preparation.	V 536			
	This Rule is not met as	s evidenced by:				

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED			
			A. BUILDING.	A. BOLEBINO.			
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DMONIV	HOME	808 NOR	TH MCKAY AVEN	IUE			
(WOW)	HOME	DUNN, NO	28334				
4) ID EFIX AG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE	
V 536	Based on record reviefailed to implement polemphasize the use of interventions for 4 of 4 Qualified Professional (FS #11). The findings Review on 12/2/21 of revealed the following policy on alternation interventions did not swould be utilized training packet for Prevention Intervention Intervention Intervention Intervention Intervention Intervention Intervention Interviews between 1: Human Resources Ma of Quality Manageme facility utilized the Nat (NCI) curriculum for the I. Example of utilization training content programa. Review on 12/2 personnel record revenied: 3/19/13 certificate for EBP expiration date of 7/1/2 Review on 12/7/21 of a received from the Human Revealed: staff #9's certificate with an expiration date	ew and interview, the facility policies and practices that alternatives to restrictive 4 staff (#8-#10 and 1 #2) and 1 of 1 former staff is are: If the facility's records g: Ves to restrictive specify which program Fevidence Based on (EBPI) 2/2/21 and 12/14/21, the anager and the Director int (DQM) reported the tional Crisis Intervention incrapeutic interventions on of different interventions on of different ams 2/21 of staff #9's ealed: I dated 6/12/20 with an increase in a fax dated 12/6/21 in an Resources Manager in a fax dated 6/11/21 in a for EBPI dated 6/11/21 in a for E	V 536				
	RMONY 1) ID EFIX AG	Continued From page Based on record revise failed to implement postembraize the use of interventions for 4 of Qualified Professiona (FS #11). The finding: Review on 12/2/21 of revealed the following policy on alternati interventions did not would be utilized training packet for Prevention Intervention	RMONY HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 38 Based on record review and interview, the facility failed to implement policies and practices that emphasize the use of alternatives to restrictive interventions for 4 of 4 staff (#8-#10 and Qualified Professional #2) and 1 of 1 former staff (FS #11). The findings are: Review on 12/2/21 of the facility's records revealed the following: - policy on alternatives to restrictive interventions did not specify which program would be utilized - training packet for Evidence Based Prevention Intervention (EBPI) Interviews between 12/2/21 and 12/14/21, the Human Resources Manager and the Director of Quality Management (DQM) reported the facility utilized the National Crisis Intervention (NCI) curriculum for therapeutic interventions I. Example of utilization of different training content programs a. Review on 12/2/21 of staff #9's personnel record revealed: - hired: 3/19/13 - certificate for EBPI dated 6/12/20 with an expiration date of 7/1/21 Review on 12/7/21 of a fax dated 12/6/21 received from the Human Resources Manager revealed: - staff #9's certificate for EBPI dated 6/11/21 with an expiration date of one year b. Review on 12/2/21 of staff #8's personnel record revealed:	REOF PROVIDER OR SUPPLIER REMONY HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 38 Based on record review and interview, the facility failed to implement policies and practices that emphasize the use of alternatives to restrictive interventions for 4 of 4 staff (#8-#10 and Qualiffied Professional #2) and 1 of 1 former staff (FS #11). The findings are: Review on 12/2/21 of the facility's records revealed the following: - policy on alternatives to restrictive interventions did not specify which program would be utilized - training packet for Evidence Based Prevention Intervention (EBPI) Interviews between 12/2/21 and 12/14/21, the Human Resources Manager and the Director of Quality Management (DQM) reported the facility utilized the National Crisis Intervention (NCI) curriculum for therapeutic interventions 1. 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Review on 12/2/21 of staff #8's personnel record revealed: - hired: 11/3/16	STREET ADDRESS, CITY, STATE_ZIP CODE 808 NORTH MCKAY AVENUE DUNN, NC 28334 DIPTOR SUMMARY STATEMENT OF DEFICIENCIES EXAMPLY OR LSC IDENTIFYING INFORMATION) V 536 Continued From page 38 Based on record review and interview, the facility falled to implement policies and practices that emphasize the use of alternatives to restrictive interventions for 4 of 4 staff (#8-#10 and Qualified Professional #2) and 1 of 1 former staff (FS #11). The findings are: Review on 12/2/21 of the facility's records revealed the following: - policy on alternatives to restrictive interventions did not specify which program would be utilized - training packet for Evidence Based Prevention Intervention (EBPI) Interviews between 12/2/21 and 12/14/21, the Human Resources Manager and the Director of Qualify Management (DOM) reported the facility utilized the National Crisis Intervention (NCI) curriculum for therapeutic interventions I. 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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
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		MHL043-075	B. WING			16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
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V 536	Continued From page 39		V 536			
	one year expiration d Interview on 12/3/21, - he was trained in d. Review on 12/2 personnel record reve - hired: 6/9/21 - certificate for NCI year expiration date e. Review on 12/ revealed: - hired: 10/1/20 - terminated: 11/2/2 - certificate for EBP one year expiration da Interview on 12/14/21: (DOO)/QP #1 reported - EBPI was used by years	Plus dated 7/30/21 with a late the QP #2 reported: NCI by the agency 2/21 of staff #3's aled: dated 6/18/21 with a one 13/21 of FS #11's record 1 Plus dated 9/10/21 with a late the Director of Operations is the agency for a couple of a reviewed the staff records				

