STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed 12/16/21. The complaint (Intake #NC00183246) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. A sister facility was identified in this report. The sister facility will be identified as facility A. Staff and/or clients will be identified using the letter A and a numerical identifier. The survey sample consisted of audits of 5 current clients & 2 former clients from sister facility A. The Director of Operations/Qualified Professional (QP#1) referenced in this report is the Administrator's wife.	V 000	It should be noted that the 2 former clients referenced in the findings were discharged effective 11/19/21, well in advance of the state survey conducted in early December 2021. Hence the former clients were not active residents in the care of this Provider at the time of the survey. It should be further noted that 5 of 5 of the facility's current client population - at the time of the survey were not compromised and there was no evidence cited by the state of client rights violations impacting the current population.	1/8/22 1/8/22
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge;	V 109	DHSR - Mental Health JAN 5 _ 2022 Lic. & Cert. Section	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 1 (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 3 of 3 Qualified Professionals (QP) (Director of Operations (DOO) /QP #1, QP #2 and the Director of Quality Management (DQM)) demonstrated the knowledge, skills and abilities required by the population served. The findings are: A. Cross reference 10A NCAC 27G .0207 Emergency Plans and Supplies (V114). Based on record review and interview the facility failed to complete disaster drills quarterly and on each shift.	V 109	The facility will ensure that persons functioning in the capacity of a QP, demonstrates knowledge, skills, abilities required to serve the population to include but not limited to the following. A-The QP will implement the disaster plan and staff will complete documentation of disaster drills quarterly on each shift in the home. B-The QP will provide training to staff to ensure all medications are administered in accordance with the physician's orders and staff will complete documentation on the MAR for all assigned clients. C- The QP will ensure that the home environment affords the appropriate services, care, habilitation to individuals who have mental illness and/or developmental disabilities. D-The QP will coordinate and monitor in the home to ensure that no more than 6 clients are served. E-The QP will monitor in the home to ensure the facility is maintained in a safe, clean, and attractive manner.	1/8/22 18/22 1/8/22 1/8/22 1/8/22 1/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 2 B. Cross reference 10A NCAC 27G .0209 Medication Requirements (V118). Based on observation, record review and interview, the facility failed to ensure that MARs were kept current for 3 of 3 audited clients (#1, #3 and #4) and failed to assure 3 of 3 staff (#8, #9 and #10) demonstrated competency in medication administration. C. Cross reference 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness - Scope (V289). Based on record review and interview the facility failed to provide a home environment where the primary purpose of these services was the care, habilitation/rehabilitation of individuals who have a mental illness and developmental disability affecting 5 of 5 clients (#1-#5). D. Cross reference 10A NCAC 27G .5603 Supervised Living for Adults with Mental Illness - Operations (V291). Based on record review and interview, the facility failed to ensure that no more than six clients were served with mental illness or developmental disabilities affecting the needs of 5 of 5 current clients (#1-#5) and 2 of 2 former clients (FC #A6 and FC #A7). E. Cross reference 10A NCAC 27G .0303 Location and Exterior Requirements (V736). Based on observation, record review and interview the facility was not maintained in a safe, clean and attractive manner F. Cross reference 10A NCAC 27G .0303 Location and Exterior Requirements (V784). Based on interview and record review the facility failed to ensure areas in which therapeutic and habilitative activities are routinely conducted were	V 109	F. QP will ensure that the individuals have access to sleeping quarters that are separate from areas used for habilitative and therapeutic activities. G-The Director of Quality Management completed the investigation timely and uploaded the findings to IRIS. The former staff was terminated accordingly. Prior to the survey exit on 12/16/21, all staff were in fact trained on abuse, neglect in accordance with recommendations from the investigation summary report. Therefore, the facility had addressed all issues and corrective actions were taken-resulting from the abuse. neglect investigation: all in advance of the survey team exit and in advance of the request for a plan of protection. In the future the Director of Quality Management will continue to complete investigations timely and ensure that all corrective actions are addressed in a timely manner to include but not limited to any recommendations for staff training.. The QP will monitor in the home 2-3 times weekly or more often to ensure continued compliance.	