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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-214	A. BUILDING: _____ B. WING _____	R 02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON W LILLY HOME	560 WILKES ROAD FAYETTEVILLE, NC 28306

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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	DHSR - Mental Health MAR 25 2022 Lic. & Cert. Section	

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

Sammy Thompson — Executive Director — 3-21-22

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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, observation, 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 records revealed there was no CLIA certificate. Finding #1: Review on 2/3/21 of client #1's record revealed: -56 year old male. -Admitted on 10/8/21. -Diagnoses of Alcohol Use Disorder Severe, Anxiety and Depression. Interview on 2/3/22 client #1 stated: -The clients had concerns the cook would be coughing and not wear a mask, and would not wash his hands following smoke breaks. -The clients had brought their concerns about the cook to the staff's attention, but nothing changed. -He had been told the cook was not required to wear a mask because he had COPD (chronic obstructive pulmonary disease). Finding #2: Review on 2/3/22 of client #3's record revealed: -62 year old male admitted 9/23/21. -Diagnoses included Stimulant use Disorder - Cocaine (severe); Post Traumatic Stress Disorder	V 105	Clia Waiver has been received 3-11 Will keep Waiver up to date.	

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V 105	Continued From page 3 (PTSD); and, Alcohol Use Disorder. -UDS results on 9/23/21, 10/20/21, and 11/17/21 were negative for marijuana, methamphetamine, amphetamine, benzodiazepines; cocaine, opiates/morphine, oxycodone and phenylcyclohexyl piperidine (PCP). Interview on 2/3/22 client #3 stated: -The Executive Director "makes the rules as she goes" regarding COVID. -All of the clients had been quarantined for 10 days after testing positive for COVID. -He refused to eat food prepared by the cook because he would not wear a mask, gloves, or wash his hands. He had complained twice to the Executive Director but nothing had been done. Finding #3: Review on 2/2/22 of client #4's record revealed: -53 year old male. -Admitted on 1/11/22. -Diagnoses of Alcohol Use Disorder Severe, Stimulant Use Disorder Cocaine Severe, Tobacco Use Disorder Severe and Cannabis Use Disorder Moderate. Interview on 2/3/22 client #4 stated: -He tested positive for COVID and had been in quarantine for 13 days. -He was "waiting for clarification but don't have a hard date" on how long he had to quarantine or when his quarantine would be over. Interview on 2/2/22 House Manager (HM) #1 stated: -When he performed a UDS he would give the client the bottle, observe them collect the specimen, let the specimen "set a second or 2," and, when he saw the results "come through," he would tell the client their results.	V 105		

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V 105	Continued From page 4 -He had not performed any COVID testing. -He had taken the clients to the veteran's hospital for COVID testing "week before last" and all 4 clients tested positive. -The clients were retested Monday (2/1/22) and 1 of the 4 clients (client #4) continued to be positive. -Client #4 remained quarantined in his room. Client #4 used his phone and computer to participate in groups and make medical appointments. Interview on 1/26/22 the North Carolina Division of Health Service Regulation CLIA Section staff stated the facility did not have a CLIA certificate. Interview on 2/2/22 the Qualified Professional (QP) stated UDS were done when a client was admitted. Interviews on 1/25/22 - 2/9/22 the Executive Director stated: -The facility did not have a CLIA waiver. -She thought a CLIA waiver was not needed unless they sent tests to an outside lab. -The facility staff performed UDS and rapid COVID-19 testing. -There was no policy and procedure for COVID-19 precautions or response to positive cases. -When a client tested positive for COVID the client had to quarantine. -(Interview on 2/2/22) All clients had recently tested positive for COVID, quarantined for 10 days, and retested. Except for client #4, the other clients were negative when retested and no longer in quarantine. -Client #4 was on his 13 th day in quarantine. (Based on this, the clients would have been tested approximately 1/21/22 and retested	V 105	CLIA Waiver has been received will keep Waiver up to date. 3-11	

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V 105	Continued From page 5 approximately 1/31/22.) -She followed the recommendation of the service contractor for client#4 to quarantine for 14 days. -She was unsure what she would do if client #4 continued to test positive after 14 days. -(Interview on 2/9/22) Client #4 had a "home" COVID test performed on 2/4/22, tested negative, and was taken off quarantine. -Other tests performed by the facility were fingerstick blood sugar (FSBS) testing if ordered. -There were no FSBS orders for the current clients 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		
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	V 107		

