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ANDREWS DRIVE FAMILY CARE FACILITY	2621 ANDREWS DRIVE SANFORD, NC 27332

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V 000	INITIAL COMMENTS A complaint survey was completed January 18, 2022. The complaints (Intake #NC00182932, NC00182933 and NC00183038) were substantiated. According to the Director of Quality Management there are no clients being served at the facility. The last time clients were served at the facility was November 19, 2021. Deficiencies were cited. The 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 will be identified using the letter A and a numerical identifier. The survey sample consisted of 2 former clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills;	V 109		

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V 109	Continued From page 1 (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 #1, QP#2/Director of Operations (DOO) and QP#3/Director of Quality Management (DQM)) demonstrated the knowledge, skills and abilities required by the population served. The findings are: Cross reference 10A NCAC 27G .5602 Supervised Living- Staff (V290). Based on record review and interview the facility failed to ensure staff-client coverage to meet the needs for 2 of 2 former clients (FC#1 and FC#2). Cross reference 10A NCAC 27G .0304	V 109		

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V 109	Continued From page 2 Therapeutic and Habilitative Areas (V784). Based on record review and interview, facility failed to ensure an area in which therapeutic and habilitative activities were routinely conducted were separate from sleeping areas for 1 of 2 former clients (FC #2). Review on 12/28/21 of QP#1's record revealed: -Hired 8/9/21. -Supervision provided by the QP#2/DOO. - Completed all required trainings. Review on 12/20/21 of the facility's investigation summary dated 12/9/21 for FC #1 revealed: -Incident occurred on 10/11/21 -Incident reported on 10/13/21 by Staff #2 to QP#2/DOO. -Incident investigated by QP#3/DQM. -Investigation completed 10/18/21. -"Summary of the investigation findings: [FC#1] said [FS#A7] (Former Staff #A7) 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#1] also reported [FS#A7] picked up her blue tennis shoe from the floor and hit her with the tennis shoe. [FC#1] reported the injuries on October 13, 2021 to two staff when they asked her what happened to her. [FC#1] did not initially report the injuries until asked by staff. [FC#1] reported the injuries days later as the assault occurred on October 11, 2021 during early morning hours at sister facility A. [FC#1] was taken to the urgent care. [FC#1] told the medical provider the origin of her injuries in that she was hit by [FS#A7] with a plastic clothes rack and with a tennis shoe. The medical provider deemed that the injuries to [FC#1] body was consistent with a physical assault and that [FC#1] was credible in her accusation of what happened to her to cause the	V 109		

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V 109	Continued From page 3 injury." Interview on 12/16/21 with QP#2 (DOO) revealed: -FC#1 and FC#2 stayed 1-2 times at sister facility A. -Both clients had bed in facility when they stated at sister facility A. Interview on 12/20/21 with QP#3 (DQM) revealed: -Both FC#1 and FC#2 stayed a few times at sister facility A. -Clients stayed at sister facility A due to staff shortage and last minutes call out of staff. -Decision was made to stay at sister facility A to avoid FC#1 and FC#2 staying at hospital. Interview on 12/28/21 with the QP#1 revealed: -He worked second shift 3pm-11pm. -He was the QP for both Andrews Drive and sister facility A. -He was not comfortable working a shift alone with FC#1 and FC#2 as they were females. -He would complete day to day tasks for the facilities. -He did not make any decisions regarding FC#1 and FC#2 staying at sister facility A. -Only knew of one time they stayed at sister facility A. -He became aware of incident when called to relieve FS#A7 of her duties while working her shift. -He was not a part of the investigation process of the incident with FC#1 and FS#A7. Interview on 12/28/21 with FC#1's and FC#2's guardian revealed: -Both clients last day at the facility was November 19, 2021. -She was not made aware each time the clients stayed overnight at sister facility A.	V 109		