1/8/22 1/8/22 1/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 3 separate from sleeping areas Review on 12/15/21 of an email dated 12/15/21 from the Human Resource Manager revealed the following dates for Former Qualified Professionals (FQP) employed between January-July 2021: - FQP #3: Hired-5/20/2013 & Terminated-1/8/2021 - FQP #4: Hired-1/23/2020 & Terminated-3/3/2021 - FQP #5: Hired-3/2/2021 & Terminated-4/28/2021 Review on 12/13/21 of (Qualified Professional) QP #2's record revealed: - hired: 8/9/21 - job description dated 8/16/21 listed job duties that included but not limited to: briefed by outgoing shift count medications, check MARs and document check status of facility repairs complete all facility inspections to meet health and safety standards supervised by the Director of Operations (DOO)/QP #1 Review on 12/14/21 of the DOO/QP #1's personnel record revealed: - hired: 6/1/05 - job description dated 6/1/05 listed duties that included but not limited to: orientate and supervise employees that provide active treatment provide direct intervention and also arrange, coordinate and monitor services develop an action plan for deficits noted within the organization act as an advocate for consumers	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 4 provide Clinical consultation at least twice a month oversee documentation in accordance with the service definitions and agency's policies and procedures Review on 12/14/21 of the Director of Quality Management's (DQM) personnel record revealed: - hired: 11/1/11 - job description dated 11/1/11 listed duties that included but not limited to: provide oversight and work closely with the DOO to ensure support of all outcomes coordinate completion of audit process for all charts assist with coordination and provide all trainings as needed G. Review on 12/13/21 of the facility's investigation summary dated 12/9/21 for FC #A6 revealed: - date of incident 10/11/21 - date allegation reported 10/13/21 - reported to DQM & DOO/QP #1 - Investigator: DQM - date investigation completed 10/18/21 - "Summary of findings: [FC #A6] said (former staff) [FS #11] came in her bedroom and hit her with a plastic clothes hanger on the back, head and legs while she was in the bed and turn down on her side and face. [FC #A6] also reported (former staff) [FS #11] picked up her blue tennis shoe from the floor and hit her with the tennis shoe. Physical Abuse was substantiated as staff [FS #11] hit [FC #A6] with a white plastic clothes hanger and hit her with the member's blue tennis shoe as well. Final Disposition/Recommendations: 1. staff [FS #11] was terminated for client rights violations of physical abuse and neglect 2. The Director of	V 109	The QP will monitor in the home 2-3 times weekly and implement the current plan of protection to ensure continued compliance. It should be noted that the 2 former clients referenced in the state findings were discharged effective 11/19/21, well in advance of the state survey conducted in early December 2021. Hence the former clients were not active residents in the care of this Provider at the time of the survey. It should be further noted that 5 of 5 of the facility's current client population - at the time of the survey were not compromised and there was no evidence cited by the state of client rights violations impacting the current population.	1/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 5 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 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	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 6 system) report was completed and appropriate notifications took place and the investigation. Findings were shared in a timely manner. Before the survey was completed the QP provided training to the Harmony Home staff on Abuse neglect prevention and the in-service was presented during the survey. The QP will monitor in the home daily to ensure that the client are protected from abuse, neglect and exploitation. The Director of Quality management will monitor weekly to ensure that the clients are protected from Abuse, neglect and