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	mhl026-005	A. BUILDING: _____ B. WING _____	R 02/23/2022

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MYROVER-REESE FELLOWSHIP HOME	613 QUALITY ROAD FAYETTEVILLE, NC 28306

(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 and follow up survey was completed on 2/23/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105		

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V 105	Continued From page 1 (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement (1) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the use of Urine Drug Screen (UDS) and COVID-19 (Coronavirus-Disease-2019) testing including the CLIA (Clinical Laboratory Improvement Amendments) waiver; and, (2) policies and procedures for the prevention and response to COVID-19 infections of clients. The findings are: Review on 1/26/22 of facility CLIA Certificate revealed, "Waiver (Pending) - 7/15/20 - 7/14/22." Finding #1: Review on 1/25/22 of client #1's record revealed: -34 year old female admitted 12/2/21. -Diagnoses included Alcohol Use Disorder, Opioid Use Disorder, Anxiety, and Depression. Interview on 1/25/22 client #1 stated: -The staff performed a UDS when clients returned from using a day pass, any time a client did not seem to be doing what they should, or smelled of alcohol. -The clients know the results of their UDS immediately. -The UDS are done in the facility office. Finding #2: Review on 1/25/22 of client #2's record revealed: -39 year old female admitted 11/8/21. -Diagnoses of Alcohol Use Disorder Severe, Stimulant Use Disorder Cocaine Severe, Bipolar, Post Traumatic Stress Disorder and Depression. -Urinalysis Record, test completed on 12/26/21	V 105		

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V 105	Continued From page 3 and 1/5/22, both negative results. Interview on 1/25/22 client #2 stated: -Resident can receive one 4 hour pass and one 24 hour pass. -If they use their pass and leave the facility, they had to submit to a urine drug test and breathalyzer test when they returned. Finding #3: Review on 1/25/22 of client #4's record revealed: -30 year old female admitted 6/23/21. -Diagnoses included Stimulant Use Disorder - Amphetamine (Severe), and Depression. -UDS results dated 11/21/21 negative for Marijuana, Methamphetamine, Amphetamine, Benzodiazepines, Cocaine, Opiates/Morphine, Oxycodone, Phenylcyclohexyl Piperidine (PCP). -UDS report signed by client #4 and Staff #5. Interview on 1/26/22 the North Carolina Division of Health Service Regulation CLIA Section staff stated the facility's CLIA certificate was expired effective 7/14/20. Interview on 1/25/22 - 2/9/22 the Executive Director stated: -The facility staff performed UDS and rapid COVID-19 testing. -She did not know the a CLIA waiver was needed unless tests were sent to an outside laboratory. -There was no policy and procedure for COVID-19. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 105		

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V 107	Continued From page 4	V 107		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual	V 107		

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V 107	Continued From page 5 employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to (1) ensure job descriptions met all requirements and, (2) a complete personnel record was maintained for each staff affecting 6 of 6 audited staff (Executive Director, Qualified Professional (QP), Peer Support Specialist, House Manager (HM) #1, HM#2, HM#4). The findings are: Review on 1/25/22 of the Executive Director's personnel record revealed: -Hire date of 5/15/19. -No documentation of a Health Care Personnel Registry (HCPR) check. -No signed job description. Review on 2/1/21 of the QP's personnel record revealed: -Hire Date of 3/14/12. -No documentation of a HCPR check. -No signed job description. Review on 1/25/22 of HM #1's personnel record revealed: -Hire date of 1/17/22. -No documentation of a HCPR check.	V 107		

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V 107	Continued From page 6 -No documentation of her level of education, competency, work experience or other qualifications. -No signed job description. Review on 1/25/22 of HM #2's personnel record revealed: -Hire date of 10/15/21. -No documentation of a HCPR check. -No documentation of her level of education, competency, work experience or other qualifications. -No signed job description. Review on 1/25/22 of HM #4's personnel record revealed: -Hire date of 1/8/22. -Previous employment with the facility from: 12/5/15-12/20/2020 -No documentation of a HCPR check. -No documentation of her level of education, competency, work experience or other qualifications. -No signed job description. Review on 2/1/22 of the Peer Support Specialist's personnel record revealed: -No hire date. -No documentation of a HCPR check. -No signed job description. Review on 2/9/22 of job descriptions for the Executive Director, QP, and HM positions revealed: -Executive Director job description did not include the minimum level of education, competency, or work experience required for the position. Responsibilities included hiring staff and ensuring staff were trained and qualified. -QP job description was a listing of "Daily Tasks,"	V 107		