else- NCI.

be trained in EBPI.

- not aware of someone trained in something

- she was unsure if the staff #10 was trained prior to her hire date or by the facility's instructor.

Interview on 12/8/21 the developer of NCI

- if a staff was hired and was trained in another program, the agency would accept that program. Once their certification expired, the staff would

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		MHL043-075	B. WING		12/	12/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
HARMONY	HOME		TH MCKAY AVEN	IUE			
		DUNN, N	C 28334				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 536	Continued From pag	e 40	V 536				
V 536	reported: - whenever asked multiple programs, "I - the facility should program specified in Interview on 12/8/21 EBPI reported: - facility should have and procedure they will. Example of staff reexpired and facility to staff techniques and client interview on 12/9/21, - due to staffing sharecertified in alternation interventions the day she was a DOO/QP #1 wanted the instructor to rescribed in	if the facility could utilize urge them not to." I have the NCI their policies. the developer of ve it in their policy will utilize EBPI ported recertification ported training as current. of FS #11's record revealed: PI Plus dated 9/10/21 with a date "dated 10/15/21 issued due to violation of NCI trights FS #11 reported: ortages, she was not ives to restrictive scheduled to attend, the her to work and informed hedule nation, she was not	V 536				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL043-075	B. WING	12/	R 12/16/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		127	10/2021
HARMONY	HOME	DUNN, NO) <u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 536	III. Example of Instruct skills Interview on 12/2/21 to Director reported: EBPI and NCI Plus Interview on 12/8/21, alternatives for restrict coertified to train book EBPI and NCI Plus for language Interview on 12/3/2 EBPI reported: verified EBPI and content of training mache EBPI utilized three EBPI prevent was the training. EBPI prevent wouthe equivalent of alternative on 12/8/21 to reported: NCI took the prevent would be they use in their policies. NCI took the prevent would be they use in their policies. NCI included traum their training. Interview on 12/14/21 to if staff were trained.	in the records were the most ctor's failure to demonstrate the Human Resources us were the same the facility's trainer for tive interventions revealed: oth EBPI and NCI Plus us were the same except 1 the developer of NCI Plus had different terial and product objectives e different types of trainings. In the de-escalation portion of all be considered matives to restrictive have which curriculum by the developer of NCI ention piece and made ma care in the content of the DQM reported: in an approved uld still be okay to work."	V 536			

STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 12/16/2021	
		MHL043-075	B. WING			
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE		
HARMONY	HOME	808 NORTH	MCKAY AVE	NUE		
		DUNN, NC	28334			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	Continued From pag	e 42	V 536			
	compliance, then that for restrictive interventual expensions of the rule requirement of the curriculum was of the rule requirements. It may be confusired to the stricture of the curriculum was of the rule requirements. It may be confusired to both trainings to see that for each curriculum met that the curriculum was of the rule requirements. Subtle nuances in staff differently in impulse the rule requirements.	t person should be qualified" tions. examine content of if they were the same. he North Carolina Division slative and Regulatory rement in rule that prevents g staff trained in different tive intervention curricula. must be approved. cess determined that he rule requirements in 7 and/or .0108. are the same however determined to meet each				
∨537	1TO 10A NCAC 27E .010 SECLUSION, PHYSI AND ISOLATION TIN (a)Seclusion, physica time-out may be emp have been trained an competence in the pre to these procedures. staff authorized to em procedures are retrain competence at least a (b)Prior to providing designs.	CAL RESTRAINT ME-OUT I restraint and isolation loyed only by staff who d have demonstrated oper use of and alternatives Facilities shall ensure that uploy and terminate these ned and have demonstrated	V 537			