exploitation. The management team will meet weekly to discuss any client right violations to ensure they are protected from any harm, abuse, neglect or exploitation. The management team will meet weekly to discuss any client right violations to ensure they are protected from any harm, abuse, neglect or exploitation. The QP [day program physician] will meet with the management team weekly to determine the status of any corrective actions to ensure compliance." This deficiency constitutes a re-cited deficiency. The QP #2 worked at the agency for 3 months and was responsible for the day to day operations of the facility. He was not consistently cognizant of maintaining the facility census and the frequency of Sister Facility A clients (FC #A6 and FC #A7) sleeping over at the facility, knowledgeable of environmental living issues in the home, medication administration errors, completion of disaster drills on every shift; failed to support direct care staff with client specific information for FC #A6 and FC #A7, and failed to facilitate a home like environment for FC #A7. FC #A7 slept on the couch at the facility. The DOO/QP #1 worked at the agency for 20 years and provided oversight and supervision over all of	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 109	Continued From page 7 the facilities as well as the QP staff. Both the DOO/QP #1 and the QP #2 failed to maintain the licensed census at the facility or to communicate the needs of FC #A6 and FC #A7 to the facility direct care staff. Harmony staff signed the medication administration record (MARs) for FC #A6 71 days from January 2021 to November 2021 and 20 days for FC #A7 from September 2021 - November 2021. The DQM assured regulatory compliance for the agency and all associated facilities as well as regulatory oversight over QP #2 and failed to ensure that medication errors were minimized, safety drills were performed quarterly and on every shift, and that staff were trained subsequent to a substantiated incident of abuse. Systematically, these deficiencies constitute a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000 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.	V 109		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c)Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 8 under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record 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 Interview on 12/2/21 staff #10 reported: - she was hired in June of 2021. - she had not completed any disaster drills since she was hired. Interview on 12/3/21 staff #8 reported: - every staff was supposed to complete disaster drills twice a month. - may have not done as many because they had been short of staff. Interview on 12/3/21 the Qualified Professional (QP) #2 reported: - he started work in August 2021. - "fire drills is what we consider a disaster drill." - had not performed any tornado drills since he started working at the facility. Interview on 12/14/21 the Director of Quality Management reported: - QP #2 informed him disaster drills were being completed at the facility	V 114	The facility will ensure that disaster and/or evacuation drills are conducted at least quarterly, under varied conditions for each shift in the home. The QP will in-service the staff in the home on the evacuation process and implementation of the schedule. The evacuation schedule will be posted for staff review. The QP will track all disaster and fire drills monthly to ensure compliance. The Quality Management Director will review all evacuation drills monthly to ensure compliance.	1/8/22 1/8/22 1/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 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.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 10 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that MARs were kept current for 3 of 3 audited clients (#1, #3 and #4) and failed to assure 3 of 3 staff (#8, #9 and #10) demonstrated competency in medication administration. The findings are: I. Example MARs not signed immediately after medications given: A. Review on 12/2/21 of client #1's record revealed: - admitted: 2/9/21 - diagnoses: Autism, Severe Intellectual Developmental Disability (IDD), Gastroesophageal Reflux Disease (GERD) and Colitis - December 1, 2021 MAR entry was blank for the following 8am medications: Clonidine HCL .1mg (milligram) (Sedative and high blood pressure) Vascepa 1GM (gram) (cardiovascular disease) Depakote extended release 500mg (anticonvulsant) Calcium 500mg (dietary supplement) Omeprazole 40mg (heartburn) Risperdal 4mg take 1/2 tablet for 2 mg dosage (irritability caused by autism) - October 2021 MAR listed Peppermint 50mg (irritable