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V 109	Continued From page 4 -When "I was informed of the overnight stay, I was told it was due to not having staff coverage." -When "I would receive information, it was not from management but direct care staff." -She had to contact management to confirm information and incidents shared about the clients. -FC#1 stated to me, "She was scared to tell about the incident with FS#A7." -She had lots of concerns regarding how the agency cared for FC#1 and FC#2. -There was an incident when FC#2 was taken to a medical appointment with no shoes on her feet. -FC#2 had history of throwing shoes and staff should have had additional shoes available for her. -When "I spoke with management regarding this incident, they responded that staff knew better and they would address the issue." Review on 1/4/22 of a Plan of Protection written by the QP#3/DQM dated 1/4/22 revealed: "There are no consumers at the current location. As shared with the state surveyor on 1/3/22 during exit conference, the facility has no immediate plans to admit any consumers at this time to Andrews Drive. QP will be re-assigned from monitoring activity and replace with a new QP, recently hired. The new QP will monitor in the home at such time when clients are placed, at least 3 times weekly to ensure continued compliance. The new QP will monitor to address continued compliance to all citations listed above. Quality Management Director will monitor weekly to ensure the actions are in place and documented accordingly- at such that clients are admitted to Andrews Drive." The QP#1 worked for the agency since August 2021 and responsible for day to day operations at	V 109		

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V 109	Continued From page 5 this facility and facility A. The facility did not have staffing that always met the needs of the clients which resulted in FC#1 and FC#2 having to stay at sister facility A. QP #1, QP#2/DOO and QP#3/DQM were not aware of the frequency of FC#1 and FC#2 staying overnight at sister facility A. FC#1 stayed at sister facility A 50 days from August to November 2021 based on staff signatures on the medication administration record (MAR) and 4 days for FC#2. During a stay at facility A on October 11, 2021, FC#1 was assaulted and injured by a staff that worked in facility A. When FC#2 would stay in facility A she had to sleep on a couch, because there was no bed for FC#2 to sleep on. This deficiency 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 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 109		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in	V 290		

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V 290	Continued From page 6 the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff-client coverage to meet the needs for 2 of 2 former clients (FC#1 and FC#2). The findings are:	V 290		

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V 290	Continued From page 7 Review on 12/16/21 of FC#1's record revealed: -Admitted 8/1/17. -Diagnoses of Bipolar Disorder with dependent Personality Disorder, Personality Disorder, Mild Intellectual Disorder, Hyperlipidemia, Asthma, Allergies (allergic rhinitis), Anemia, Non-insulin Dependent Diabetes Mellitus, Constipation, Neurodermatitis, Spinal Stenosis, Flaccid Bladder, Balata lower extremity edema, Myalgia, Chronic Obstructive Pulmonary Disease, Onychomycosis, Bursitis and Wheezing. -Discharged 11/19/21. Review on 12/16/21 of FC#2's record revealed: -Admission date of 12/10/12. -Diagnoses of Autistic Disorder, Intellectual Disability-Unspecified as cannot measure but consistent with at least Moderate level, Bipolar Affective Disorder- Severe and Hearing Loss. -Discharge date of 11/19/21. Review on 12/20/21 of FC#1's Medication Administration Record (MAR) from August 2021 through November 2021 revealed: -Various staff initials of sister facility A appeared who administered medication for FC#1 for 50 days. Review on 12/20/21 of FC#2's MAR for October 2012 and November 2021 revealed: -Various staff initials of sister facility A who had administered medication for FC#2 4 days. Interview on 12/17/21 with Staff #1 revealed: -Had worked with agency for 25 years. -She worked the shift of 3pm-8am. -She worked 1-2 days at the home. -Both FC#1 and FC#2 stayed a few times at sister facility A but could not recall the dates. -Instruction came from QP#2 (DOO) regarding	V 290		

