STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-237	A. BUILDING: _____ B. WING _____	R 01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOMES II	**801 N MEBANE STREET BURLINGTON, NC 27217**

(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 on 1/19/22. The complaint was unsubstantiated (intake #NC00184393). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The survey sample consisted of audits of 5 current clients, 1 former client and 1 deceased client.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,	V 108		

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V 108	Continued From page 1 the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure two of four audited staff (#2 and #3) had current training in Cardiopulmonary Resuscitation (CPR) and First Aid (FA) and one of four audited staff (#2) had training to meet the needs of the clients as specified in the treatment/habilitation plan. The findings are: The following is evidence the facility failed to ensure staff had current training in CPR/FA. a. Review on 1/13/22 of the facility's personnel files revealed: - Staff #2 had no specific hire date documented. - Staff #2 was hired as a Paraprofessional. - Staff #2's CPR and FA training expired on 11/4/21. -There was no documentation of current CPR and FA training for staff #2. b. Review on 1/13/22 of the facility's personnel files revealed: - Staff #3 had no specific hire date documented. - Staff #3 was hired as a Paraprofessional. - Staff #3's CPR and FA training expired on	V 108		

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V 108	Continued From page 2 8/26/21. -There was no documentation of current CPR and FA training for staff #3. Interview on 1/12/22 with staff #2 revealed: -She started working at the group home about six months ago. -She thought all of her paperwork was in her personnel folder. If something was missing from her personnel folder the Director/Licensee would have to be contacted. -Staff was not responsible for ensuring the appropriate paperwork was in the personnel folder. Interview on 1/14/22 with staff #3 revealed: -She started working at the group home around October 2020. -The Director/Licensee was responsible for making sure their personnel folders had the appropriate trainings. Interview on 1/14/22 with the Director/Licensee revealed: -He thought the Qualified Professional or one of her staff did the most of the trainings for the group home staff. -The Qualified Professional had a business and had some of her staff doing required training for his group home staff. -He thought The Qualified Professional or one of her staff did the FA/CPR training with his group home staff. -He did not realize staff #2 and staff #3 FA and CPR training had expired. -He confirmed the FA and CPR training was not current for staff #2 and staff #3. The following is evidence the facility failed to ensure staff had training to meet the needs of the	V 108		

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V 108	Continued From page 3 clients as specified in the treatment/habilitation plan. Review on 1/13/22 of the facility's personnel files revealed: - Staff #2 had no documentation of training to meet the mental health and developmental disability needs of the clients. Interview on 1/14/22 with the Director/Licensee revealed: -He thought the Qualified Professional did the client specific training with staff #2 when was she was hired. -He confirmed there was no documentation of training to meet the mental health and developmental disability needs of the clients for staff #2.	V 108		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including:	V 110		

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V 110	Continued From page 4 (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews one of four audited staff (#1) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Review on 1/12/22 of deceased client #6's (DC #6) record revealed: -Admission date of 12/2/15. -Diagnoses of Schizophrenia-Undifferentiated, Seizure Disorder, Alzheimer's with late onset, Hyperlipidemia, Chronic Atrial Fibrillation, Hypertension, Vitamin B12 Deficiency and Tobacco Use Disorder. -He died on 12/11/21. -He was 85 years old. Review on 1/13/22 of the facility's personnel files revealed: - Staff #1 had no specific hire date documented. - Staff #1 was hired as a Paraprofessional.	V 110		