bowel syndrome) blank entries for 12 noon on 4th, 5th, 6th, 11th, 12th, 13th, 15th, 18th and 19th	V 118	The facility will ensure that medications are administered in compliance with physician's orders and documentation is complete and accurate on the MAR. For Client #1, #3 and #4 the QP will monitor 2 times weekly to ensure that staff initial the MAR as required. The QP will in-service all staff on the importance of initialing off on the MAR for all clients during medication administration. Staff will be instructed to administer all medications and confirm through a crosswalk of the MAR during each medication pass. The QP will monitor the MARs for all clients, 2-3 times weekly in the home to ensure compliance. The Director of Quality Management will monitor the MAR weekly in the home to ensure continued compliance and consult with the QP and/or direct care staff accordingly.	1/8/22 1/8/22 1/8/22 1/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 11 B. Review on 12/2/21 of client #3's record revealed: - admitted 2/4/13 - diagnoses of Moderate IDD, Cerebral Palsy, Deafness and Epilepsy Unspecified Review on 12/2/21 of client #3's December 2021 MAR revealed: - no staff signatures for morning medications on 12/1/21 - medications listed on the MAR: Zoloft 100mg everyday (anxiety) Carbamazepine 300mg twice a day (seizures) Vitamin B12 daily (blood & nerve cells healthy) Triamcinolone 25% twice a day (skin conditions) C. Review on 12/2/21 of client #4's record revealed: - admitted 3/7/09 - diagnoses: Major Depressive Disorder, Recurrent Episode-Moderate, Unspecified Anxiety Disorder, Developmental Expressive/Receptive Language Disorder and Moderate Intellectual Disability - December 2021 MAR listed medications that included the following: Fiber Laxative 625 mg, 1 tablet once a day (constipation) Multivitamin 1 tablet once a day (nutritional supplement) Lisinopril 10mg, 1 tablet daily (blood pressure) Cetirizine 10 mg, 1 tablet by mouth daily (allergies) Vitamin D3 2000 capsule, 1 capsule once a day (dietary supplement)	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: B. WING	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 12 Solifenacin Succinate 10 mg, 1 tablet every morning (overactive bladder) Denta 5000 plus 1.1 % cream, use one application for daily use (tooth decay prevention) Polyethylene glycol 3350 17/grams, Mix 2 capfuls in 8 ounces of water and drink by mouth twice daily (constipation) Omeprazole 20 mg, 1 capsule by mouth twice a day Montelukast Sodium 10mg, 1 tablet in the evening (chronic allergies) Ondansetron 4mg, dissolve one tablet in mouth every eight hours as needed (nausea) Trazodone 50mg, take $^1/_2$ tablet at bedtime only if needed (insomnia) - no initials for the 12/1/21 morning medications. Interview on 12/2/21 staff #10 reported: - she worked at the facility on 12/1/21. - she administered medications on the morning of 12/1/21. - she had forgotten to sign the MAR sheet for 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. Interview on 12/3/21 the QP #2 reported: - hired: 8/9/21 - 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	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 13 (DOO)/QP #1 reported: - QP #2 ensured the MARs were current - DOO/QP #1 checked the MARs quarterly - she (DOO/QP #1) checked to see how the medications were transcribed on the MARs and missing staff initials - last checked the clients MARs the early part of October 2021 Interview on 12/14/21 the Director of Quality Management (DQM) reported: - checked the MARs more than quarterly - when he visited the facility, would check the clients MARs - there were few or no missing staff initials - last reviewed MARs in November 2021 II. Example MAR initialed after medication discontinued: Review on 12/2/21 of client #1 s record revealed: - physician s order dated 6/15/21 Peppermint 50 mg one tablet three times a day - discontinue order dated 10/28/21 for Peppermint - October 29-November 2021 MARs listed initials that Peppermint had been administered three times a day - December 1, 2021 MAR entry listed initials the 12noon and 4pm dosages were administered - December 2, 2021 MAR entry listed initials the 8am dosage was administered Observation on 12/2/21 between 11:30am-12:30pm of client #1 s meds revealed: - no Peppermint 50 mg tablet Interviews on 12/2/21 and 12/8/21 staff #10 reported: - worked at the group home the day of this	V 118	For Client #1 the peppermint medication was discontinued as supported by a copy of the physician's orders. The QP will coordinate with the Pharmacist for appropriate transcribing on the MAR to reflect current physician's orders. The QP will monitor the MAR 2-3 times weekly in the home to ensure continued compliance. The Director of Quality Maangemnt will monitor the MAR weekly and crosswalk current physician's orders to ensure continued compliance.	