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V 107	Continued From page 6 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 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 5 of 5 audited staff (Executive Director, Qualified Professional (QP), Peer Support Specialist, House Manager (HM) #1, and HM#5). The findings are:	V 107		

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V 107	Continued From page 7 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 2/1/22 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 the HM #1's personnel record revealed: -Hire date of 4/5/13. -No documentation of his level of education, competency, work experience or other qualifications. -No signed job description. Review on 1/25/22 of the HM #5's personnel record revealed: -Hire date of 8/30/21. -No documentation of his 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 the facility's job descriptions revealed: -Executive Director's job description did not include the minimum level of education,	V 107	2-25 file has been updated with All required documents All NCPR will be completed prior to starting employment.	

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V 107	Continued From page 8 competency, or work experience required for the position. Responsibilities included hiring staff and ensuring staff were trained and qualified. -QP's job description was a listing of "Daily Tasks," "Weekly Tasks," and "Monthly Tasks." -QP's job description did not include the minimum level of education, competency, work experience, or other qualifications required for the position. -HM's job description did not include the minimum level of education, competency, work experience or other qualifications required for the position. -There was no job description for the Peer Support Specialist. Interview on 2/2/22 the Peer Support Specialist stated: -Hired December 2020. Interview on 2/4/22 the Executive Director stated: -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	Job descriptions have been updated Applications have been put in employee file 2-25 Job descriptions have been signed 2-25 Applications & Job descriptions will be put in employee files prior to employment	
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	V 108		

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V 108	Continued From page 9 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, 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 1 of 2 audited paraprofessional staff (House Manager (HM) #5) were trained in infectious diseases and bloodborne pathogens, first aid and cardiopulmonary resuscitation (CPR). The findings are:	V 108		

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V 108	Continued From page 10 Review on 2/2/22 of the HM #5's personnel record revealed: -Hire date of 8/30/21. -Expired CPR certification 6/15/21. -No Bloodborne pathogen training. Interview on 2/1/22 the HM #5 stated: -He began as HM in August of 2021. -He works 3rd shift 10 pm-5 am. -He works alone. Interviews between 1/25/22 and 2/4/22 the Executive Director stated: -In her current position she was responsible for the staff training to include CPR and Bloodborne Pathogens. -She was working on coordinating annual training for all staff. This deficiency has been cited 3 times since the original cite on 8/23/18. 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	CPR, First Aid & NCI will be completed prior to hire. CPR & First Aid 1-31 training have been completed. Training is set up for Bloodborne Pathogens	
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	V 110		

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V 110	Continued From page 11 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 (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 4 of 4 audited paraprofessional staff (Executive Director, Peer Support Specialist, House Manager (HM) #1, and HM#5); and, 1 of 4 audited paraprofessional staff (Executive Director) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are:	V 110		

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V 110	Continued From page 12 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's 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 direct care staff." -Ensure staff were "... appropriately trained and qualified to provide services." Review on 2/1/22 of the Executive Director's personnel record revealed: -Hire date of 5/15/19. Review on 2/2/22 of the HM #1's personnel record revealed: -Hire date of 4/5/13. -Review on 2/2/22 of the HM #5's personnel records revealed: -Hire date of 8/30/21. Review on 2/1/22 of the Peer Support Specialist's personnel record revealed: -No hire date. Reviews on 2/1/22 - 2/9/22 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 Peer Support Specialist	V 110	Updated Supervision plan is being created	2-25

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V 110	Continued From page 13 stated: -She was hired December 2020. 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. 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, assisting 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	V 110		

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V 110	Continued From page 14 facility operations she would consult a retired Executive Director who had worked at the facility for "roughly" 25 years and was a 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's mission. -She described her prior association with the program as being "raised on the property... I grew up here." -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.	V 114		