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V 107	Continued From page 7 "Weekly Tasks," and "Monthly Tasks." QP job description did not include the minimum level of education, competency, work experience or other qualifications required for the position. -HM job description did not include the minimum level of education, competency, work experience or other qualifications required for the position. Interview on 2/2/22 the Peer Support Specialist reported: -She was hired December of 2020. Interview on 2/4/22 the Executive Director stated: -It was her responsibility as the Executive Director to make sure HCPR checks were done for new hires. -All new hires were required to complete an application and to be interviewed. -She kept the job applications for current staff in her desk. -There were job descriptions with qualifications for all positions. -The staff had not signed their job descriptions. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 107		
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	V 108		

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V 108	Continued From page 8 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, 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 review and interview the facility failed to ensure 3 of 5 audited paraprofessional staff (House Manager (HM) #1, #2, and #4) were trained in infectious diseases and bloodborne pathogens, first aid and cardiopulmonary resuscitation (CPR). The findings are: Finding #1: Review on 1/25/22 of the HM #1's personnel record revealed:	V 108		

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V 108	Continued From page 9 -Hire date of 1/17/22 -No First Aid and CPR -No Bloodborne pathogen training Interview on 1/25/22 the HM #1 reported: -She had worked at the facility since 1/17/22. -She worked by herself. Finding #2: Review on 1/25/22 of HM #2's personnel record revealed: -Hire date of 10/15/21 -No First Aid and CPR -No Bloodborne pathogen training Interview on 1/25/22 HM #2 reported: -She had not completed First Aid and CPR training or bloodborne pathogen training. -She worked second shift and overnights by herself. Finding #3: Review on 1/25/22 of HM #4's personnel record revealed: -Hire date of 1/8/22 -Previous employment with the facility from: 12/5/15-12/20/2020. -No current First Aid and CPR. Certified 6/15/19 expired: 6/15/21. -No Bloodborne pathogen training. Interview between 1/25/22 and 2/9/22 the Executive Director reported: -She was responsible for coordinating the training for the House Managers. -HM #1 was a new hire. -She was aware that HM #1 did not have First Aid and CPR training. -She planned to coordinate new hire orientation in the future for HM #1 to include First Aid and CPR.	V 108		

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V 108	Continued From page 10 There was no scheduled date for the First Aid and CPR training. - HM #1 worked by herself during her shift. -She planned to coordinate annual training for all staff to include First Aid and CPR, Bloodborne Pathogens and privacy training but "had not gotten around to it yet." This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	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: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and	V 110		

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V 110	Continued From page 11 (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 review and interview the governing body failed to develop and implement policies and procedures for individualized supervision plans of paraprofessionals by a Qualified or Associate Professional (QP or AP) affecting 5 of 5 audited paraprofessional staff (Executive Director, Peer Support Specialist, House Manager (HM) #1, HM#2, and HM#4); and, 1 of 5 audited paraprofessional staff (Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served . The findings are: Review on 2/9/22 of the QP's job description revealed no responsibility for supervision of paraprofessional staff. Review on 2/9/22 of the Executive Director's job description and Policy and Procedures dated 5/1/12 revealed: -The Executive Director responsibilities included the following: -Ensuring the "agency" was in compliance with all laws and regulations. -Management of human resources that "fully conforms to current laws and regulations." -"... clinical supervision of all non-medical	V 110		

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V 110	Continued From page 12 direct care staff." -Ensure staff were "... appropriately trained and qualified to provide services." Review on 1/25/22 of the Executive Director's personnel record revealed: -Hire date of 5/15/19. Review on 1/25/22 of HM #1's personnel record revealed: -Hire date of 1/17/22. Review on 1/25/22 of HM #2's personnel records revealed: -Hire date of 10/15/21. Review on 1/25/22 of HM #4's personnel records revealed: -Hire date of 1/8/22. Review on 2/1/22 of the Peer Support Specialist's personnel record revealed: -No hire date. Review on 1/25/22 and 2/1/22 of personnel records for the paraprofessional staff listed above revealed no documentation of an individualized supervision plan by a QP or AP. Interview on 2/2/22 the QP stated: -She was the only QP for the facility. -She worked part time, about 20 hours a week for the facility and 2 other sister facilities of the same licensure category. -She was not responsible to train staff. -She did not conduct staff training "classes" but she would "show" staff how to do something, and she gave the example, "how to complete paperwork." -She did not supervise the paraprofessionals.	V 110		

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V 110	Continued From page 13 Interview on 2/4/22 the Executive Director stated: -She was first hired as an administrative assistant, then was promoted to the Executive Director position in January 2021. -She served as the "acting" Executive Director beginning in October 2020 when the prior Executive Director left the organization -She graduated from high school; she did not have a college degree. -Her job experience prior to hire included positions at a hospital and a physician's office. -In her current position she was responsible for the "day to day" operations, financial management duties, assisted clients with the admission process, staff training, personnel records management, and staff supervision. -She reported to the Board. -No one else was responsible for staff supervision unless she was unavailable and then the Peer Support Specialist or QP would provide staff supervision if needed. -She had never been a QP or AP and knew she did not have the educational qualifications to be a QP. -When she had concerns or questions about facility operations she would consult a retired Executive Director who had worked at the facility for "roughly" 25 years and was her family member. -This retired Executive Director was not a current employee or Board member. -Board members were not involved in "day to day" operations. -She was knowledgeable about the facility by having observed the retired Executive Director work for years to carry out the program mission. -She described her prior association with the program as being "raised on the property... I grew up here."	V 110		