1/8/22 1/8/22 1/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 14 interview as well as 12/1/21 - did not recall a medication called Peppermint for client #1 - worked with client #1 at the day program the date of the interview - if she signed the MAR, then the Peppermint medication was administered. Interview on 12/3/21 staff #8 reported: - not aware of a medication called "Peppermint" for client #1 Interview on 12/2/21 the DQM reported: - thought the medication for Peppermint was taken to the day program to be administered - the day program indicated Peppermint medication was not there and was not administered - he would follow up on the status of the medication Interview on 12/3/21 the Personal Assistant for the DOO/QP #1 reported: - she did whatever the DOO/QP #1 instructed her to do - when medications came in from the pharmacy, she reviewed and compared with the MARs - if there were concerns such as missing medications, she would contact the pharmacy - she did look at the MARs but never noticed discrepancy with the Peppermint medication for client #1 Interview on 12/14/21 the DOO/QP #1 reported: - QP #2 reviewed MARs for accuracy. - periodic checks of the MARs would have been conducted between herself and DQM. - quarterly, she reviewed the MARs after QP #2	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 15 - during her review, she had not noticed any missed signatures. - not aware of staff not initialing the MARs. - she last reviewed the MARs in September/October 2021. 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.	V 118		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;	V 289	It should be noted that the 2 former clients referenced in the state findings were discharged effective 11/19/21, well in advance of the state survey conducted in early December 2021. Hence the former clients were not active residents in the care of this Provider at the time of the survey. It should be further noted that 5 of 5 of the facility's current client population - at the time of the survey were not compromised and there was no evidence cited by the state of client rights violations impacting the current population.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 16 (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only](d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record review and interview the facility	V 289	The facility will ensure coordination efforts with qualified professionals and management to address access to a home environment where the primary purpose would be to support the care, habilitation of individuals served with mental health and developmental disabilities. The QP will maintain contact with all residential facilities daily to ensure each client is afforded access to a home environment. The QP will serve as back-up staff should a staff call out abruptly. The Director of Operations will be notified immediately to help support the coordination of staff resources to ensure individual access to a home environment. The Director of Operations, CEO and Director of Quality Management will discuss the occupancy status weekly to ensure continued compliance.	1/8/22 1/8/22 1/8/22 1/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 17 failed to provide a home environment where the primary purpose of these services was the care, habilitation/rehabilitation of individuals who have a mental illness and developmental disability affecting 5 of 5 clients (#1-#5). The findings are: Review on 12/3/21 of the facility's public file revealed the facility was licensed for 6 clients Review between 12/2/21 and 12/16/21 of client #1 - #5's records revealed: - they had resided at the facility between 2009 - 2021 A. Review on 12/3/21 of Former Client (FC) #A6's record revealed: - unknown admission date to Sister Facility A and discharged from Sister Facility A on 11/19/21 - diagnoses of Bipolar Disorder with dependent Personality Disorder, Mild Intellectual Developmental Disorder, Hyperlipidemia, Asthma, Spinal Stenosis & Chronic Obstructive Pulmonary Disorder Review on 12/15/21 of a faxed behavioral plan to the Division of Health Service Regulation (DHSR) for FC A#6 revealed: - dated 11/27/2020 with no signatures - Qualified Professionals (QP) listed were the Director of Operations (DOO)/QP#1 & the Director of Quality Management (DQM) - behaviors consisted of: "aggression including threats to harm others, hitting and spitting at staff, yelling, profanity, use of either the body or any other object as a weapon...physically assaultive