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V 110	Continued From page 5 Review on 1/12/22 of facility records revealed: -A report of death dated 12/14/21 completed by the Director/Licensee-"[DC #6] fell off kitchen chair and was having a seizure. Staff immediately took precautions and steps for his safety. Staff ask [DC #6] after his seizure ended did he want him to call 911 and have him sent to the hospital but he refused to go. Staff helped him to his bed. Kept a check on him continually through the day. He went to wake him for dinner and found him unresponsive. He tried to resuscitate him and called 911 immediately. [DC #6] passed away on 12/11/21 at 4:20 pm." -There was no documentation of an incident report for DC #6's death. Interview on 1/13/22 with staff #1 revealed: -He was at the home when DC #6 passed away in December 2021. He was working alone during that incident. -On 12/8/21 DC #6 had a seizure. DC #6 fell on the floor face forward in the kitchen area during lunch. -DC #6 stood up and hit the floor "really hard" when he fell. -DC #6 fell on his right shoulder and hit the right side of his head on the floor. -He thought the seizure lasted for about 10 minutes. -Once DC #6 came out of the seizure, he helped him off of the floor and took him to his bedroom. DC #6 wanted to lay down on his bed. -He checked on DC #6 in about 45 minutes and noticed the right side of his forehead was swollen. -He asked DC #6 if he wanted him the call Emergency Medical Services (EMS) and DC #6 replied "no." -He called the Director/Licensee about the incident with DC #6.	V 110		

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V 110	Continued From page 6 -The Director/Licensee said he felt like DC #6 needed to go to the hospital. -He asked DC #6 again if he needed medical attention. DC #6 said he didn't want to go to the hospital. -A few hours later he noticed the right side of DC #6's forehead was bruised. He asked DC #6 again if he wanted to go to the hospital and DC #6 replied "no." -The Director/Licensee also tried to get DC #6 to go to the hospital and DC #6 refused. -On 12/11/21 when DC #6 passed away, he got up that morning and went outside to smoke a cigarette after eating breakfast. -DC #6 came back into the home and went into his bedroom. -DC #6 said his right shoulder was hurting. He put a hot cloth on DC #6's shoulder. -DC #6 told him he wanted to take a nap. -He checked on DC #6 later and asked if he wanted lunch. DC #6 said he didn't want anything for lunch. -He checked on DC #6 a few more times after that. He thought he checked on DC #6 about every 45 minutes to an hour. -Around 4 pm he checked on DC #6 prior to preparing dinner. -He called DC #6's name and he was not responsive. He called 911 and told them DC #6 was unresponsive. -He started doing Cardiopulmonary Resuscitation (CPR) on DC #6 while he was on the phone with the 911 operator. He pulled DC #6 onto the floor and started doing chest compressions. -EMS staff arrived and took over, "EMS staff could not bring [DC #6] back." DC #6 died at the group home. Interviews on 1/12/22, 1/14/22 and 1/18/22 with the Director/Licensee revealed:	V 110		

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V 110	Continued From page 7 -DC #6 passed away in December 2021. -Staff #1 called him and said DC #6 had the seizure at the group home and died. -He was not at the home on the day DC #6 passed away. Staff #1 was working and knew more details about that incident with DC #6. -When staff #1 called him, he told him DC #6 had a seizure earlier that morning. Staff #1 said he checked on DC #6 later that day. Staff #1 told him he found DC #6 unresponsive. Staff #1 said he called EMS and attempted CPR. Staff #1 told him DC #6 passed away. -He did not know DC #6 had the seizure a few days before he passed away. -He thought everything with DC #6 happened on the same day. -He wasn't sure why staff #1 told a different version of the incident with DC #6. -He told staff in the past they should call EMS if a client falls. Review on 1/19/22 of a Plan of Protection (POP) written by the Director/Licensee dated 1/19/22 revealed: What immediate action will the facility take to ensure the safety of the consumers in your care?: "Conduct immediate staff meeting and explain the importance of properly reporting all level of incidents with consumers. Staff are to always notify [Administrator and Director/Licensee] of incidents immediately ." Describe your plans to make sure the above happens. "Continue to do follow up meetings and trainings with staff and continue to monitor staff." -There were numerous attempts on 1/19/22 to obtain a POP to address the above area of deficient practice. DC #6 diagnoses included Schizophrenia-Undifferentiated, Seizure Disorder,	V 110		