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V 110	Continued From page 14 -She had a "passion" for the facility. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 110		
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 review and interviews the facility failed to ensure fire and disaster drills were held at least quarterly and repeated on each shift. The findings are: Review on 1/25/22 of the facility records from 1/1/21 to 12/31/21 revealed: -No disaster drills were documented for the 1st quarter (1/1/21-3/31/21) of 2021 for 1st shift. -No fire drills were documented for the 2nd	V 114		

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V 114	Continued From page 15 quarter (4/1/21-6/30/21) of 2021 for 2nd and 3rd shifts. -No disaster drills were documented for the 2nd quarter of 2021 for 1st and 2nd shifts. -No fire drills were documented for the 3rd quarter (7/1/21-9/30/21) of 2021 for 1st, 2nd or 3rd shifts. -No disaster drills were documented for the 3rd quarter of 2021 for 1st, 2nd or 3rd shifts. -No disaster drills were documented for the 4th quarter (10/1/21-12/31/21) of 2021 for 1st shift. Interview on 1/25/22 client #1 stated: -Fire and disaster drills were held maybe once weekly. Interview on 1/25/22 client #2 stated: -Fire and disaster drills were held monthly. Interview on 1/25/22 client #4 stated: -Fire and disaster drills were held monthly on different shifts. Interview on 1/25/22 the Executive Director stated: -1st shift 6am- 2pm -2nd shift 2pm - 10pm Monday -Thursday and 2pm - 11pm on Friday. -3rd shift was from 10pm - 6am. -Weekend shifts were 7am - 11pm on Saturday and 6am - 10pm on Sunday. -Fire and disaster drills were supposed to be 1 per shift per quarter but held at least monthly. -She understood fire and disaster drills should be held on every shift each quarter. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		

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V 118	Continued From page 16	V 118		
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. This Rule is not met as evidenced by:	V 118		

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V 118	Continued From page 17 Based on record review, observation, and interview, the facility failed to, (1) maintain accurate MARs, (2) ensure medications were available to be administered as ordered, and, (3) allow clients to self-administer medication only after authorization in writing by the physician, affecting for 2 of 3 clients audited (#2, #4). The findings are: Finding #1: Review on 1/25/22 of client #2's record revealed: -39 year old female. -Admitted on 11/8/21. -Diagnoses of Alcohol Use Disorder Severe, Stimulant Use Disorder Cocaine Severe, Bipolar, Post Traumatic Stress Disorder and Depression. -Health Summaries report dated 1/12/22 listed Risperidone 1mg (milligram) tablet, take 1/2 tablet at bedtime for mood. Review on 1/25/22 of signed physician orders for client #2 revealed: -11/2/21: Amlodipine besylate 2.5 mg, 1 daily. (high blood pressure) -No signed physician order for Risperidone 1 mg, 1/2 tablet at bedtime for mood. Review on 1/25/22 of client #2's MARs from 11/1/21-1/25/22 revealed: -Risperidone 1 mg 1/2 tablet administered daily from 12/16/21 - 1/25/22 except for a blank on 12/30/21. Observation on 1/25/22 between 2:45 pm - 3:15 pm of client #2's medications revealed: -Amlodipine besylate 2.5 mg was not available for review. Interview on 1/25/22 client #2 stated: -She had taken her medications as prescribed.	V 118		

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V 118	Continued From page 18 -She received her medications through the mail and sometimes missed medication for a day waiting for medication to arrive. -It was her responsibility to order her medications. -She had taken her last dose of Amlodipine besylate the morning of 1/25/22. Finding #2: Review on 1/25/22 of client #4's record revealed: -30 year old female admitted 6/23/21. -Diagnoses included Stimulant Use Disorder - Amphetamine (Severe), and Depression. -No order documented for client #4 to self administer her medications. -There was no MAR for January 2022. Review on 1/25/22 of client #4's medication orders revealed: -7/1/21 orders were as follows: -Citalopram 20 mg daily (Depression). -Bupropion 150 mg daily (Depression). -Quetiapine 50 mg, 1-2 tablets at bedtime as needed for sleep. -Ibuprofen 600 mg twice daily as needed for pain. -10/4/21: Ibuprofen 600 mg every 8 hours as needed. -11/11/21: Aluminum hydroxide - 500 mg/5 ml (milliliters); take 5 ml as needed (PRN) for heartburn or gas. -There was no order to discontinue the aluminum hydroxide 500 mg/5 ml. -There was no order to clarify which ibuprofen order to follow or to discontinue the order dated 10/4/21. Review on 1/25/22 of client #4's MARs for November and December 2021 revealed: -"OS" was a code used to document a client was "off site" at a scheduled medication dosing time.	V 118		