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V 114	Continued From page 15 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were held at least quarterly and repeated on each shift. The findings are: Review on 2/2/22 of the facility records from 1/1/21 to 12/31/21 revealed: -No fire drills were documented for the 1st quarter (1/1/21-3/31/21) of 2021 for 2nd, 3rd and weekend shifts. -No disaster drills were documented for the 1st quarter of 2021 for the 1st, 3rd and weekend shifts. -No fire drills were documented for the 2nd quarter (4/1/21-6/30/21) of 2021 for 1st, 2nd and 3rd shifts. -No disaster drills were documented for the 2nd quarter of 2021 for 1st, 3rd and weekend shifts. -No fire drills were documented for the 3rd quarter (7/1/21-9/30/21) of 2021 for 2nd, 3rd and weekend shifts. -No disaster drills were documented for the 3rd quarter of 2021 for 1st, 3rd and weekend shifts. -No fire drills were documented for the 4th quarter (10/1/21-12/31/21) of 2021 for 1st, 3rd and weekend shifts. -No disaster drills were documented for the 4th quarter of 2021 for 1st and weekend shifts. Interview on 2/3/22 client #1 stated: -The facility had done a disaster drill about 2 weeks prior and a fire drill before that. -He was unsure what type of disaster drill but they were told to meet in the bathroom. Interview on 2/3/22 client #2 stated: -The facility held fire and disaster drills.	V 114	Fire & disaster drills will be held monthly on every shift	

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V 114	Continued From page 16 Interview on 2/3/22 client #3 stated: -Fire and disaster drills were held about every 2 weeks. Interview on 2/3/22 client #4 stated: -The facility held fire and disaster drills. -The facility held a hurricane drill in the bathroom. -The facility held a fire drill and the clients had to meet out front. Interview on 2/1/22 the Executive Director stated: -1st shift 7am- 3pm. -2nd shift 3pm - 10pm. -3rd shift was from 10pm - 7am. -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 needed to be completed on every shift each quarter.	V 114		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and	V 116	Updated Dr's order and self Administers orders have been obtained for Clients	

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V 116	Continued From page 17 approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 26E .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. This Rule is not met as evidenced by: Based on record review and interview the facility failed to assure that dispensing of medications was restricted to persons authorized by law to do so, affecting 1 of 3 audited clients (#3). The findings are: Review on 2/3/22 of client #3's record revealed: -62 year old male admittted 9/23/21. -Diagnoses included Stimulant Use Disorder - Cocaine (severe); Post Traumatic Stress Disorder (PTSD); and Alcohol Use Disorder. Review on 2/3/22 of client #3's medication orders and order dates revealed:	V 116		

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V 116	Continued From page 18 -9/23/21 orders included: -Naltrexone 50 mg (milligrams) daily (prevent relapse of alcohol or drug abuse) -Fish oil 1,000 mg BID (twice daily) (cardiac health) -Prazosin 2 mg, 2 tablets (= 4 mg) at bedtime (PTSD) -Hydroxyzine 25 mg, 2 at bedtime (= 50 mg) PRN (as needed) for insomnia/anxiety or agitation -Trazodone 150 mg at bedtime (depression; sleep aid) -Quetiapine 100 mg at bedtime (depression; sleep aid) -Sertraline 100 mg, 2 tablets daily (= 200 mg) (depression; PTSD) -Cholecalciferol 25 mcg (micrograms) daily (vitamin D3 supplement) -12/22/21: Order for Sertraline 200 mg changed from "daily" (had been scheduled for 6 am) to be given at bedtime. Review on 2/3/22 and 2/9/22 of client #3's MARs for 11/1/21 - 2/9/22 revealed: -"OS"was printed on the MARs as the code to document "Off site handed (medication) to client." -"OS" was documented for routine scheduled doses of the following: -11/13/21: 9 pm doses of fish oil 1,000 mg, prazosin 4 mg, trazodone 150 mg, quetiapine 100 mg. -11/14/21: 6 am doses of cholecalciferol 25 mcg, naltrexone 50 mg, sertraline 200 mg, and fish oil 1,000 mg. -12/11/21: 9 pm doses of fish oil 1,000 mg, prazosin 4 mg, trazodone 150 mg, quetiapine 100 mg, Depakote 1,000 mg ER, hydroxyzine 50 mg PRN at bedtime. -12/12/21: 6 am doses of naltrexone 50 mg, fish oil 1,000 mg, sertraline 200 mg.	V 116	I will make sure all Clients have updated Disorder and also . self administas orders	