Division of Health Service Regulation

STATE FORM

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING		İ	
	MHL043-075	B. WING		R 12/16/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
HARMONY HOME		MCKAY AVE	NUE		
	DUNN, NC 2	28334			
PREFIX (EACH DEFICIENCY !	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
training is completed and demonstrated. (c) A pre-requisite for tall demonstrating competer training in preventing, ret the need for restrictive in (d) The training shall be include measurable learn measurable testing (writt of behavior) on those ob methods to determine pacourse. (e) Formal refresher training yeach service provider annually). (f) Content of the training provider plans to employ the Division of MH/DD/S. Paragraph (g) of this Rull (g) Acceptable training proclude, but are not limited (1) refresher inform the use of restrictive inted (2) guidelines on volunderstanding imminent and others);	eventions, staff including oyees, students or ste training in the use of raint and isolation time-ese interventions until the end competence is saking this training is noce by completion of educing and eliminating interventions. It is competency-based, raining objectives, and measurable easing or failing the ining must be completed in periodically (minimum on that the service is and measurable easing or failing the ining must be approved by SAS pursuant to sale. It is programs shall end to, presentation of: mation on alternatives to erventions; when to intervene end danger to self safety and respect for all persons involved restrictive interventions in an interventions; ergency safety	V 537			

i .	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		MHL043-075	B. WING		12/16/2021	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, S			
HARMONY	HOME		RTH MCKAY AVE NC 28334	ENUE		
(V.4) ID	SIIMMARYST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (VE)	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETE	
V 537	assessment and monipsychological well-bei use of restraint throug restrictive intervention (6) prohibited p (7) debriefing st their importance and p (8) documentation of initial at least three years. (1) Documentation of initial at least three years. (1) Documentation of initial at least three years. (1) Documentation of initial at least three years. (2) The Division review/request this documentation of initial at least three years. (3) The Division review/request this documentation of initial at least three years. (4) Trainers share by scoring 100% on the aimed at preventing, represented for restrictive interval at preventing, represented by scoring training program teach physical restraint and information of the training competence by scoring testing in an instructor (4) The training competency-based, incobjectives, measurable	toring of the physical and ng of the client and the safe hout the duration of the physical and the safe hout the duration of the physical and somethods/procedures shall maintain all and refresher training for sion shall include: ated in the training and the shere they attended; and same. Sion of MH/DD/SAS incumentation at any time, sion and Training and the structure of the same of the s	V 537			
	failing the course. (5) The content service provider plans	of the instructor training the to employ shall be				