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V 118	Continued From page 19 -Citalopram 20 mg and bupropion 150 mg were scheduled to be administered at 6 am daily. -Citalopram 20 mg: "OS" was documented for 30 daily doses between 11/1/21 and 12/29/2021. -Bupropion 150 mg: "OS" was documented for 31 daily doses between 11/1/21 and 12/29/21. -Citalopram 20 mg was not documented on 11/23/21. -Quetiapine 50 mg was documented nightly between 11/1/21 and 12/29/21, except for 11/21/21 and 11/24/21. The number of tablets (1 or 2) administered had not been documented. -A line had been drawn through the MAR documentation blocks for each medication on 12/30/21 and 12/31/21, with a note, "medication counted out and put in lock box." -The 7/1/21 order for ibuprofen 600 mg (twice daily as needed) had been transcribed onto the MARs. -The 10/4/21 order for ibuprofen 600 mg (every 8 hours as needed) had not been transcribed onto the MARs. -Ibuprofen 600 mg was documented with "OS" on 11/18/21, 11/19/21, 11/24/21, 11/29/21, 12/9/21; "Reason" documented, "anticipated pain." No administration times were documented. -The 11/11/21 order for aluminum hydroxide had not been transcribed onto the MARs. Observation of client #4's medications on 1/25/22 at 4 pm revealed there was no aluminum hydroxide on hand. Interview on 1/25/21 client #4 stated: -She was a "graduated resident" having completed the program, but chosen to extend her stay to work and save money to pay for her next living situation. -As a "graduated resident" she was allowed to keep her medications in a locked box and self	V 118		

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V 118	Continued From page 20 administer her medications. -Staff no longer recorded her medications on the MAR. -Before she "graduated" staff would put her 2 morning medications in an envelope and give it to her to take at her work site. -When she requested, ibuprofen was put in the envelope for her to take at her work site when needed. -She took 1 quetiapine tablet for sleep if it was a night before she had to go to work the next day. If not working the following day she would take 2 quetiapine tablets for sleep. -She had asked her doctor to prescribe a medication for gas. -When she went to the pharmacy she was not able to purchase the medication (aluminum hydroxide); she told the staff to "not to worry about it;" she had not needed the medication. -She had to go to the Emergency Room (ER) to get her medications refilled and the ER physician had written for ibuprofen every 8 hours. -The order for ibuprofen 600 mg twice daily had "worked" for her. Interview on 1/25/22 the Executive Director stated: -Client #2's amlodipine besylate 2.5 mg medication was not available for review. -Client #2's amlodipine besylate 2.5 mg medication refill had been ordered but had not been delivered by the mail. -Client #2's amlodipine besylate 2.5 mg medication last dose was administered that morning. -She was unable to locate the client #2's physician order for Risperidone 1 mg. -Client #4 used a transportation service that arrived before 6 am; therefore, staff placed client #4's morning medications in a small envelope to	V 118		

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take with her to self administer.
-Staff would document "anticipated pain" for ibuprofen when it was sent with client #4 because they did not know when she would take the medication.
-Client #4 had not been discharged, but they considered her "completed from the 180 day program."
-When client #4 completed the 180 day program, they marked through the remaining December 2021 MAR blocks and gave her a locked box to store her medications until she moved from the home.
-Client #4 self-administered all of her medications after she completed the program.
-Client #4's medications were no longer recorded on a MAR.
-Client #4 did not have an order to self administer.

Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.

Review on 2/9/22 of the Plan of Protection dated 2/9/22 written by the Executive Director revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? We will instruct each resident to speak with their physician to obtain self-administration order for their medication. Also, we will make sure of any resident taking midday medications are back on property at 2 o'clock Medication will no longer be package and sent with resident. Will provide residents PRN medications."
-"Describe your plans to make sure the above happens. I will meet with all residents to explain to them that they will need to speak with their physician to obtain a self-administration order for

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their medications to allow them to give themselves their medication while off property. If the resident needs assistance with this staff will be available to assist them. I will be holding a staff meeting tomorrow to let all house managers know that all residents need to be back on property no later than 2 o'clock if they are scheduled to take midday medication. Will make sure when a resident is prescribed a PRN medication by physician and are unable to purchase the medication our facility will purchase the medication for them."

This deficiency constitutes a re-cited deficiency.