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V 116	Continued From page 19 -1/8/22: 9 pm doses of fish oil 1,000 mg, prazosin 4 mg, trazodone 150 mg, sertraline 200 mg, quetiapine 100 mg, Depakote 1,000 mg ER, and hydroxyzine 50 mg PRN at bedtime. -1/9/22: 6 am doses of naltrexone 50 mg, fish oil 1,000 mg, Interview on 2/3/22 client #3 stated: -Staff would remove his medications from the medication bottles and place them in envelopes for him to take with him when he left the facility on "pass." -He would have 1 envelope with his morning medications, and 1 with his bedtime medications inside. -The staff would write his name and the time the medications were to be taken on the envelopes. -The staff did not write the name of the "pills" on the envelopes.	V 116	Self Administers orders have been obtained. The staff will count out meds and send all medication w/ bottles with clients when they are on weekend pass	
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	V 118		

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V 118	Continued From page 20 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: 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) administer medications on the written order of the physician, affecting for 1 of 3 clients audited (#3). The findings are: Review on 2/3/22 of client #3's record revealed: -62 year old male admitted 9/23/21. -Diagnoses included Stimulant Use Disorder - Cocaine (severe); Post Traumatic Stress Disorder (PTSD); and Alcohol Use Disorder. -"Health Summaries" dated 12/6/21, not signed by a physician, listed the following medications: -Lanaprost 0.005% eye drops, 1 drop in each eye every evening; expiration date 11/11/22. -Divalproex 500 mg (milligrams), 2 tablets at bedtime for mood stabilization; last filled 8/30/21;	V 118	Clients are aged have obtained need Dr's orders	

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V 118	Continued From page 21 expiration 8/30/22. Review on 2/3/22 of client #3's orders between 9/23/21 - 2/2/22 revealed: -9/23/21 orders included: -Naltrexone 50 mg daily (prevent relapse of alcohol or drug abuse) -Fish Oil 1,000 mg BID (twice daily) (cardiac health) -Prazosin 2 mg, 2 tablets (= 4 mg) at bedtime (PTSD) -Hydroxyzine 25 mg, 2 at bedtime (= 50 mg) PRN (as needed) for insomnia/anxiety or agitation -Trazodone 150 mg at bedtime (depression; sleep aid) -Quetiapine 100 mg at bedtime (depression; sleep aid) -Sertraline 100 mg, 2 tablets daily (= 200 mg) (depression; PTSD) -Cholecalciferol 25 mcg (micrograms) daily (vitamin D3 supplement) -Thiamine 100 mg daily (vitamin B supplement) -12/22/21: Order for Sertraline 200 mg changed from "daily" (6 am) to be given at bedtime. -There were no orders to discontinue the following: -Cholecalciferol 25 mcg daily. -Thiamine 100 mg daily. -There were no orders for the following: -Latanoprost 0.005% Ophthalmic Solution, 1 drop in each eye every evening. (glaucoma) -Depakote 500 mg ER (extended release), 2 tablets (=1,000 mg) at bedtime for mood stabilization. Review on 2/3/22 and 2/9/22 of client #3's MARs for 11/1/21 - 2/9/22 revealed: -Latanoprost 0.005% Ophthalmic Solution, 1 drop	V 118		

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V 118	Continued From page 22 in each eye was transcribed to be administered at 9 pm starting 11/22/21. -Depakote 500 mg ER 1,000 mg was transcribed to be administered at 9 pm starting 12/10/21. -"X" was printed on the MARs as the code to document "PRN not requested." -"X" was documented for routine scheduled doses of the following: -Naltrexone 50 mg: 6 am dose on 1/16/22. -Fish Oil 1,000 mg: 6 am doses on 1/25/22 - 1/31/22, 2/1/22 - 2/9/22; 9 pm doses on 1/1/22, 1/19/22, 1/24/22 - 1/31/22, and 2/1/22 - 2/8/22. -Prazosin 4 mg: 9 pm doses on 1/1/22, 1/11/22, and 1/19/22. -Trazodone 150 mg: 9 pm doses on 12/18/21, 1/1/22, 1/11/22, and 1/19/22. -Quetiapine 100 mg: 9 pm doses on 12/18/21, 1/1/22, 1/11/22, and 1/19/22. -Sertraline 200 mg: 9 pm dose on 1/19/22. -Cholecalciferol 25 mcg: 6 am doses on 11/22/21 - 11/30/31. -Thiamine 100 mg: 6 am doses on 11/2/21 - 11/30/31. -Latanoprost 0.005% Ophthalmic Solution 9 pm doses on 12/18/21, 1/1/22, and 1/19/22. -Depakote 1,000 mg ER: 9 pm doses on 12/12/21 - 12/30/21, 1/1/22, 1/11/22, and 1/19/22. -Orders had not been transcribed and medication administration had not been documented on client #3's MARs for December 2021, January 2022, or February 2022 for the following: -Cholecalciferol 25 mcg daily -Thiamine 100 mg daily -Blanks on client #3's MARs on 11/15/21 for the 6 am scheduled doses of the following: -Cholecalciferol 25 mcg -Naltrexone 50 mg -Sertraline 100 mg -Fish Oil 1,000 mg	V 118		