Division of Health Service Regulation

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A CONTRACTOR OF THE PARTY OF TH	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	3:		IFLETED	
		NULL 040 075	B. WING	B WING		R	
		MHL043-075	D. 771170		12/	16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE			
HARMONY	/ HOME	808 NORT	H MCKAY AVE	ENUE			
		DUNN, NO	28334				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 537	Continued From page	45	V 537				
	approved by the Divis	ion of MH/DD/SAS					
		raph (j)(6) of this Rule.					
		nstructor training programs					
		pe limited to, presentation					
		ing the adult learner;					
	(B) methods for teaching content of						
	the course;	3 1000 1000 1000 1000 1000 1000 1000 10					
		of trainee performance; and					
	(D) documentation procedures.(7) Trainers shall be retrained at least						
		rate competence in the					
		sical restraint and isolation					
	Rule.	in Paragraph (a) of this					
	(8) Trainers shall CPR.	be currently trained in					
	(9) Trainers shall	have coached experience					
		restrictive interventions at					
	least two times with a	positive review by the					
	coach.						
1		teach a program on the					
1	use of restrictive intervannually.	entions at least once					
1		complete a refresher					
1	instructor training at lea	A COMPANY OF THE PROPERTY OF T			=		
	(k) Service providers sl						
		I and refresher instructor					
1	training for at least thre						
	(1) Documentatio	n shall include:					
		ated in the training and					
	the outcome (pass/fail)						
		here they attended; and					
	(C) instructor's r						
100		of MH/DD/SAS may					
		umentation at any time.					
	(I) Qualifications of Coa						
		meet all preparation					
3	requirements as a train	CI.	I .	1		I	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: R B. WING MHL043-075 12/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH MCKAY AVENUE HARMONY HOME **DUNN. NC 28334** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The facility will implement policies V 537 V 537 Continued From page 46 and procedures concerning its use 2/14/22 Coaches shall teach at least three (2)of physical restraints, seclusion and times, the course which is being coached. Time Out to include but not limed to Coaches shall demonstrate annual and updated staff training as competence by completion of coaching or train-the-trainer instruction. needed, or as required. (m) Documentation shall be the same preparation as for trainers. The Quality Management Director will coordinate with the EBPI Instructor and Training Coordinator 2/14/22 to ensure that EBPI and/or NCI Plus training on all staff is brought up-to-This Rule is not met as evidenced by: date and kept current, per facility Based on record review and interview, the facility policy. failed to implement policies and practices that emphasize the use of Seclusion, Physical Restraint and Isolation Time Out for 4 of 4 current The facility reserves the right as staff (#1-#3 and Qualified Professional #2) and 1 outlined in the rules to have staff of 1 former staff (FS #11). The findings are: trained in either and to implement training for EBPI and/or NCI Plus. 2/14/22 Review on 12/2/21 of the facility's records revealed the following: policy on Seclusion, Physical Restraint and Isolation Time Out did not specify which The Director of Quality Management program would be utilized will consult with the EBPI Instructor training packet for Evidence Based and facility Training Coordinator on 2/14/22 Prevention Intervention (EBPI) a quarterly basis to ensure that I. Example of utilization of different 100% of staff have updated training training content programs and certificates for the same on file. a. Review on 12/2/21 of staff #9's personnel record revealed: hired: 3/19/13 certificate for EBPI Base Plus dated 6/12/20 with an expiration date of 7/1/21 Review on 12/7/21 of a fax dated 12/6/21 received from the Human Resource Manager revealed:

TAG RESULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 47 - staff #9's certificate for EBPI Base Plus dated 6/11/21 with an expiration date of one year expiration date b. Review on 12/2/21 of staff #8's personnel record revealed: - hired: 11/3/16 - certificate for EBPI Base Plus dated 11/17/21 c. Review on 12/7/21 of the Qualified Professional (QP) #2's personnel record revealed: - hired: 8/9/21 - certificate for EBPI Base Plus dated 7/30/21 with a one year expiration date Interview on 12/3/21, the QP #2 reported: - he was trained in NCI by the agency d. Review on 12/2/21 of staff #10's personnel record revealed: - hired: 6/9/21 - certificate for NCI Plus dated 6/18/21 with a one year expiration date e. Review on 12/13/21 of FS #11's record revealed: - hired: 6/9/21 - certificate for TCI Plus dated 9/10/21 with a one year expiration date Interview on 12/14/21 the Director of Operations (DOO)/QP #1 reported: - EBPI was used by the agency for a couple of years		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER HARMONY HOME SOB NORTH MCKAY A VENUE DUNN, NC 28334 ID PROVIDER'S PLAN OF CORRECTION PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX TAG							R
MARMONY HOME SUMMARY STATEMENT OF DEFICIENCIES DEFINITION DID PROFITE PROVIDER'S PLAN OF CORRECTION (SA) DEFICIENCY MUST BE PRECEED BY FULL PROFITE ACTION SHOULD BE (REACH DEFICIENCY MUST BE PRECEED BY FULL PROFITE ACTION SHOULD BE (REACH DEFICIENCY MUST BE PRECEED BY FULL PROFITE ACTION SHOULD BE (REACH DEFICIENCY) TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY COMPLET			MHL043-075	B. WING			
DUNN, NC 28334 DUNN, NC 28334 DUNN, NC 2834 DUNN, NC	NAME OF PE	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
SUMMARY STATEMENT OF DEFIGURISES DEFICIENCY SUMMARY STATEMENT OF DEFIGURISES DEFICIENCY SUMMARY STATEMENT OF DEFICIENCY TAG SCAN CHEROLOGY MUST BE REPRESEDED BY SPILL FROM STATE SCAN CHEROLOGY STATE SCAN CHERO	HARMONY	HOME			NUE		
PREFIX TAG PREFIX PREFIX			The second secon	28334	I		Τ
- staff #9's certificate for EBPI Base Plus dated 6/11/21 with an expiration date of one year expiration date b. Review on 12/2/21 of staff #8's personnel record revealed: - hired: 11/3/16 - certificate for EBPI Base Plus dated 11/17/21 c. Review on 12/7/21 of the Qualified Professional (QP) #2's personnel record revealed: - hired: 8/9/21 - certificate for EBPI Base Plus dated 7/30/21 with a one year expiration date Interview on 12/3/21, the QP #2 reported: - he was trained in NCI by the agency d. Review on 12/2/21 of staff #10's personnel record revealed: - hired: 6/9/21 - certificate for NCI Plus dated 6/18/21 with a one year expiration date e. Review on 12/13/21 of FS #11's record revealed: - hired: 10/1/20 - terminated: 11/2/21 - certificate for EBPI Base Plus dated 9/10/21 with a one year expiration date linterview on 12/13/21 the Director of Operations (DOO)/QP #1 reported: - EBPI was used by the agency for a couple of years	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
 Human Resources reviewed the staff records quarterly/every 6 months. Not aware of someone trained in something 	V 537	- staff #9's certificad dated 6/11/21 with any ear expiration date b. Review on 12/personnel record revelopersonnel record revelopersonnel record revelopersonal (QP) #2 revealed: - hired: 8/9/21 - certificate for EBF with a one year expiral Interview on 12/3/21, - he was trained in d. Review on 12/3/21, - he was trained in d. Review on 12/3/21, - he was trained in d. Review on 12/3/21, - he was trained in d. Review on 12/3/21, - certificate for NCI one year expiration de e. Review on 12/12/2 - certificate for EBF with a one year expiration de linterview on 12/14/21 (DOO)/QP #1 reported - EBPI was used by years - Human Resources quarterly/every 6 more	ate for EBPI Base Plus in expiration date of one 1/2/21 of staff #8's ealed: PI Base Plus dated 11/17/21 of the Qualified 's personnel record PI Base Plus dated 7/30/21 ation date the QP #2 reported: NCI by the agency 1/2/21 of staff #10's ealed: Plus dated 6/18/21 with a late 1/13/21 of FS #11's record PI Base Plus dated 9/10/21 ation date the Director of Operations d: by the agency for a couple of last reviewed the staff records at ths.	V 537			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			MHL043-075	B. WING	12	R 12/16/2021			
	NAME OF PE	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE, ZIP CODE	1 200	10/2021		
	HARMONY	HOME	808 NOR	TH MCKAY AVEN	UE				
L			DUNN, N	IC 28334					
	(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE		
	V 537	program, the agency of Once their certification trained in EBPI Base - She was unsure if prior to her hire date of Interview on 12/8/21 reported: - Whenever asked multiple programs, "I - The facility should their program for sect and isolation time out Interview on 12/8/21 to EBPI reported: - Facility should have and procedure they will. Example of staff repexpired and facility reported and facility reported: - Review on 12/13/21 to certificate for EBP 9/10/21 with a one ye - "corrective action" the facility to staff due techniques and client Interview on 12/9/21, - due to staffing shore-certified in alternation interventions. - the day she was s	and was trained in another would accept that program. In expired, the staff would be Plus. The staff #10 was trained or by the facility's instructor. The developer of NCI of the facility could utilize urge them not to." If have in their policy NCI as fusion, physical restraint of the developer of we it in their policy will utilize EBPI plus forted recertification forted training as current. In FS #11's record revealed: If Base Plus dated ar expiration date of dated 10/15/21 issued by the to violation of NCI rights FS #11 reported: fortages, she was not ever to restrictive or cheduled to attend, the first own, she was not wes to restrictive or the was not west on the was not west or she was not west or she was not west or she was not was n	V 537					
	1	interventions		1					