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V 110	Continued From page 8 Alzheimer's with late onset, Hyperlipidemia, Chronic Atrial Fibrillation, Hypertension, Vitamin B12 Deficiency and Tobacco Use Disorder. Staff #1 stated DC #6 had a seizure on 12/8/21. Staff #1 stated DC #6 fell face forward and hit the floor really hard. Staff #1 stated DC #6 hit the right side of his head and shoulder when he fell during the seizure. Staff #1 noticed DC #6's forehead was swollen about 45 minutes later. Staff #1 stated he asked DC #6 if he wanted EMS to be called. Staff #1 stated DC #6 said he did not need any medical attention. Staff #1 checked on DC #6 a few hours later and noticed the area on his forehead was bruised. Staff #1 never called EMS although DC #6's forehead was swollen and bruised. Staff #1 worked on 12/11/21 and found DC #6 unresponsive around 4 pm. Staff #1 stated he called EMS. Staff #1 attempted CPR until EMS staff arrived. EMS staff were not able to resuscitate DC #6 and he was pronounced dead. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $10,000 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 110		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to	V 112		

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V 112	Continued From page 9 receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility the facility failed to schedule a review of a plan at least annually affecting two of two current clients (#1 and #2) and the facility failed to have written consent or agreement by the client or responsible party affecting one of two current clients (#1) and one of one deceased client (DC #6). The findings are: The following is evidence the facility failed to schedule a review of a plan at least annually. a. Review on 1/12/22 of client #1's record revealed:	V 112		

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V 112	Continued From page 10 -Admission date of 8/17/16. -Diagnoses of Schizophrenia, Type II Diabetes, Hypertension, Hyperlipidemia, Chronic Kidney Disease stage 4, Osteoporosis and Allergic Rhinitis. -The Person Centered Plan (PCP) was dated 12/13/20. -There was no documentation that client #1 had a plan completed for 2021. b. Review on 1/12/22 of client #2's record revealed: -Admission date of 4/29/16. -Diagnoses of Major Depressive Disorder, Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea, Proteinuria, Hypertension, Hypersensitivity Lung Disease, Benign Prostatic Hyperplasia, Gastroesophageal Reflux Disease, History of Cerebrovascular Accident and Left Hemiparesis. -The PCP was dated 5/18/20. -There was no documentation that client #2 had a plan completed for 2021. Interview on 1/14/22 with the Director/Licensee revealed: -The PCP's should be current for clients #1 and #2. -He thought the PCP's may be at the other group home. Staff don't always put paperwork in the appropriate place. -He confirmed the facility failed to schedule a review of a plan at least annually for clients #1 and #2. The following is evidence the facility failed to have written consent or agreement by the client or responsible party. a. Review on 1/12/22 of client #1's record	V 112		

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V 112	Continued From page 11 revealed: -The PCP was dated 12/13/20. -The PCP had no written consent or agreement by the client or responsible party. b. Review on 1/12/22 of DC #6 record revealed: -Admission date of 12/2/15. -Diagnoses of Schizophrenia-Undifferentiated, Seizure Disorder, Alzheimer's with late onset, Hyperlipidemia, Chronic Atrial Fibrillation, Hypertension, Vitamin B12 Deficiency and Tobacco Use Disorder. -He died on 12/11/21. -He was 85 years old. -The PCP was dated 12/14/20. -The PCP had no written consent or agreement by the client or responsible party. Interview on 1/14/22 with the Director/Licensee confirmed: -The facility failed to have written consent or agreement by the client or responsible party for client #1 and DC #6.	V 112		
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.	V 114		

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V 114	Continued From page 12 (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 interviews, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies. The findings are: Review of the facility's fire drill log on 1/12/22 revealed: -1/28/21-no shift indicated. -No other fire drills were documented. Review of the facility's disaster drill log on 1/12/22 revealed: -There was no documentation of disaster drills. Interview with client #1 on 1/13/22 revealed: -He lived at the group home for about three years. -They did fire and disaster drills in the past. -He was not sure how often the drills were done with staff. Interview with client #2 on 1/13/22 revealed: -He lived at the group home for a few years. -He wasn't sure if they did any fire or disaster drills with staff. Interview on 1/13/22 with staff #1 revealed: -Staff normally worked a 24 hour shift. -He had been working at the group home for about three years. -He had not done a fire and/or disaster drill at the group home since 2019. -He was not sure if other staff completed fire and	V 114		

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V 114	Continued From page 13	V 114		

disaster drills with clients.
-He confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies.