Client #2 was a 39 year old female admitted 11/5/21 with diagnoses of Alcohol Use Disorder Severe, Stimulant Use Disorder Cocaine Severe, Bipolar, Post Traumatic Stress Disorder, and Depression, and had an order for amlodipine besylate 2.5 mg daily (high blood pressure). On 1/25/22 client #2 had no blood pressure medication on hand and stated she was responsible for requesting refills that were delivered by mail. Not having client #2's blood pressure medication refilled before she took her last dose would result in missed blood pressure medications. The facility did not have a signed order for client #2 to receive risperidone 1 mg 1/2 tablet daily, but it had been documented daily from 12/16/21 - 1/25/22. The facility could not ensure client #2 received risperidone as ordered without having signed orders prior to medication administration.

Client #4 was a 30 year old female admitted 6/23/21 with diagnoses of Stimulant Use Disorder - Amphetamine (Severe), and Depression. A physician had never authorized client #4 to self administer her medications. The facility would

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V 118	Continued From page 23 send 2 psychotropic medications (citalopram and bupropion) and pain medication (ibuprofen) with her to self administer while at work. After 180 days of residential treatment, client #4 self administered all of her medications and no MAR was documented after 12/29/21. Allowing client #4 to self administer medications without her physician's authorization, and failure to document medications resulted in a system that could not ensure client #4 received her medications as ordered. Client #4 had reported to her physician she needed medication for relief of gas/heartburn symptoms. The facility had not provided the medication; therefore, it would not be available if client #4 needed the medication for symptom relief. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety, and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 30th day.	V 118		
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 24 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a Health Care Personnel Registry (HCPR) was completed for 5 of 5 audited paraprofessional staff (House Manager (HM) #1, #2, #4, Peer Support Specialist, Executive Director). The findings are: Review on 1/25/22 of the HM #1's personnel records revealed: -Hire date of 1/17/22 -No documentation of a HCPR check. Review on 1/25/22 of the HM #2's personnel records revealed: -Hire date of 10/15/21 -No documentation of a HCPR check. Review on 1/25/22 of the HM #4's personnel records revealed: -Hire date of 1/8/22 -Previous employment with the facility from: 12/5/15-12/20/2020. -No documentation of a current HCPR check. Previous HCPR check: 11/13/15. Review on 2/1/22 of the Peer Support Specialist's personnel record revealed: -No hire date. -No documentation of a HCPR check. Review on 1/25/22 and 2/03/22 of the Executive Director's personnel record revealed: -Hire date of 5/15/19. -On 1/25/22 there was no HCPR check in the Executive Director's personnel record. -On 2/03/22, there was a HCPR check dated 1/26/22.	V 131		

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V 131	Continued From page 25 Interview on 2/2/22 the Peer Support Specialist reported: -She was hired December of 2020. Interview on 1/25/22 the Executive Director reported: -She was unclear what the HCPR check looked like and asked for an example. -HM #1, #2 and #4 were new hires and not all of their initial hiring paperwork had been completed. -She would have the HCPR completed for all three staff. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 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	V 133		

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V 133	Continued From page 26 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 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	V 133		

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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 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

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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 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

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V 133	Continued From page 29 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 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);	V 133		

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V 133	Continued From page 30 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)	V 133		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to request state criminal background checks within five business days of employment for 4 of 5 audited paraprofessional staff (House Manager (HM) #1, #2, #4, Peer Support Specialist). The findings are:

Finding #1:
Review on 1/25/22 the HM #1's personnel record revealed:
-Hire date: 1/17/22
-No documentation of a criminal background request.

Finding #2:
Review on 1/25/22 of the HM #2's personnel records revealed:
-Hire date of 10/15/21
-No documentation of a criminal background request.

Finding #3:
Review on 1/25/22 of the HM #4's personnel records revealed:
-Hire date of 1/8/22
-Previous employment with the facility from: 12/5/15-12/20/2020.
-No documentation of a current criminal background request. Previous criminial background check: 12/9/15.

Finding #4:

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V 133	Continued From page 31 Review on 2/1/22 of the Peer Support Specialist's personnel record revealed: -No hire date. -No documentation of a criminal background request. Interview on 2/2/22 the Peer Support Specialist reported: -She was hired December of 2020. Interview on 1/25/22 the Executive Director reported: -HM #1, #2, and #4 were new hires and not all of their initial hiring paperwork had been completed. -She would have the criminal background checks completed for all three staff. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 133		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility.	V 289		

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V 289	Continued From page 32 (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)	V 289		