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V 118	Continued From page 23 Observations on 2/2/22 at 12:05 pm of client #3's medications revealed the following medications were not on hand: -Fish Oil 1,000 mg -Cholecalciferol 25 mcg -Thiamine 100 mg -Depakote 500 mg ER Interview on 2/3/22 client #3 stated: -He was seen by a primary care physician, an ophthalmologist, and psychiatrist. -His medications were delivered through the mail and he always received them on time. -The ophthalmologist ordered his eye drops in November 2021. -The primary care physician discontinued his vitamin D3 and thiamin. -He would give a copy of his "Health Summary" to staff for his orders. -He would access his electronic medical record and let House Manager (HM) #2 view his medication orders. -The facility was aware his physician had ordered fish oil "over the counter," and that he was not willing to pay for it. -If the facility would provide the fish oil he would take it. Interview on 2/2/22 HM #1 stated: -He was the day shift HM and had been employed for 9 years. -One of his job duties was to administer medications. -If a client requested a PRN he would give them the bottle for that medication and the client would take what they were supposed to be given. -Most often morning medications had been administered prior to his shift. -It had happened that a client "runs out" of their medications; " ... the mail is slow."	V 118		

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V 118	Continued From page 24 -He would take the clients to the veteran's hospital to get a partial "script" if they were out of a medication. -"X" written on the MAR could mean the client refused or ran out of their medications. -If a client refused a medication 4-5 times he would tell them to go to veteran's hospital and have it discontinued. -"OS" was written on the MAR when they had sent a client's medications with them to take when they were out of the facility on "pass." The clients would get a "pass" for 4 hours each week and a 24 hour pass every other weekend after they completed 30 days of treatment. -He did not know why there were blanks on the MAR. -The Health Summaries were used for medication orders. 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 their medications to allow them to give	V 118		

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V 118	Continued From page 25 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 #3 was a 62 year old male admitted 9/23/21 with diagnoses that included Stimulant Use Disorder - Cocaine (severe); PTSD; and Alcohol Use Disorder. Between client #3's admission and 2/1/22 there were 36 doses of 7 medications (naltrexone, prazosin, hydroxyzine, trazodone, quetiapine, sertraline, and Depakote) that had not been accurately documented. The facility did not have: (1) orders for 2 of client #3's medications (Depakote and Lanaprost); (2) orders to discontinue 2 supplements that had not been given since November, and (3) no administration of a 3rd ordered supplement (fish oil) since 1/25/22 because the facility did not provide the medication. 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	V 131		

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V 131	Continued From page 26 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. 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) check was completed for 4 of 5 audited paraprofessional staff (House Manager (HM) #5, Peer Support Specialist, Qualified Professional (QP), Executive Director). The findings are: Review on 2/2/22 of the HM #5's personnel records revealed: -Hire date of 8/30/21. -No documentation of a HCPR check for current hire date. 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 2/1/22 of the QP's personnel record revealed: -Hire date 3/14/12 -No documentation of a HCPR check. Review on 1/25/22 and 2/03/22 of the Executive Director's personnel record revealed:	V 131	HCPR has been Completed & will be Completed Prior to employment HCPR has been Completed & will be Completed Prior to employment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-214	A. BUILDING: _____ B. WING _____	R 02/23/2022

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V 131	Continued From page 27 -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. Interview on 2/2/22 the Peer Support Specialist stated: -Hired December 2020. Interview on 1/25/22 the Executive Director reported: -HCPR checks were not completed prior to hire for staff. -She was unclear what the HCPR check looked like and requested an example on 1/25/22. 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	Will get HCPR prior to any new staff being hired	
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	V 133	Criminal back ground Checks will be done prior to hire	