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL043-075	B. WING		12/	16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
HARMONY HOME		MCKAY AVE	NUE			
	40.400.000	DUNN, NC	28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 537	Quality Management emphasized, if you we put your hands on the she was terminat 10/11/21. She did no action" because she Interview on 12/2/21 to Director revealed: - verified trainings is current III. Example of Instructions wills Interview on 12/2/21 to Director reported: - EBPI Base Plus as Interview on 12/8/21, the alternatives for restrict corrections or extrict corrections. Plus - EBPI Base Plus as except for language Interview on 12/3/21 to EBPI reported: - verified EBPI and content of training management of training management complex holds and alternativentions would be seen to she was a series of the public to the public t	DO/QP#1 and Director of (DQM) had "always vere not traineddo not esse people" ed due to an incident on the sign the "correction did not agree with it. With the Human Resources in the records were the most estor's failure to demonstrate. The Human Resources and NCI Plus were the same estentially strainer for invertice interventions revealed: both EBPI Base Plus and and NCI Plus were the same estentially same estentially strainer for invertice interventions revealed: both EBPI Base Plus and and NCI Plus were the same estentially same estentially strainer for invertice included trainings. The simple blocks, the estimation of the curriculum included trainings for the interventions, base	V 537	DELINOT)		
	and transports.agencies should h	nave which content of				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SO PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		SURVEY			
			A. BOILDING		1	R
		MHL043-075	B. WING		10	16/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, ST	ATE, ZIP CODE		
HARMONY HOME			MCKAY AVE	NUE		
7,031,000		DUNN, NC	28334	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 736	Continued From page training program they Interview on 12/14/2- if staff were trained intervention then "it we if the staff's "certif compliance, then that for restricitive intervntice he would need to both trainings to see Interview on 12/9/21 to Mental Health Legis Affairs Team: "There is no require a provider from having alternative and restrice Each curriculum recurriculum met the run NCAC 27E .0107 and No two curricular each curriculum was of the rule requirement. Subtle nuances in staff differently in impure it may be confus when all staff do not for	e 50 y use in their policy 1 the DQM reported: d in an approved ould still be okay to work." icates were within person should be qualified" ons. examine content of if they were the same. the North Carolina Division slative and Regulatory irement in rule that prevents g staff trained in different ctive intervention curricula. The province of the same however determined to meet each onts. The each curriculum may train lementing an intervention. In each curriculum may train lementing an intervention. In g to the service recipient collow the same protocols" and Grounds Maintenance 3 LOCATION AND EMENTS Its grounds shall be clean, attractive and	V 537	DEFICIENCY)		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORPECTION DESCRIPTION NUMBER: COM		SURVEY				
ANDFLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			LLILD		
		MHL043-075	B. WING		I	R 6/2021
					12/1	0/2021
NAME OF PI	ROVIDER OR SUPPLIER			TATE, ZIP CODE		
HARMONY	HOME	DUNN, NC	H MCKAY AVE	INCE		
	OUMANDY OT		7	PROMPERIORIAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 736	Continued From page This Rule is not met a Based on observation	s evidenced by:	V 736	The QP will conduct inspection times weekly to address clear safe and orderly conditions of home and its grounds. The QP will complete a	nliness, f the	
	Review on 12/2/21 of maintained by the Div Regulation revealed a Inspection report date	anner. The findings are: the facility's public record ision of Health Service local Sanitation d 10/20/21 which included		maintenance request form to any issues noted. The QP wil follow-up weekly on all mainterequest orders to determine the status until corrected.	l enance	
	but not limited to the formal section of the	ified oilet seat" od & rings rusty" "very worn" on 12/2/21 of the		All the issues noted from San Inspection are being addresse such actions were taking place the time of the survey as documentation was presented surveyors of the same.	ed and e at	1/8/22
	revealed the following - male's bathroom vanity 2 of 4 when flipped brown stains and resid - female bathroom vanity 1 light	light bulbs missing up, toilet seat had thick		All issues noted from surveyo on 12/2/21 will be addressed. The QP continues to monitor in home 2-3 times weekly to ensign continued compliance.	in the	1/8/22
	a ring around it small indentice the wall client #1's bedroot brown stains mattress large circular carpet that ranged in selarge plate	on the size of a fist noted in		The Director of Quality Manag will review and track all Health Sanitation Inspections conduct and will monitor in the home w to ensure continued compliand	and ted veekly	1/8/22