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V 289	Continued From page 33 (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to operate within the scope of the licensed capacity and ensure care, habilitation, and supervision designed to meet the needs of the individual affecting 3 of 3 audited clients (#1, #2, #4). The findings are: Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105) Based on record review and interview the facility failed to develop and implement (1) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the use of Urine Drug Screen (UDS) and COVID-19 (Coronavirus-Disease-2019) testing including the CLIA (Clinical Laboratory Improvement Amendments) waiver; and, (2) policies and procedures for the prevention and response to COVID-19 infections of clients. Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V107) Based on record review and interview, the facility failed to (1) ensure job descriptions met all requirements and, (2) a complete personnel record was maintained for each staff affecting 6 of 6 audited staff (Executive Director, Qualified Professional (QP), Peer Support Specialist, House Manager (HM) #1, HM#2, HM#4)	V 289		

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V 289	Continued From page 34 Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V108) Based on record review and interview the facility failed to ensure 3 of 5 audited paraprofessional staff (House Manager (HM) #1, #2, and #4) were trained in infectious diseases and bloodborne pathogens, first aid and cardiopulmonary resuscitation (CPR). Cross Reference: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) Based on record review and interview the governing body failed to develop and implement policies and procedures for individualized supervision plans of paraprofessionals by a Qualified or Associate Professional (QP or AP) affecting 5 of 5 audited paraprofessional staff (Executive Director, Peer Support Specialist, House Manager (HM) #1, HM#2, and HM#4); and, 1 of 5 audited paraprofessional staff (Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. Cross Reference: G.S. 131E-256. Health Care Personnel Registry (d2) (V131) Based on record review and interview the facility failed to ensure a Health Care Personnel Registry (HCPR) was completed for 5 of 5 audited paraprofessional staff (House Manager (HM) #1, #2, #4, Peer Support Specialist, Executive Director). Cross Reference: G.S. 122C-80. Criminal History Record Checks (V133) Based on record reviews and interviews the facility failed to request state criminal background checks within five business days of employment for 4 of 5 audited paraprofessional staff (House Manager (HM) #1, #2, #4, Peer Support Specialist). Cross Reference: 10A NCAC 27G .5602 Staff	V 289		

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V 289	Continued From page 35 (V290) Based on record review and interview the facility failed to ensure (1) that at least one staff member on duty was trained in alcohol and other drug withdrawal symptoms for 2 of 5 audited paraprofessional staff (House Manager (HM) #1 #2); (2) 1 of 3 audited clients (#4) was capable of remaining in the community without supervision for specific periods of time. Cross Reference: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536) Based on record reviews and interviews, the facility failed to assure 3 of 5 audited paraprofessional staff (House Manager (HM) #1, #2 and #4) were trained in Alternatives to Restrictive Interventions. Cross Reference: 10A NCAC 27G .0304 Facility Design and Equipment(d)(4) (V768) Based on observation, record review, and interview, the facility failed to ensure overnight accommodations for persons other than clients were separate from client bedrooms. Review on 1/25/22 of the facility's license showed it was licensed as a .5600E facility for supervised living for adults, with a capacity of 11, whose primary diagnosis is substance abuse dependency. Observations on 1/25/22 between 10:15 am and 10:45 am revealed the facility was operating with a client capacity of 10. Interview on 1/25/22 and 2/23/22 the Executive Director stated: -The overnight staff slept in one of the downstairs client bedrooms. -She would pursue changing the facility license capacity to 10 because the facility had to provide	V 289		

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V 289	Continued From page 36 a bedroom for the overnight staff. Review on 2/9/22 of the Plan of Protection dated 2/9/22 written by the Executive Director revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? No resident will be left unsupervised on property. CLIA Waiver will be obtained. Signed and maintain job description, have employee application, education background, health registry in file on each staff member and background check. Have each staff member trained appropriately with PAWS (Post Acute Withdrawal Syndrome), NCI (Non Crisis Intervention), CPR First Aid and Bloodborne Pathogen Supervision by qualified professional Training annually will be completed Sleeping Body will no longer take up state bed." -"Describe your plans to make sure the above happens. If a house manger must leave the property for any reason, they will carry all residents with them, or we will have another staff member come in to cover while they are off property. We will reapply for CLIA waiver to have on hand for urine and covid testing. While having staff meeting tomorrow, I will have all staff sign a copy of their job description to be placed into their employee file. I ran all staff through the health care registry and also all staff without background check is scheduled to have it done. I have scheduled PAWS training for all staff for this Friday morning the 11th of February, CPR, NCI and First aid training has been completed and put into their employee files. Qualified Professional will over see our Executive Director and our Paraprofessionals Will come up with a system to make sure all staff training is completed annually I will submit an amendment for out license to lower the number of beds we are licensed for."	V 289		