behavior...elopement will include any attempt to leave any facility without staff supervision..." Review on 12/13/21 of a Harmony Home incident report dated 10/11/21 revealed:	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 18 - "[FC #A6] was up from 12am - 2:23am screaming and cursing until 2:30 am" Review on 12/13/21 of FC #A6's medication administration record (MARs) from January 2021 through November 2021 revealed: - Harmony Home staff initials appeared approximately 71 days. Attempted interviews on 12/2/21 with clients of Harmony Home revealed they were nonverbal or did not comprehend the questions Interview on 12/2/21 staff #10 reported: - began work in June 2021. - she worked 3rd shift 11pm to 8 am. - she was familiar with FC #A6. - FC #A6 stayed at the facility multiple times overnight between August 2021 and September 2021. - FC #A6 stayed overnight at the facility because Sister Facility A did not have enough staff. - she was not given advance notice that a new client would be staying at the facility from the Qualified Professional (QP) or management. - she found FC #A6 at the facility asleep when she arrived for her shift. Interview on 12/3/21 staff #8 reported: - had worked for 8 years as a paraprofessional at the facility. - worked 3rd shift 11pm to 8 am - she was familiar with FC #A6 who resided at Sister Facility A. - FC #A6 would come back and forth between Harmony Home and Sister Facility A - came to work one night and saw FC #A6 in the bedroom - management did not provide any information	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: B. WING	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 19 about FC #A6 - her record came over later - she called the office and the DOO/QP #1 said FC #A6 would be with them for a short period - the short period was from February - November 2021 - FC #A6 spent 2 to 3 days each week at the facility overnight. - Sister Facility A couldn't keep consistent staff with her due to FC #A6's combative, aggressive and verbal behaviors (cursing). - first time she saw FC #A6 at the facility was in February 2021 or March 2021 of this year. - observed her three times during the end of October 2021 through mid November 2021. - the DOO/QP #1 told her FC #A6 would only be at the facility temporarily, but stayed off and on through November 2021. Interview on 12/7/21 staff #9 reported: - worked at the facility since 2015. - worked 2nd shift 4pm - 9pm or 4pm - 11pm - drove the facility's van to transport clients to their appointments and to the day program - FC #A6 started to come to the facility in February 2021 or March 2021 of this year. - was a client of Sister Facility A. - FC #A6's behaviors consisted of: would curse, talk down about your family, yell at staff & make threats Interview on 12/10/21 (former staff) FS #11 reported: - started at the facility 10/2020 and last day was 11/2/21 - the DOO/QP #1 brought clients from other homes to the facility, if the client's home was short of staff. - "the [DOO/QP #1] would not tell us they (Sister Facility A clients) were coming over	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 20 (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 - 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:	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 21 - FC #A6 was not a resident of the facility. - she was aware she had spent the night at the facility a few times, but was unsure exactly how many times. - staffing shortages or "call outs" at Sister Facility A would have been the reason that FC #A6 spent the night at the facility. - "sometimes staff would call out only 10 minutes prior to the shift." Interview on 12/14/21 the DQM reported: - he was unaware FC #A6 stayed overnight at the facility - he did not authorize for staff to relocate clients from Sister Facility A to another facility. - decisions to relocate clients to a sister facility would be performed by the QP #2 or DOO/QP #1. B. Review on 12/3/21 of FC #A7's record revealed: - unknown admission date to Sister Facility A and discharged from Sister Facility A on 11/19/21 - diagnoses: Pervasive Development Disorder, Unspecified, Anxiety Disorder Unspecified, Bipolar Disorder Unspecified, Moderate Intellectual Disabilities, Hearing Loss, Seizure Disorder, and Limited Communication Skills. - 9/2/20 behavior plan included self injurious behavior, severe disruptive behaviors, aggression, property destruction...will hit, bite, spit and scratch Review on 12/13/21 of FC #A7's MARs from September 2021 through November 2021 revealed: - Harmony Home staff initials appeared approximately 20 days. Interview on 12/2/21 staff #9 reported: - FC #A7 was not a client of the facility.	