Interviews on 1/12/22 and 1/14/22 with staff #2 revealed:
-She started working at the group home about six months ago.
-She did a fire drill in October 2021 with the clients.
-She did document the drill, however it was not on the appropriate form the group home used.
-She could not locate the appropriate form for the fire drill.
-She confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies.

Interview on 1/14/22 with staff #3 revealed:
-She started working around October 2020 at the group home.
-She thought she did a fire drill in November 2021, however she did not document the drill.
-She confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies.

Interview on 1/14/22 with the Director/Licensee revealed:
-He told staff a few months ago they needed to do fire and disaster drills.
-Staff told him the drills were completed.
-He did not know staff had not documented the drills on the appropriate form.
-The forms for the fire and disaster drills are at the home and staff just don't take the time to look for anything.
-He confirmed staff failed to conduct fire and disaster drills under conditions that simulate

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ALAMANCE HOMES II	801 N MEBANE STREET BURLINGTON, NC 27217

(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 14 emergencies.	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		

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V 118	Continued From page 15 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications was administered by an unlicensed person trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications affecting one of four audited staff (#1). The findings are: Review on 1/13/22 of the facility's personnel files revealed: -Staff #1 had no specific hire date documented. -Staff #1 was hired as a Paraprofessional. -There was no documentation of medication administration training. a. Review on 1/12/22 of client #1's record revealed: -Admission date of 8/17/16. -Diagnoses of Schizophrenia, Type II Diabetes, Hypertension, Hyperlipidemia, Chronic Kidney Disease stage 4, Osteoporosis and Allergic Rhinitis. Review on 1/12/22 of Medication Administration Record's (MAR's) for client #1 revealed: -January 2022 MAR-Staff #1's initials were listed. -December 2021 MAR-Staff #1's initials were listed. -November 2021 MAR-Staff #1's initials were listed. b. Review on 1/12/22 of client #2's record revealed: -Admission date of 4/29/16. -Diagnoses of Major Depressive Disorder, Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea, Proteinuria,	V 118		

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V 118	Continued From page 16 Hypertension, Hypersensitivity Lung Disease, Benign Prostatic Hyperplasia, Gastroesophageal Reflux Disease, History of Cerebrovascular Accident and Left Hemiparesis. Review on 1/12/22 of Medication Administration Record's (MAR's) for client #2 revealed: -January 2022 MAR-Staff #1's initials were listed. -December 2021 MAR-Staff #1's initials were listed. -November 2021 MAR-Staff #1's initials were listed. c. Review on 1/12/22 of deceased client #6's (DC #6) record revealed: -Admission date of 12/2/15. -Diagnoses of Schizophrenia-Undifferentiated, Seizure Disorder, Alzheimer's with late onset, Hyperlipidemia, Chronic Atrial Fibrillation, Hypertension, Vitamin B 12 Deficiency and Tobacco Use Disorder. -He died on 12/11/21. -He was 85 years old. Review on 1/12/22 of Medication Administration Record's (MAR's) for DC #6 revealed: -December 2021 MAR-Staff #1's initials were listed. -November 2021 MAR-Staff #1's initials were listed. -October 2021 MAR-Staff #1's initials were listed. Interview on 1/13/22 with staff #1 revealed: -He did administer medication to the clients when he worked at the group home. -He did medication administration training about 2 years with a local pharmacy. -He wasn't sure why his medication administration certificate was not in his personnel folder.	V 118		

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V 118	Continued From page 17 -He confirmed there was no documentation of medication administration training in his personnel folder. Interview on 1/14/22 with the Director/Licensee revealed: -The local pharmacy did the medication administration training for the group home staff. -He knew staff #1 took the medication administration training when he was hired. -He was not sure why staff #1's medication administration training was not in his personnel folder. -He confirmed there was no documentation of medication administration training in his personnel folder for staff #1. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in	V 119		