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V 290	Continued From page 8 when clients stayed at sister facility A. Interview on 12/17/21 with Staff #2 revealed: -Had been with agency for 21 years. -Home was short staffed and when they did not have coverage would take to sister facility A. -Directives came from QP#2 (DOO) when clients stayed at sister facility A. -Both FC#1 and FC#2 stayed at sister facility A more than one time. Interview on 12/21/21 with Staff #A4 revealed: -Been with agency since 2015. -Solely worked at sister facility A. -Worked shift of 11pm-8am. -FC#1 stayed overnight at sister facility A. -She never met FC#2 as she never stayed when she worked. -FC#1 stayed at sister facility A beginning late February 2021 until her discharge in November 2021. -FC#1 would go back and forth from her home to sister facility A. -FC#1 slept in the extra bedroom. -Staff didn't want to deal with FC#1's behaviors. -FC#1 would stay at sister facility A due to staff calling out. -QP#2 (DOO) said would only be short term that FC#1 and FC#2 would stay at sister facility A. -Two weeks, became months and then routine for FC#1 and FC#2 to go back and forth from their home to sister facility A. Interview on 12/22/21 with Staff #A5 revealed: -Had been with agency since June 2021. -Worked shift of 7pm-8am. -Both FC#1 and FC#2 stayed at sister facility A. -Stated that FC#1 came over during months of July, August and September 2021. -Stated that FC#2 only stayed 2-3 times.	V 290		

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V 290	Continued From page 9 -FC#1 slept in the open bedroom. -FC#2 slept on the couch in a room with a door. -Fellow coworkers would make aware or upon my arrival on shift would see FC#1 and FC#2 at sister facility A. Interview on 12/28/21 with Staff #A6 revealed: -Been with agency since 2013. -She worked second shift at sister facility A. -She worked a few times at Andrews Drive. -FC#1 and FC#2 both stayed at sister facility A. -FC#1 and FC#2 stayed at sister facility A when shorted staff at their home. -FC#1 stayed a few days during the week and would return back to her home. -She recalled that FC#2 only stayed 1-2 times. -She recalled both FC#1 and FC#2 stayed at sister facility A 1-2 times at the same time. -She could not recall the dates when FC#1 and FC#2 stayed at sister facility A. -She would be notified by QP#2 (DOO) or Staff #2 when FC#1 and FC#2 stayed at sister facility A. This deficiency is crossed 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 290		
V 784	27G .0304(d)(12) Therapeutic and Habilitative Areas 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules,	V 784		

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V 784	Continued From page 10	V 784		

residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements:
(12) The area in which therapeutic and habilitative activities are routinely conducted shall be separate from sleeping area(s).

This Rule is not met as evidenced by:
Based on interview and record review the facility failed to ensure an area in which therapeutic and habilitative activities were routinely conducted were separate from sleeping areas for 1 of 2 former clients (FC #2). The findings are:

Review on 12/16/21 of FC #2's record revealed:
-Admission date of 12/10/12.
-Diagnoses of Autistic Disorder, Intellectual Disability-Unspecified as cannot measure but consistent with at least Moderate level, Bipolar Affective Disorder- Severe and Hearing Loss.
-Discharge date of 11/19/21.

Interview with FC#2 was not available due to discharge and location unknown.

Interview on 12/22/21 with Staff #A5 revealed:
-Been with agency since June 2021.
-She worked the shift 7pm-8am.
-FC#2 only came and stayed at the sister facility 2-3 times.
-FC#2 slept on the couch but the room had a door.

Interview on 12/28/21 with Staff #A6 revealed:
-Been with agency since 2013.
-She worked second shift at sister facility A.
- She worked a few times at Andrews Drive.
-She worked at the home with FC #1 and FC#2 but at separate times as the clients were never

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V 784	Continued From page 11 together. -She recalled only 1-2 times that FC #2 stayed at sister facility A. -FC#2 slept in the staff area on the couch. Interview on 12/28/21 with the QP#1 (Qualified Professional) revealed: -Been with agency since August 9, 2021. -Worked second shift 3pm-11pm in both facilities. -FC#2 stayed overnight at sister facility A one-time but cannot recall the date. -FC#2 had a bed when stayed at sister facility A. Interview on 1/3/22 with QP #2/DOO (Director of Operations) revealed: -FC#2 stayed at sister facility A 1-2 times. -FC#2 had a bed when at sister facility A. This deficiency is crossed 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 784		