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 22 - FC #A7 slept over at the facility when there was a staffing issue at Sister Facility A. - FC #A7 slept over 3-4 times from September 2021-November 2021. Interview on 12/6/21 FC #A7's guardian reported: - FC #A7 came to the facility with FC #A6 as there was no staff at Sister Facility A. Interview on 12/10/21 FC #A6's LME/MCO/CC reported: - she was aware that FC #A7 was staying overnight at the facility even though she was not the Care Coordinator for FC #A7. Interview on 12/10/21 the LME/MCO/CC's supervisor for FC #A7 reported: - the guardian was upset FC #A7 had visits to Harmony Home and slept on a couch - on 10/19/21 a conference call was held with the Administrator, DOO/QP#1 and the DQM - she was informed FC #A7 had one overnight stay at Harmony Home due to staffing - would be concerned if she had several overnight stays at the facility - concerned about the following: why they moved FC #A7 with behavioral challenges to another facility, no staff at the sister facility, why FC #A7 was placed in a facility with unfamiliar clients & why management did not make them aware there were several overnight stays Interview on 12/3/21 the QP #2 reported: - "she (FC #A7) was not there long. She was there a month. (Sister A facility)" - "I don't know where she slept but on the women's side of the facility." Interview on 12/7/21 staff #9 reported: - sister facility A staff would inform her when	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 23 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 overnight with FC #A6 & FC #A7 at Sister Facility	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 289	Continued From page 24 A because he was a male Interview on 12/14/21 the DQM reported: - he could not authorize a client from a sister facility to stay overnight at another facility - the QP #2 or the DOO/QP #1 would give the authorization - he and DOO/QP #1 had a conference call with FC #A7's LME/MCO/CC about a change in her medications only - did not recall when the conference call was Interview on 12/14/21 the Administrator reported: - was not apart of any conference calls pertaining to FC #A7 - was not aware FC #A6 & FC #A7 had overnight stays at the facility - prior to any clients being moved from the sister facility, QP #2 would be contacted and QP #2 would notify the DQM or the DOO/QP #1 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.	V 289		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 25 qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that no more than six clients were served with mental illness or developmental disabilities affecting the needs of 5 of 5 current clients (#1-#5) and 2 of 2 former clients (FC #A6 and FC #A7). The findings are: Review on 12/2/21 of client #1's record revealed: - date of admission (DOA): 2/9/21 - diagnoses: Autism, severe Intellectual Developmental Disability (IDD), Gastroesophageal Reflux Disorder (GERD) and Colitis Review on 12/2/21 of client #2's record revealed: - DOA: 12/15/09	V 291	The facility will ensure coordination efforts with qualified professionals and management to ensure that no more than 6 clients are served at the home to support individuals with mental health and developmental disabilities. The QP will maintain contact with all residential facilities daily to ensure each home does not serve any number of clients beyond the licensed occupancy capacity. The Director of Operations will be notified immediately to help support the coordination of staff resources to ensure the home does not serve any number of clients beyond current occupancy capacity. The Director of Operations, CEO and Director of Quality Management will discuss the occupancy status weekly to ensure continued compliance. The facility contends that at no time did it serve clients beyond the capacity of 6 individuals at any given time or date.	1/8/22 1/8/22 1/8/22 1/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 26 - diagnoses: Autism Disorder and Profound IDD Review on 12/2/21 of client #3's record revealed: - DOA: 2/4/13 - diagnoses: Moderate Intellectual Disabilities, Cerebral Palsy, Deafness and Epilepsy Unspecified Review on 12/2/21 of client #4's record revealed: - DOA: 3/07/09 - diagnoses: Major Depressive Disorder, Recurrent Episode-Moderate, Unspecified Anxiety Disorder, Developmental Expressive/Receptive Language Disorder and Moderate Intellectual Disability Review on 12/2/21 client #5's record revealed: - DOA: 2017 - diagnosis: Moderate IDD Review on 12/2/21 of FC #A6's record revealed: - unknown admission date to Sister Facility A and discharged from Sister Facility A on 11/19/21 - diagnoses of Bipolar Disorder with dependent