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	1, ,	SURVEY MPLETED
					R
	MHL043-075	B. WING		12	/16/2021
NAME OF PROVIDER OR SUPPLIER HARMONY HOME		DDRESS, CITY, STAT TH MCKAY AVENU C 28334			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
cigarette butt noted in orangement of several sections of a pill noted on a size of a client #1 had toiletitous on the size of months ago and the mattress. Interview on 12/3/21 standard in a maintenance repair requests of months ago and the mattress. Interview on 12/3/21 standard in a maintenance repair requests of months ago and the mattress. Interview on 12/3/21 standard in a maintenance repair requests of any results of size of any results of size of any results of size	ar holes the size of comforter mestain noted on the wall apped hard gray matter the arms, legs, bottom of chairs aff #10 reported: a checklist for cleaning a real cleaner", others ing incidents often s was replaced a couple plastic was left on the aff #8 reported: a report system to report are reported but not always ridge & bulbs blown" and things got better equired repairs at this time are Qualified Professional are "one of the best kept liness" ort was completed monthly intenance requests to him to home twice a month adention in the female men former client (FC) A punched the wall. He intion occurred prior to his the company.	V 736			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
		A. BUILDING		F	2
	MHL043-075	B. WING		and the second discountry	6/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	TATE, ZIP CODE		
HARMONY HOME	808 NORTH	MCKAY AVE	NUE		
	DUNN, NC 2	28334			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES BT BE PRECEDED BY FULL SENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
V 736 Continued From page 53		V 736			
mattress/toilet seat/tub, hol on dining chairs or any per requests	nding maintenance				
Quality Management (DQN - not aware of items obs tour except the stained car - repairs for the home ha	M) reported: served during the rpet ad to be approved				
by Housing and Urban Dev - not sure the status of the process or when it was sub	ne carpet removal omitted				
Review on 12/7/21 of a fax DQM revealed: - "HUD repair not initiate internal route to address re - receipt dated 12/7/21 fo table attached	ed, going the epairs"				
Interview on 12/14/21 the I - with repairs, he noticed during the 12/2/21 tour of t - issues had been identif resolved through managen - he monitored the home	d the condition the home fied, addressed and ment. e once every 2				
months. Every other month he had not reviewed the conducted by the local hea agency put corrective a was brought to my attention	e sanitation report Ith department. actions in place. "It n."				
 agency had an outside the carpet. agency completed a ma "I can't tell the specificity." verified he saw somethin he found out the toilet was a sanitizing with Clorox and number of the contractor can take took the responsibility of actions. 	aintenance report. ing on the toilet. Later stained as result of not fecal matter. ke a while, so agency				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	150 6	(X3) DATE SURVEY COMPLETED	
			B. WING			R	
		MHL043-075	D. VVIIVO		12/	16/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST				
HARMONY	HOME	DUNN, NO	TH MCKAY AVE	NUE			
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE	
V 736	Continued From page	e 54	V 736				
	in the wall. The [QP] v oversight of assuring Not spoke to him (QP	First time I noticed the hole would monitor the staff and the cleaning of the home. about Harmony. "I've not requently as some of the					
	Administrator reporte - had a cleaning cre - client had toileting the tour. He felt these not ongoing - he had the table r of the survey - "We have contract have brought it to our						
	NCAC 27G .0203 Cor Professionals and Ass	rule violation and must					
V 784	27G .0304(d)(12) Thei Areas	rapeutic and Habilitative	V 784				
	AND EQUIPMENT (d) Indoor space requirements of the minimum square freffect at that time. Unlikese Rules, residential	irements: Facilities per 1, 1988 shall satisfy ootage requirements in less otherwise provided in al facilities licensed after meet the following indoor					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I have been been been been been been been be	E CONSTRUCTION	(X3) DATE S	SURVEY PLETED
		A. BUILDING		-	
	MHL043-075	B. WING			R 1 6/2021
AME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE		
ARMONY HOME	808 NORTH	MCKAY AVE	NUE		
	DUNN, NC	28334			Т
PREFIX (EACH DEFICIENCE	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETE DATE
This Rule is not met Based on interview a failed to ensure areas habilitative activities a separate from sleeping. Review on 12/3/21 or unknown admission and discharged from sleeping and	ch therapeutic and are routinely conducted m sleeping area(s). as evidenced by: nd record review the facility in which therapeutic and are routinely conducted were not are are routinely conducted were not are active and are routinely conducted were not attention date to Sister Facility A sister Facility A on 11/19/21 sive Development Disorder, Disorder Unspecified, pecified, Moderate s, Hearing Loss, Seizure I Communication Skills. staff #9 reported: #A7 was not a client of this are at the facility when there at Sister Facility A. r 3-4 times from September 1. erved sleeping on the sofa in a staff bedroom. I FS #11 reported: illity since October 2020. he couch "on a regular FC #A7's guardian reported: he facility with FC #A6 as		The facility will ensure coording efforts with qualified profession and management to ensure the sleeping quarters for the individual are separate from areas utilized habilitative or therapeutic activated provide and maintain contact with a residential facilities daily to enthat each home provide separasleeping quarters for all individual served. The Director of Operations will notified immediately to help such the coordination of staff resourensure the home have separasleeping quarters for any residential is present in the home on overnight basis. The Director of Operations, Cand Director of Quality Management will discuss the occupancy state weekly to ensure continued compliance. The facility contends that at nowas a client forced to sleep on couch and if it occurred it was result of client choice and not frequest of staff or management.	onals nat riduals ed for vities. all asure duals libe upport rces to te dent an EO ement tus of time in the the the	1/8/22 1/8/22 1/8/22