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V 119	Continued From page 18 accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record reviews and interviews the facility staff failed to dispose of prescription medications in a manner that guards against diversion or accidental ingestion affecting two of two current clients and one of one deceased client (DC #6). The findings are: a. Review on 1/12/22 of client #1's record revealed: -Admission date of 8/17/16. -Diagnoses of Schizophrenia, Type II Diabetes, Hypertension, Hyperlipidemia, Chronic Kidney Disease stage 4, Osteoporosis and Allergic Rhinitis. b. Review on 1/12/22 of client #2's record revealed: -Admission date of 4/29/16. -Diagnoses of Major Depressive Disorder, Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea, Proteinuria, Hypertension, Hypersensitivity Lung Disease, Benign Prostatic Hyperplasia, Gastroesophageal	V 119		

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V 119	Continued From page 19 Reflux Disease, History of Cerebrovascular Accident and Left Hemiparesis. c. Review on 1/12/22 of deceased client #6 (DC #6) record revealed: -Admission date of 12/2/15. -Diagnoses of Schizophrenia-Undifferentiated, Seizure Disorder, Alzheimer's with late onset, Hyperlipidemia, Chronic Atrial Fibrillation, Hypertension, Vitamin B12 Deficiency and Tobacco Use Disorder. -He died on 12/11/21. -He was 85 years old. Review on 1/12/22 of physician's orders for DC #6 revealed: -Order dated 10/14/20 for Acetaminophen 325 milligrams (mg), two tablets every 12 hour. -Order dated 7/22/20 for Vitamin B-12 1000 micrograms (mcg), one tablet daily; Aspirin Low 81 mg, one tablet in the morning; Therems Multivitamin, one tablet daily and Zyprexa 10 mg, one tablet at bedtime. -Order dated 6/15/19 for Memantine HCL 5 mg, one tablet daily. -Order dated 6/11/19 for Amlodipine Besylate 10 mg, one tablet daily and Atorvastatin 10 mg, one tablet in evening. -Order dated 1/11/19 for Lamotrigine 150 mg, one tablet two times daily. d. Review on 1/12/22 of former client #7's (FC #7) record revealed: -Admission date was unknown. -Diagnosis were unknown. -Discharge date was unknown. -There was no documentation of physician's orders. Observation on 1/12/22 at approximately 1:40 pm	V 119		

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V 119	Continued From page 20 of the medication area revealed: -There was a plastic trash bag full of medication packets for DC #6 and FC #7. -There were four medication packets with all of the above prescribed medication for DC #6. -The medication packets had start date 12/8/21, 12/15/21, 12/22/21 and 12/29/21. -There was a bottle of Vitamin B-12 1000 mcg for DC #6. The medication expired on 4/15/21. -There was a bottle of Zyprexa 10 mg for DC #6 . The medication was filled on 10/23/21. -There were four bottles of Lamotrigine 150 mg for DC #6. Three of the bottles were filled on 1/20/20 and one was filled on 4/1/20. -There were nineteen medication packets which contained Benztropine 1 mg, Lithium Carbonate 300 mg and Loratadine 10 mg for FC #7. -The medication packets for FC #7 had start dates of 4/28/21 through 9/8/21. Interview on 1/12/22 with staff #2 revealed: -They had not returned DC #6 medications to the pharmacy. -DC #6 was not taking the medication that was in the bottles. -DC #6 was only got medications from the medication packet. -DC #6 was originally getting his medication from the Veteran Affairs clinic. -When the pandemic started DC #6 was switched over to the pharmacy all the other clients were using. -She kept the medications that were not being used for DC #6 in a plastic bag in the medication closet. -The pharmacy would sometimes send medications for clients who no longer reside in the home. -She told the pharmacy to stop sending the medications for FC #7. The pharmacy kept	V 119		

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V 119	Continued From page 21 sending the medication although she asked that they stop. -She was going to send those medications back to pharmacy this week. -She didn't know FC #7. He was already discharged when she started working at the home. Other staff said FC #7 left the group home a while ago. -She confirmed facility staff failed to ensure medications were disposed of in a manner that guards against diversion or accidental ingestion. Interview on 1/14/22 with the Director/Licensee revealed: -He knew those medications for DC #6 and FC #7 were in the medication closet. -He was supposed to take those medications back to the pharmacy and get a refund for the unused medication. -He had been to the group home on numerous occasions, however he would always forget to take the bag of medication back to the pharmacy. -He confirmed facility staff failed to ensure medications were disposed of in a manner that guards against diversion or accidental ingestion.	V 119		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.	V 131		

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V 131	Continued From page 22	V 131		

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to employment affecting one of four audited staff (#2). The findings are:

Review on 1/13/22 of the facility's personnel files revealed:
-Staff #2 had no specific hire date documented.
-Staff #2 was hired as a Paraprofessional.
-The HCPR check was completed on 11/4/19.
-There was no documentation the current agency completed a HCPR check for staff #2 prior to hire.