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V 289	Continued From page 37 This deficiency constitutes a re-cited deficiency. The facility, operated at a capacity of 10 but licensed for 11, served clients whose primary diagnosis was substance abuse related. The Executive Director was responsible for the day to day operations, supervision of the paraprofessionals, training the paraprofessionals and maintaining employee records. The Executive Director met the requirements of a paraprofessional staff. The facility had a part time QP who was responsible for the facility and two sister facilities. The QP did not provide supervision or training of the paraprofessional staff. The Executive Director did not maintain staff personnel records to include education, experience, job descriptions, criminal record checks and HCPR checks. The Executive Director failed to ensure staff was qualified for the position. Paraprofessional staff were not trained to meet client needs in CPR/First Aid and Bloodborne Pathogens. Paraprofessional staff, to include the Executive Director, were not trained in program specific training for alcohol and drug withdrawal symptoms. The competency of the Executive Director resulted in the inability to ensure paraprofessionals were trained to meet clients' needs. The Executive Director was responsible for ensuring regulatory compliance with the CLIA waiver was unaware a CLIA waiver was needed. The facility required clients to submit to urine drug screenings and the facility provided the results. The systematic procedures of the facility and the competency of the Executive Director resulted in staff who were not trained or supervised by a qualified professional. This also resulted in the inability of the facility and staff to provide treatment services to the clients served. This deficiency constitutes a Type A1 rule violation for serious neglect and must be	V 289		

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V 289	Continued From page 38 corrected within 23 days. An administrative penalty of $3,000.00 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 289		
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 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	V 290		

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V 290	Continued From page 39 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 (1) that at least one staff member on duty was trained in alcohol and other drug withdrawal symptoms for 2 of 5 audited paraprofessional staff (House Manager (HM) #1 #2); (2) 1 of 3 audited clients (#4) was capable of remaining in the community without supervision for specific periods of time. The findings are: Finding #1: Review on 1/25/22 the HM #1's personnel record revealed: -Hire date: 1/17/22 -No documentation of training on alcohol and drug withdrawal symptoms. Interview on 1/25/22 the HM #1 stated: -She worked at the facility for a week. -She was being trained by the Executive Director. -She worked alone.	V 290		

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V 290	Continued From page 40 Review on 1/25/22 of the HM #2's personnel records revealed: -Hire date of 10/15/21 -No documentation of training on alcohol and drug withdrawal symptoms. Interview on 1/25/22 with the HM #2 reported: -She was a former graduate of the program and had "real life experience." -She had not received any formal training on alcohol and drug withdrawal symptoms. -She worked alone. Finding #2 Review on 1/25/22 of client #4's record revealed: -30 year old female admitted 6/23/21. -Diagnoses included Stimulant Use Disorder - Amphetamine (Severe), and Depression. -No assessment for unsupervised time. Interview 1/25/22 client #4 stated: -She worked full time. -An outside transportation service transported her to work before 6am. Interview on 1/25/22 -2/9/22 the Executive Director reported: -Staff were not required to have substance abuse training. -Most of her staff were in recovery from substance abuse. -She was unclear about the requirement for staff to have training on alcohol and drug withdrawal symptoms. -Believed that this training was part of the Nonviolent Crisis Intervention (NCI) plus training which all staff would take once hired. -Believed the NCI plus training was scheduled for staff next week but she did not have a date. -Client #4 left for work around 6am and returned	V 290		

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V 290	Continued From page 41 around 3pm. -Client #4 had not been assessed for unsupervised time in the community or for work. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 290		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal	V 366		

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V 366	Continued From page 42 regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The	V 366		

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V 366	Continued From page 43 final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to implement written policies governing their response to level I incidents for medication refusals. The findings are: Review on 1/25/22 of client #2's record revealed:	V 366		

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V 366	Continued From page 44 -39 year old female. -Admitted on 11/8/21. -Diagnoses of Alcohol Use Disorder Severe, Stimulant Use Disorder Cocaine Severe, Bipolar, Post Traumatic Stress Disorder and Depression. Review on 1/25/22 of the facility records from November 2021 - January 2022 revealed no level I incident reports for medication refusals. Review on 1/25/22 of signed physician orders for client #2 dated 11/11/21 revealed: -Benzocaine 20% dental gel, apply a small amount to affected area 3 times daily. (oral pain reliever) Review on 1/25/22 of client #2's Medication Administration Record (MAR) from 11/1/21 - 1/25/22 revealed: -Benzocaine 20% dental gel refused on 11/12/21 (9pm), 11/19/21 (2pm, 9pm), 11/22/21 (2pm), 11/24/21 (9pm), 11/29/21 (9pm), 12/1/21-1/4/22. Interview on 1/25/22 client #2 stated: -She had a tooth pulled and was prescribed medication. -She refused the medication when she no longer needed it but it took a while for the doctor to discontinue the medication order. Interview on 1/25/22 the Executive Director stated: -The facility documented medication refusals on the back of the MAR. -The facility did not document medication refusals as a level I incident. -If a client refused a medication, the facility requested the client to contact the prescribing provider to have it discontinued.	V 366		

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V 536	Continued From page 45	V 536		
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 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;	V 536		

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V 536	Continued From page 46 (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 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	V 536		