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE S	SURVEY PLETED
/			A. BUILDING:		-	
		MUI 042 075	B. WING		6,100,4,11	R
		MHL043-075			12/	16/2021
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, ST			
HARMONY	HOME	DUNN, NC	H MCKAY AVE	NUE		
	CHMMADY CT		T	DDGWD5DG BLAN OF GODDSTIEN		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 784	Continued From page	e 56	V 784			
	Care Coordinator (LM - she was aware the overnight at the facility not the Care Coordinator (LM) - she had been told couch or a chair at the linterview on 12/13/21 - FC #A7 went to Harrie on 12/10/21 - FC #A7 slept on a linterview on 12/10/21 reported: - a staff from Sister FC #A7 slept on the color linterview on 12/10/21 (LME/MCO/CC) reported: - the guardian was to Harmony Home - the guardian inform on a couch during here on 10/19/21 a conwith the Administrator (DOO)/Qualified Profes Director of Quality Marked why she sleed was told FC #A7 in clients' bedrooms Interview on 12/14/21 Professional (QP) #1 reference of the color linterview on 12/14/21 Professional (QP) #1 reference color line was told for the color line was told f	anaged Care Organization E/MCO/CC) reported: at FC #A7 was staying by even though she was ator for FC #A7. If that FC #A7 slept on the e facility. I FC #A6 reported: Iarmony Home with her a couch FC #A6's guardian Facility A made her aware couch the supervisor for rted: upset FC #A7 had visits med them FC #A7 slept r visits to Harmony Home iference call was held r, Director of Operations essional (QP)#1 and the inagement (DQM) ept on a couch had a history of destroying the DOO/Qualified eported: that FC #A7 had slept on by				
		the DQM reported:				

Division of Health Service Regulation

6899

				E SURVEY DMPLETED		
						R
		MHL043-075	B. WING		12/	16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HARMONY	HOME		TH MCKAY AVE	ENUE		
000000000000000000000000000000000000000	GUUUU 97	DUNN, NO	T			T
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 784	Continued From pag	e 57	V 784			
	Harmony Home or sl	ept on a couch				
		couch, was because		9		
	she wanted to and th	nat was her right"				
	Interview on 12/10/2	1 the Administrator reported:				
		and Urban Development for				
		ccupied at Harmony Home ave to sleep on a couch				
	- there was a client	t of the facility that took				
		ne, and that client's bed re was no need for FC #A7				
	to sleep on the couch					
		Service Regulation				
	"information was 100 some disgruntled em	% incorrect. We have ployees."				
		ss referenced into 10A mpetencies of Qualified				
	Professionals and As (V109) for a Type A1	sociate Professionals rule violation and must				
	be corrected within 2	3 days.				

January 5, 2022

DHSD - Frank Palth

JAN 5 _ 2022

Ms. Renee Kowalski, Supervisor Mental Health Licensure and Certification Section N.C. Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

Lic. & Cert. Section

Re: Annual, Complaint and Follow-up survey completed December 16, 2021
Harmony Home
808 North McKay Avenue
Dunn, NC 28334
MHL#043-075
Intake #NC00183246

Dear Ms. Kowalski:

See attached hard copy of the plan of correction (POC) for the Harmony Home's survey, completed 12/16/21. We hope that you will find the attached POC acceptable. If you have questions, feel free to contact myself or Vidya Persad, Director of Operations. Otherwise, we very much look forward to your follow-up visit.

Kindest regards,

James Harris, Director Quality Management

& ASSOCIATES INC.

Provider of MH/IDD/SAS

JAMES HARRIS, QP, MPA Director, Quality Management