Interview on 1/12/22 with staff #2 revealed:
-She started working at the group home about six months ago.
-She thought all of her paperwork was in her personnel folder. If something was missing from her personnel folder the Director/Licensee would have to be contacted.
-Staff was not responsible for ensuring the appropriate paperwork was in the personnel folder.

Interview on 1/14/22 with the Director/Licensee revealed:
-It was his responsibility to ensure the personnel records were up to date.
-He thought staff #2 was supposed to do her own HCPR check when she was hired.
-He did not realize he was responsible for completing the HCPR check for staff #2.
-He confirmed the agency had no documentation

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V 131	Continued From page 23 of a HCPR check completed prior to employment for staff #2. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 131		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of	V 133		

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V 133	Continued From page 24 Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public	V 133		

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V 133	Continued From page 25	V 133		

records obtained from a State agency.
(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:
(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.
The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.
(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:
(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.
(2) Failure to check an employee's history of criminal offenses if the employee's criminal

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V 133	Continued From page 26 history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina	V 133		

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V 133	Continued From page 27 Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the criminal history record check was conducted within five business days of making the conditional offer of employment affecting two of four audited staff (#2 and #3).	V 133		

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V 133	Continued From page 28 The findings are: a. Review on 1/13/22 of the facility's personnel files revealed: - Staff #2 had no specific hire date documented. - Staff #2 was hired as a Paraprofessional. -She had a criminal history record check completed on 11/5/19. -There was no documentation the current agency completed a criminal history record check for staff #2. b. Review on 1/13/22 of the facility's personnel files revealed: - Staff #3 had no specific hire date documented. - Staff #3 was hired as a Paraprofessional. -There was no documentation of a criminal history record check for staff #3. Interview on 1/12/22 with staff #2 revealed: -She started working at the group home about six months ago. -She thought all of her paperwork was in her personnel folder. If something was missing from her personnel folder the Director/Licensee would have to be contacted. -Staff was not responsible for ensuring the appropriate paperwork was in the personnel folder. Interview on 1/14/22 with staff #3 revealed: -She started working at the group home around October 2020. -The Director/Licensee was responsible for making sure their personnel folders had the appropriate documentation. Interview on 1/14/22 with the Director/Licensee revealed: -It was his responsibility to ensure the personnel	V 133		

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V 133	Continued From page 29 records for staff were up to date. -He thought staff #2 and staff #3 were supposed to do her own criminal background check when they were hired. -He did not realize he was responsible for completing the criminal background checks for staff. -He confirmed the agency had no documentation of a criminal history record check for staff #2 and staff #. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 133		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident;	V 367		

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V 367	Continued From page 30 (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided	V 367		

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V 367	Continued From page 31 by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure incidents were reported to the LME for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 1/12/22 of deceased client #6's (DC #6) record revealed: -Admission date of 12/2/15. -Diagnoses of Schizophrenia-Undifferentiated, Seizure Disorder, Alzheimer's with late onset, Hyperlipidemia, Chronic Atrial Fibrillation, Hypertension, Vitamin B 12 Deficiency and Tobacco Use Disorder.	V 367		