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V 536	Continued From page 47 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 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.	V 536		

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V 536	Continued From page 48 (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 3 of 5 audited paraprofessional staff (House Manager (HM) #1, #2 and #4) were trained in Alternatives to Restrictive Interventions. The findings are: Finding #1: Review on 1/25/22 of the HM #1's personnel record revealed: -Hire date: 1/17/22 -No documentation of training in Alternatives to Restrictive Interventions. Interview on 1/25/22 the HM #1 stated: -She worked at the facility for 1 week. Finding #2: Review on 1/25/22 of the HM #2's personnel records revealed:	V 536		

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V 536	Continued From page 49 -Hire date of 10/15/21 -No documentation of training in Alternatives to Restrictive Interventions. Interview on 1/25/22 with the HM #2 reported: -She was unclear as to the specific kind of training that Alternatives to Restrictive Interventions entailed. -She had not received any training in Alternatives to Restrictive Interventions. Finding #3: Review on 1/25/22 of the HM #4's personnel records revealed: -Hire date of 1/8/22 -Previous employment with the facility from: 12/5/15-12/20/2020 -Previous training in Nonviolent Crisis Intervention (NCI) plus 6/9/20 expired 6/8/21. Interview on 1/25/22 the Executive Director reported: -She was aware that the HM #1, #2 and #4 had not completed Nonviolent Crisis Intervention (NCI) plus training, but this had not been done yet as the staff were all new hires. -She believed the NCI plus training was scheduled for staff next week but she did not have a date. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 536		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS	V 736		

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V 736	Continued From page 50 (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 interview the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 1/25/22 between 10:15am - 10:45am the tour of the facility revealed: -There were 5 adjacent kitchen floor tiles near the sink that were broken and loose. -The light fixture in the kitchen did not appear to be properly secured to the ceiling, loose on the left side. -The laminate floor in the bathroom was buckled and uneven. -Client bedroom #5 had a blown light bulb in the fixture and the ceiling fan made a knocking sound while on. -Client bedroom #1 had 6 quarter size circular brown spots on the ceiling. -Client bedroom #1 had a brown linear stain about 1 inch wide in the perimeter of corner about 3 feet by 2 feet. -The entryway had a brown spot about 6 inches in the right corner. -Client bedroom #3 had a crack across the length of the ceiling. -The upstairs bathroom had paint peeling around the wall soap dispenser. Interview on 1/25/22 the Executive Director stated:	V 736		

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V 736	Continued From page 51 -The facility recently received a grant and they planned to make repairs or relocate. -She received an estimate to replace the roof. -She would ensure repairs were made to the facility and it was maintained in a safe, clean and attractive manner.	V 736		
V 750	27G .0304(b)(3) Maintenance of Elec., Mech., & Water Systems 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (3) Electrical, mechanical and water systems shall be maintained in operating condition. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure the facility's water systems were maintained in operating condition. The findings are: Observation on 1/25/21 between 10:15am - 10:45am the tour of the facility revealed: -The kitchen sink faucet had a continuous steady water drip. -Both bathrooms on the main floor had a slow water drip from the sink faucets. -The upstairs bathroom sink faucet had a slow water drip. Interview on 1/25/21 the Executive Director stated:	V 750		

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V 750	Continued From page 52 -She was not aware of the water drips. -She would ensure that the repairs were made to the facility.	V 750		
V 768	27G .0304(d)(4) Non-Client Accommodations 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: (4) In facilities with overnight accommodations for persons other than clients, such accommodations shall be separate from client bedrooms. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure overnight accommodations for persons other than clients were separate from client bedrooms. The findings are: Review on 1/25/22 of the facility's license revealed a licensed capacity of 11 clients. Observations on 1/25/22 during the facility tour between 10:15 am and 10:45 am revealed: -3 client bedrooms downstairs, 2 rooms with 2 beds, and 1 room with 1 bed. -3 client bedrooms upstairs, each with 2 beds. Interview on 1/25/22 the House Manager #2 stated: -She had been a client in the facility before being	V 768		

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V 768	Continued From page 53 employed by the facility. -She was a live in staff and occupied one of bedrooms downstairs. -The facility had room for 10 clients. -In addition to her bedroom, there were 5 other bedrooms set up for 2 clients per room. Interview on 1/25/22 the Executive Director stated: -The facility had a "sleeping body" at night. -The overnight sleep staff stayed in one of the downstairs client bedrooms. -There was a staff sleep room, but it was used for other purposes, such as a confidential meeting place for clients and their counselors. -She was not aware staff could not sleep in a client room. -The "sleeping body's" room had always been identified as a staff room since she was hired. -She understood facility could not provide accommodations for staff in licensed client bedrooms. This deficiency is cross referenced into 10A NCAC 27G .5601 Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 768		