Personality Disorder, Mild Intellectual Disorder, Hyperlipidemia, Asthma, Spinal Stenosis and Chronic Obstructive Pulmonary Disorder Review on 12/2/21 of FC #A7's record revealed: - unknown admission date to Sister Facility A and discharged from Sister Facility A on 11/19/21 - diagnoses: Pervasive Development Disorder, Unspecified, Anxiety Disorder Unspecified, Bipolar Disorder Unspecified, Moderate Intellectual Disabilities, Hearing Loss, Seizure Disorder and Limited Communication Skills. Interview on 12/3/21 staff #8 reported: - she would be the only staff at the facility with	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	Continued From page 27 Harmony Home's 5 clients, FC #A6 & FC #A7 Interview on 12/10/21 Former Staff (FS) #11 reported: - worked at the facility since October 2020. - the bus from the day program would bring FC #A6 and FC #A7 to the facility. - "the facility only held 6 clients. One staff on duty at the facility had all 7 sometimes 3-4 times a week." Refer to V289 regarding facility census. Outlined in this citation included the following information: - Example that FC #A6 stayed overnight at the facility. - Example that FC #A7 stayed overnight at the facility. 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.	V 291		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 28 aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record review and interview 1 of 1 former staff (FS #11) subjected 1 of 2 former clients (FC #A6) to abuse. The findings are: Review on 12/14/21 of FS #11's record revealed: - hired 10/2020 - terminated 11/2/21 - Abuse and Neglect training certificate dated 9/9/21 Review between 12/2/21 and 12/14/21 of staff #8-#10's records revealed - Abuse and Neglect training certificate dated 9/9/21 Review on 12/16/21 of an inservice sheet dated 12/14/21 revealed: - signatures of staff #8-#10 "Title of Training: Abuse, Neglect, Exploitation" - Qualified Professional (QP) #2 noted as the Instructor Review on 12/3/21 of FC #A6's record revealed: - unknown admission date to Sister Facility A and discharged from Sister Facility A on 11/19/21	V 512	The facility did take appropriate actions and terminated the former staff who abused the client in question. The Director of Quality Management completed the investigation timely and uploaded the findings to IRIS. Again, the former staff was terminated accordingly. Prior to the survey exit on 12/16/21, all staff 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 corrective actions were taken-resulting from the abuse. neglect investigation: all in advance of the survey team exit and in advance of the request for a plan of protection. In the future the Director of Quality Management Director will continue to complete investigations timely and ensure that all corrective actions are addressed in a timely manner to include but not limited to any recommendations for staff training. The QP will monitor in the home 2-3 times weekly or more often to ensure continued compliance.	1/8/22 1/8/22 1/8/22 1/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-075	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 512	Continued From page 29 - diagnoses of Bipolar Disorder with dependent Personality Disorder, Mild Intellectual Developmental Disorder, Hyperlipidemia, Asthma, Spinal Stenosis & Chronic Obstructive Pulmonary Disorder Review on 12/15/21 of a faxed behavioral plan to the Division of Health Service Regulation (DHSR) for FC #A6 - dated 11/27/2020 with no signatures - QP's listed were the Director of Operations (DOO)/QP#1 & the Director of Quality Management (DQM) - behaviors consisted of: "aggression including threats to harm others, hitting and spitting at staff, yelling, profanity, use of either the body or any other object as a weapon...physically assaultive behavior...elopement will include any attempt to leave any facility without staff supervision..." Review on 12/13/21 of the facility's investigation summary dated 12/9/21 for FC #A6 revealed: - date of incident 10/11/21 - date allegation reported 10/13/21 - reported to DQM & DOO/QP #1 - Investigator: DQM - date investigation completed 10/18/21 - date findings reported to Administrator: 10/18/21 - date of investigation summary: 12/9/21 - "Summary of findings: [FS #11] indicated that [staff #10] reported that approval was given for her to relieve her on 10/11/21 during early morning hours. Management report that they had no knowledge that [FS #11] had come in to relieve [staff #10], nor gave approval...client [FC #A6] displayed verbal aggression and severe disruptive behaviors as client was yelling and cursing in her bedroom and client and staff confirmed the behaviors. The behaviors occurred	V 512		