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	MHL026-214	A. BUILDING: _____ B. WING _____	R 02/23/2022

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V 133	Continued From page 28 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 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	V 133		

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V 133	Continued From page 29 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 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.	V 133		

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V 133	Continued From page 30 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 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,	V 133		

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V 133	Continued From page 31 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 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	V 133		

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V 133	Continued From page 32 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 review and interview the facility failed to request state criminal background checks within five business days of employment for 3 of 5 audited paraprofessional staff (House Manager (HM) #1, #5, Peer Support Specialist). The findings are: Review on 2/2/22 of the HM #1's personnel record revealed: -Hire date of 4/5/2013. -No documentation of a criminal background was completed. Review on 2/2/22 of the HM #5's personnel records revealed: -Hire date of 8/30/21. -No documentation of a criminal background was completed. 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 stated: -Hired December 2020.	V 133	Had completed when hired a copy was put in his file Criminal records will be completed prior to hire.	

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V 133	Continued From page 33 Interview on 1/25/22 the Executive Director reported: -She would have the criminal background checks completed for all staff. This deficiency constitutes a re-cited deficiency. 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. (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	V 289	Clients will not be left unsupervised	

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V 289	Continued From page 34 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)(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:	V 289		

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V 289	Continued From page 35 Based on record review, observation and interview, 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 (#2, #3, #4). The findings are: Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105) Based on record review, observation, 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 5 of 5 audited staff (Executive Director, Qualified Professional (QP), Peer Support Specialist, House Manager (HM) #1, and HM#5). Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (V108) Based on record review and interview the facility failed to ensure 1 of 2 audited paraprofessional staff (House Manager (HM) #5) were trained in infectious diseases and bloodborne pathogens, first aid and cardiopulmonary resuscitation (CPR). Cross Reference: 10A NCAC 27G .0204	V 289	CLIA Waiver has been received & will stay up to date. Training will be done prior to hire	

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	MHL026-214	A. BUILDING: _____ B. WING _____	R 02/23/2022

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V 289	Continued From page 36 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 4 of 4 audited paraprofessional staff (Executive Director, Peer Support Specialist, House Manager (HM) #1, and HM#5); and, 1 of 4 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) check was completed for 4 of 5 audited paraprofessional staff (House Manager (HM) #5, Peer Support Specialist, Qualified Professional (QP), Executive Director). Cross Reference: G.S. 122C-80. Criminal History Record Checks (V133) Based on record review and interview the facility failed to request state criminal background checks within five business days of employment for 3 of 5 audited paraprofessional staff (House Manager (HM) #1, #5, Peer Support Specialist). Cross Reference: 10A NCAC 27G .5602 Staff (V290) Based on record review, observation 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 1 of 5 audited paraprofessional staff (House Manager (HM) #5); (2) a minimum of one staff member shall be present at all times when any adult client is on the premises and (3) 4 of 4	V 289	post acute withdrawal syndrome training has been Completed	

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V 289	Continued From page 37 clients (#1, #2,#3, #4) were capable of remaining in the home or community without supervision for specific periods of time. Cross Reference: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536) Based on record review and interview, the facility failed to assure 1 of 5 audited paraprofessional staff (House Manager (HM) #2) was 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 revealed it was licensed as a .5600E facility for supervised living for adults, with a capacity of 16, whose primary diagnosis was substance abuse dependency. Observations on 2/3/22 between 11:55 am and 12:30 pm revealed the facility was operating with a client capacity of 14. The room adjacent to the office was identified as the "sleeping body" HM bedroom. Interviews on 2/1/22 - 2/23/22 the Executive Director stated: -The bedroom used by the overnight staff had always been identified as a staff room since she was hired. -She would pursue changing the license capacity to 14 because the facility had to provide a bedroom for the overnight staff. Review on 2/9/22 of the Plan of Protection dated	V 289	NO resident is being left unsupervised NCI training has been completed License is now at 14 instead of 16 License has been changed to 14	

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V 289	Continued From page 38 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, CPR First Aid and Bloodborne Pathogen Supervision by qualified professional Training annually will be completed Sleeping Body will no longer take up state bed. Will have all staff trained appropriately for our client's needs." -"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 our license to lower the number of beds we are licensed for. All staff will be trained in PTSD (Post Traumatic Stress Disorder, Seizure disorder, diabetes and	V 289	CLIA Waiver was Obtained. Signed job description's and applications have been placed in employee files. PAWS training along w/ CPR & first AID have been completed. Sleeping body is no longer taking up a State bed.	

