Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-187	A. BUILDING: _____ B. WING _____	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES NEST RETREAT	320 CHISHOLM TRAIL JACKSONVILLE, NC 28546

(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 survey was completed on November 12, 2021. Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: Review on 11/10/21 of the facility's fire and disaster drill documentation for 10/1/20 - 9/30/21 revealed: -No disaster drills on the first shift documented during the quarter, 7/1/21 - 9/30/21.	V 114	DHSR-Mental Health NOV 24 2021 Lic. & Cert. Section V114 - All copies of old disater form will be removed and all group home staff will be instructed to utilize current form that distinguishes the times of the three shifts.	11/18/2021

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE BS QP — (X6) DATE

JORGE RIOS 11/18/2021

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V 114	Continued From page 1 -No fire drills on the second or third shift documented during the quarter, 1/1/21 - 3/31/21. Interview on 11/10/21 client #2 stated: -They practiced hurricane drills by putting their hands over their head and going inside a big closet in one of the client's bedroom. -For a fire drill they would go outside to the neighbor's property. Interview on 11/10/21 the Chief Executive Officer/Qualified Professional stated: -The shifts were 8 am - 3:59 pm (first shift); 4 pm - 11:59 pm (second shift), and 12 am - 7:59 am (third shift). -It looked like the staff had used an old form that could have contributed to errors in documentation of the times and shifts the drills were held. -He would make sure drills were completed and documented correctly.	V 114	V114 - Old fire drill form will be removed from group home and all group home staff will be retrained on how to fill out the current forms to ensure drills are completed during all three shifts within the quarter. V114 Safety officer will review the completed safety drill forms to confirm they are filled out correctly, are on the correct form, and cover all shifts within the quarter.	11/18/2021 Ongoing
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such	V 291		

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V 291	Continued From page 2 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 reviews, observations, and interviews, the facility failed to coordinate services between the facility operator and the qualified professionals who are responsible for treatment affecting 1 of 3 audited clients (#6). The findings are: Review on 11/10/21 of client #6's record revealed: -28 year old male admitted on 11/1/19. -Diagnoses included moderate intellectual developmental disability, autism spectrum disorder; cerebral palsy, and seizure disorder. -Order dated 6/1/21 by client #6's primary care physician for, "Left wrist contractor (contractures) referral to OT (occupational therapy." -No documentation the OT referral had been made. -FL2 dated 7/29/21 documented client #6 was non-verbal. Review on 11/10/21 of client #6's individual service plan dated 1/1/21 revealed client #6 had a	V 291	V291 - All documentation received from doctors will be reviewed by an AP or QP after each doctor's visit to ensure recomendations and referrals are properly addressed. - Appointment for renewed referral to OT was completed on 11/16/2021. OT appointment is scheduled for 12/06/2021.	11/18/2021 and Ongoing 12/06/2021

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V 291	Continued From page 3 communication device. Interview and observation of client #6 on 11/10/21 at 10:45 am revealed: -Client #6 made no verbal responses to questions. -In response to "yes-no" questions the movement with his head was so slight it was impossible to determine if client #6 was responding "yes" or "no." -When client #6 exited the room he had a slight limp and held his left arm in a flexed position at the elbow. Interview on 11/10/21 Staff #2 stated: -She was a Life Skills Coach and had worked at the facility about 2 and a half years. -Client #6 had a communication device. -She was the person who "set up" the communication device. -She had tried to get all staff to use the communication device, but the device charger had been lost more than a few months ago. -Before the charger was lost, client #6 was making progress in learning how to use the device. -The prior Group Home Manager had been made aware the charger had been lost. Interviews on 11/10/21 and 11/12/21 the Chief Executive Officer/Qualified Professional stated: -Client #6 had not received the OT ordered 6/1/21. -The Group Home Manager called the local hospital physical therapy department on 11/10/21 to schedule an appointment and was informed a new order was needed before the client could be seen. -Client #6's primary care provider had been contacted for an appointment to obtain another	V 291	V291 - Power cord for communication device has been received and commuication device is being used daily. - Communication device and charger added to electronic MAR so that staff must verify both are present and working. Staff informed that they must notify supervisor if device or charger is missing or not functioning. Routine MAR review will also alert supervisors of issue due to missing provider initials.	11/13/2021 11/18/2021 and Ongoing

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V 291	Continued From page 4 OT order. -Client #6 had a communication device and the charger had been lost. -He would make sure the charger was replaced and the device put back in service.	V 291		

Emergency Drills

FIRE and FACILITY EVACUATION

Site Eagles Nest Retreat Address 320 Chisholm Trail, Jacksonville NC 28546

Name of person conducting drill _____

Date _____ Time Started _____ (am, pm) Time Completed _____ (am, pm)

*For residential settings, each drill must be conducted during each of the three shifts.
Place check mark next to shift during which drill was conducted.

Shift 1 ____ (8 am-3:59 pm) Shift 2 ____ (4 pm-11:59 pm) Shift 3 ____ (12 am-7:59 am)

Were program participants involved? Yes___ No ___ If No, Explain _____

_____

Were individuals moved to a safe location and all accounted for? Yes ___ No ___

Was the building evacuated? Yes____ No ____

Were people left in the building who did not move to a safe location? Yes___ No ___

If yes, who and why? _____

Were the emergency procedures followed? Yes____ No____

If no, what procedures in the policy were not followed? _____

_____

Does the policy/procedure(s) need to be changed to enhance safety? Yes___ No____

If yes, recommendations:

1. _____
2. _____
3. _____

Emergency Drills

SEVERE WEATHER and NATURAL DISASTERS

Site Eagles Nest Retreat Address 320 Chisholm Trail, Jacksonville NC 28546

Name of person conducting drill _____

Date _____ Time Started _____ (am, pm) Time Completed _____ (am, pm)

*For residential settings, each drill must be conducted during each of the three shifts.
Place check mark next to shift during which drill was conducted.

Shift 1 ____ (8 am-3:59 pm) Shift 2 ____ (4 pm-11:59 pm) Shift 3 ____ (12 am-7:59 am)

Type of emergency: Hurricane _____ Tornado _____ Other: _____

Were program participants involved? Yes___ No ___ If No, Explain _____

_____

Were individuals moved to a safe location and all accounted for? Yes ___ No ___

Were people left in the building who did not move to a safe location? Yes___ No ___

If yes, who and why? _____

Were the emergency procedures followed? Yes____ No____

If no, what procedures in the policy were not followed? _____

_____

Does the policy/procedure(s) need to be changed to enhance safety? Yes___ No____

If yes, recommendations:

4. _____

5. _____

6. _____

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

November 16, 2021

Jorge Rios
IQUOLIOC, Inc.
211 Drummer Kellum Rd.
Jacksonville, NC 2846

Re: Annual Survey completed November 12, 2021
Eagles Nest Retreat, 320 Chisholm Trail, Jacksonville, NC 28546
MHL # 067-187
E-mail Address: jorgerios@iqu-inc.org

Dear Mr. Rios:

Thank you for the cooperation and courtesy extended during the annual survey completed November 12, 2021.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is January 11, 2022.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.

- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Gloria Locklear at 910-214-0350.

Sincerely,

Betty Godwin, RN, MSN
Nurse Consultant 1
Mental Health Licensure & Certification Section

Ryan Meredith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Assistant