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V 367	Continued From page 32 -He died on 12/11/21. -He was 85 years old. Review on 1/12/22 of facility records revealed: -A report of death dated 12/14/21 completed by the Director/Licensee-"[DC #6] fell off kitchen chair and was having a seizure. Staff immediately took precautions and steps for his safety. Staff ask [DC #6] after his seizure ended did he want him to call 911 and have him sent to the hospital but he refused to go. Staff helped him to his bed. Kept a check on him continually through the day. He went to wake him for dinner and found him unresponsive. He tried to resuscitate him and called 911 immediately. [DC #6] passed away on 12/11/21 at 4:20 pm." Interview with staff #1 on 1/13/22 revealed: -He did an incident report on the day DC #6 passed away in December 2021 and sent it to the Director/Licensee. -He didn't do a separate incident report for the seizure DC #6 had 3 days before he passed away. Interviews on 1/12/22 and 1/14/22 revealed: -DC #6 had a seizure in October 2021. -She did an incident report for the seizure incident with DC #6. -She also contacted the Director/Licensee and Qualified Professional about the incident. -The Director/Licensee came to the group home often and picked up documentation. She thought he possibly picked up the incident report for that seizure incident with DC #6 in October 2021. There was no documentation of incident reports completed by group home staff for the above issues.	V 367		

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V 367	Continued From page 33 Interviews with the Director/Licensee on 1/14/22 and 1/18/22 revealed: -He could not remember if staff #2 informed him that DC #6 had a seizure in October 2021. -Staff generally do the incident reports at the home. He would normally put those incident reports into the Incident Response Improvement System (IRIS) as needed. -He couldn't remember if he put an incident report in IRIS for a seizure DC #6 had in October 2021. -He thought they were a little confused about submitting the appropriate paperwork after DC #6 passed away. -He called someone from our division about submitting the paperwork. He thought it was the Complaint Intake Unit. -He did not think the incident report was put into IRIS when DC #6 passed away. -He confirmed the facility failed to ensure Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse	V 536		

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or injury to a person with disabilities or others or property damage is prevented.
(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.
(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Staff shall demonstrate competence in the following core areas:
(1) knowledge and understanding of the people being served;
(2) recognizing and interpreting human behavior;
(3) recognizing the effect of internal and external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with persons with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing

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and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name;
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualifications and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the

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V 536	Continued From page 36 course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers.	V 536		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure two of four audited staff (#1 and #3) had current training on the use of alternatives to restrictive interventions. The findings are:

a. Review on 1/13/22 of the facility's personnel files revealed:
-Staff #1 had no specific hire date documented.
-Staff #1 was hired as a Paraprofessional.
-The Evidenced Based Protective Intervention (EBPI) training certificate expired on 12/20/21.
-There was no documentation of a current training on the use of alternatives to restrictive interventions for staff #1.

b. Review on 1/13/22 of the facility's personnel files revealed:
-Staff #3 had no specific hire date documented.
-Staff #3 was hired as a Paraprofessional.
-The EBPI training certificate expired on 1/31/21.
-There was no documentation of a current training on the use of alternatives to restrictive interventions for staff #3.

Interview on 1/13/22 with staff #1 revealed:
-He had been working at the group home for about three years.
-The Director/Licensee would normally ensure the required trainings were in their personnel folders.

Interview on 1/14/22 with staff #3 revealed:
-She started working at the group home around October 2020.
-The Director/Licensee was responsible for

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V 536	Continued From page 38 making sure their personnel folders had the appropriate trainings. Interview on 1/14/22 with the Director/Licensee revealed: -He thought the Qualified Professional or one of her staff did the most of the trainings for the group home staff. -The Qualified Professional had a business and had some of her staff doing required training for his group home staff. -He thought The Qualified Professional or one of her staff did the EBPI training with his group home staff. -He did not realize staff #1 and staff #3 EBPI training had expired. -He confirmed staff #1 and staff #3 had no documentation of current training on the use of alternatives to restrictive intervention	V 536		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor . The findings are:	V 736		