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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 289	Continued From page 39 Hyper and Hypotension. Additional training will be completed based on the needs of our residents." This deficiency constitutes a re-cited deficiency. The facility operated at a capacity of 14 and served clients whose primary diagnosis was substance abuse related. The Executive Director did not provide supervision of the paraprofessionals, ensure training the paraprofessionals or maintain 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 the supervision and 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 were 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 who 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 facility did not have a COVID policy. All clients tested positive for COVID and had to quarantine for 5 days. Client #4 tested positive again after the initial quarantine. The Executive Director was unable to provide COVID guidance but continued to have	V 289	Training will be done prior to start date of hire. Personnel records have been updated CPR/First Aid have been Completed. PALS training Completed CLIA waiver was obtained	

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V 289	Continued From page 40 client #4 quarantine. 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 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 corrected within 23 days. An administrative penalty of $3000.00 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	V 290	Clients will not be left unsupervised	

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V 290	Continued From page 41 clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review, observation 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 1 of 5 audited paraprofessional staff (House Manager (HM) #5); (2) a minimum of one staff member shall be present at all times when any adult client is on the premises and (3) 4 of 4 clients (#1, #2,#3, #4) were capable of remaining in the home or community without supervision for specific periods of time. The findings are: Finding #1	V 290		

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V 290	Continued From page 42 Review on 2/2/22 the HM #5's personnel record revealed: -Hire date of 8/30/21. -No documentation of training on alcohol and drug withdrawal symptoms. Interview on 2/4/22 the HM #5 stated: -He had worked at the facility since August. -He worked as the House Manager. -He worked a shift from 10 pm-5 am. -He worked alone. -He had not had formal training in alcohol or other drug withdrawal symptoms from the facility. He was a graduate of the program. Finding #2 Interview on 2/2/22 at 9:45 am the HM #1 stated: -He was leaving the facility in a few minutes to pick up groceries. -He would have the clients walk over to the fellowship hall individually, while he was out, for interviews with Division of Health Service Regulation (DHSR) surveyors. Interview on 2/2/22 at 9:50 am the Peer Support Specialist stated: -HM #1 was leaving the facility to pick up groceries and would return shortly. -Clients #1, #2, and #3 would walk over to the fellowship hall for interviews. -Client #4 was still on quarantine in his room at the facility and could not leave the facility and would participate in an interview via phone. Observation on 2/2/22 of the facility at 10:00 am revealed: -The facility was located on a campus which included a sister facility, a fellowship hall/conference building, and an office building all within walking distance of each other.	V 290	PALS trainings Completed PALS trainings Completed	

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V 290	Continued From page 43 -HM #1 left the facility in his vehicle. -There were 4 clients at the facility when HM #1 left the facility. -Clients #1,#2, and #3 presented themselves individually at the campus fellowship hall for interviews while HM #1 was away from the facility. Finding #3 Review on 2/3/21 of client #1's record revealed: -56 year old male. -Admitted on 10/8/21. -Diagnoses of Alcohol Use Disorder Severe, Anxiety and Depression. -No documentation of unsupervised time in client #1's treatment plan. Review on 2/2/22 of client #2's record revealed: -36 year old male. -Admitted on 8/31/21. -Diagnoses of Alcohol Use Disorder -No documentation of unsupervised time in client #2's treatment plan. Review on 2/3/22 of client #3's record revealed: -62 year old male. -Admitted 9/23/21. -Diagnoses of Stimulant Use Disorder - Cocaine (severe); Post Traumatic Stress Disorder (PTSD); and Alcohol Use Disorder. -No documentation of unsupervised time in client #3's treatment plan. Interview on 2/3/22 client #3 stated: -HM #1 would transport him to doctor appointments and "drop him off." -Sometimes he would have a "long wait" until HM#1 returned to transport him back to the facility. Review on 2/2/22 of client #4's record revealed:	V 290	Clients will not be left un-supervised	