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V 736	Continued From page 39 Observation on 1/12/22 at approximately 11:20 am revealed: -Clients #2 and #3 bedroom-The wooded floor had peeling paint. The walls were stained. There was a mold like substance on the wall near client #2's bed. The bedroom door had peeling paint. -Hallway-The wooden floor had peeling paint. There was a small hole in floor covered with metal sheet. -Kitchen area-The linoleum flooring was cracked. The blinds had food stains and were broken. -DC #6's bedroom-The wooden floor had peeling paint. The walls had black marks. The inside part of window had a piece of plexiglass over it. Outside of the window was broken and there were approximately twelve shards of glass encased in the window. The wooden portion of the window was cracked. There was a thin sheet of plastic over the outside portion of the window. -Clients #3 and #4's bedroom-The wooden floor had peeling paint. The walls were stained. -Client #5's bedroom-The wooden floor had peeling paint. There was a pile of on the floor in the corner of the bedroom. The walls were cracked near the baseboard area. -Bathroom #1- There was a strong urine smell. The shower curtain was hanging and there were seven rusted shower curtain rings. There were used bandages on floor. -Bathroom 2- The toilet was loose. The toilet paper holder was missing from the wall. There were approximately ten burn marks on the sink. The paint on the baseboards was cracked. The door to bathroom had dirt like stains on outside and peeling paint. Door to bathroom would not close all the way. -Den area-There was pane of glass missing from the window. There was a piece of paper inserted into the window pane. The blinds were dusty and broken. One of the couch cushions was covered	V 736		

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V 736	Continued From page 40 with a plastic trash bag. The wall near the couch had peeling paint. Interview on 1/12/22 with staff #2 revealed: -The Director/Licensee was aware of most of the issues with the group home. -The Director/Licensee did not own the home. -She was not sure if the Director/Licensee had reached out to the landlord about the issues with the home. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. Interview on 1/13/22 with staff #3 revealed: -Staff talked with the Director/Licensee about the repairs the home needed. -He was not sure why the Director/Licensee had not reached out to the landlord about the home repairs. -DC #6 broke the window in his bedroom. DC #6 foot went through the window. DC #6 told him he was turning over in the bed and kicked the window by mistake. -Someone did come out the same day the glass was broken out of the window. The repair person put plexiglass in the window. -He was told windows were ordered for the den and DC #6 bedroom. He was told the windows were on back order for about 3 months. -He confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. Interview on 1/14/22 with the Director/Licensee revealed: -He was aware of most of the issues with the home.	V 736		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 41 -He does not own the home. He talked with the landlord and the landlord kept making excuses as to why the repairs were not completed. -He had even made repairs for the home out of his pocket. He had "gone into the hole" making repairs to that home. -The windows for that home had been ordered. They are waiting because the windows are on back order. -He confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive, orderly manner and kept free from offensive odor. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		
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, 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 observation and interviews, the facility failed to ensure a sleeping area for over night staff was separate from areas used for therapeutic and habilitative activities. The	V 784		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-237	A. BUILDING: _____ B. WING _____	R 01/19/2022

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V 784	Continued From page 42 findings are: Observation on 1/12/22 at approximately 11:20 AM revealed: -There was no bedroom to accommodate staff working in the group home over night. Interview on 1/13/22 with staff #1 revealed: -He worked at the group home for about three years. -He worked a 24 hour shift from 8 am to 8 am the next day. He thought he worked about 2-3 days a week. -He slept in den area on the pull out bed at the home. He had been sleeping in the den area since he worked at the home. -Staff had no separate bedroom in the home. -The clients normally watched television and/or participated in other activities in the den area. Interview on 1/12/22 with staff #2 revealed: -She worked at the group home for about six months. -She worked a 24 hour shift. She worked 8 am to 8 am the next day at the home. She worked about 3-4 days a week between both homes. -There was no bedroom for staff. -She slept in the den area on the couch after the clients go into their bedrooms. Interview on 1/14/22 with staff #3 revealed: -She started working at the group home around October 2020. -She worked at the home 3-4 days a week. She normally worked a 24-48 hour shift. -She slept on the couch in the den area of the home. The home did not have a separate sleeping area for staff. -They had been doing that since she started working at the home in October 2020.	V 784		

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V 784	Continued From page 43 Interview on 1/14/22 with the Director/Licensee revealed: -He didn't realize staff sleeping in the den area was an issue. -The clients do watch television in the den area and/or participate in other activities. -He told staff they could use one of the bedrooms in the upstairs area for sleeping. -All of the staff said they preferred to sleep on the couch at night instead of sleeping in a bedroom upstairs. -Staff said they preferred the den area because there was cable television. -The bedrooms upstairs did not have cable television.	V 784		