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V 290	Continued From page 44 -53 year old male. -Admitted on 1/11/22. -Diagnoses of Alcohol Use Disorder Severe, Stimulant Use Disorder Cocaine Severe, Tobacco Use Disorder Severe and Cannabis Use Disorder Moderate. -No documentation of unsupervised time in client #4's treatment plan. Interview on 1/25/22 -2/9/22 the Executive Director stated: -She was unclear about the requirement for staff to have training on alcohol and drug withdrawal symptoms. -She believed that this training was part of the Nonviolent Crisis Intervention (NCI) plus training which all staff would take once hired. -She believed the NCI plus training was scheduled for staff the next week but she did not have a date. -It was common practice for a facility's HM to leave the facility and the sister facility HM would be responsible for all clients on the campus. This deficiency constitutes a re-cited deficiency. 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	PALS training Completed NCI training Completed Residents will not be left unsupervised	
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	V 366		

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V 366	Continued From page 45 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 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;	V 366		

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V 366	Continued From page 46 (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 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	V 366		

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V 366	Continued From page 47 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 interview the facility failed to implement written policies governing their response to level I incidents for medication refusals. The findings are: Review on 2/2/22 of client #2's record revealed: -36 year old male. -Admitted on 8/31/21. -Diagnoses of Alcohol Use Disorder Review on 2/2/22 of the facility records from November 2021 - January 2022 revealed no level I incident reports for medication refusals. Review on 2/2/22 of signed physician orders for client #2 dated 11/11/21 revealed: -Omeprazole 20 mg (milligrams) EC (enteric-coated), take 1 daily (gastroesophageal reflux disease) -Trazodone HCL (hydrochloride) 100 mg, 1 at bedtime (antidepressant) -Naltrexone 50 mg, 1 BID (twice daily) (alcohol cravings)	V 366	ALL Level I incidents will be reported	

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V 366	Continued From page 48 -Prazosin HCL 1 mg, 1 at bedtime (hypertension) Review on 2/2/22 of signed physician orders for client #2 dated 1/13/21 revealed: -Discontinuation of omeprazole, naltrexone, and prazosin HCL. Review on 2/2/22 of client #2's Medication Administration Record (MAR) from 11/1/21 - 1/30/22 revealed: -Medication refusals for omeprazole, naltrexone, and prazosin HCL from 11/1/21 - 1/13/22. Interview on 2/22/22 client #2 stated: -He had refused medications when he didn't need them. -He did not need the omeprazole, naltrexone, and prazosin HCL. -It was the client's responsibility to get their medications discontinued and he had been unable to get the Veteran's Administration (VA) to discontinue the medications until 1/13/22. Interview on 2/2/22 the HM #1 stated: -He was not trained to document medication refusals as a Level I incident. -Client #2 was supposed to obtain new physicians orders to discontinue any medications that he did not need. He would need to contact the VA to discontinue any medications. 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	will report all medication refusals as Level I incident	

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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; (2) recognizing and interpreting human	V 536		

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V 536	Continued From page 50 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 by scoring a passing grade on testing in an	V 536		

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V 536	Continued From page 51 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. (2) The Division of MH/DD/SAS may	V 536		

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V 536	Continued From page 52 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 review and interview, the facility failed to assure 1 of 5 audited paraprofessional staff (House Manager (HM) #2) was trained in Alternatives to Restrictive Interventions. The findings are: Review on 2/2/22 of the HM #5's personnel record revealed: -Hire date of 8/30/21. -No current documentation of training in Alternatives to Restrictive Interventions. - Nonviolent Crisis Intervention (NCI) Plus training received during previous employment with the facility on 6/14/19 and expired 6/13/20. Interview on 2/4/22 the HM #5 stated: -He worked 3rd shift from 10 pm-5 am. -He worked alone. Interview on 1/25/22 the Executive Director	V 536	Training will be completed prior to hire. NCI training completed	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON W LILLY HOME	560 WILKES 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 736	Continued From page 54 expose drywall approximately 12 inches long and 6 inches wide. -The chair cushion seat exposed the pillow padded stuffing. -The loveseat in the common sitting area had leather ripped around the edge of the loveseat. -The common sitting area had a crack on the ceiling the length of the wall. -Bedroom #2: walls smudged/discolored; broken window blind; finish of top of client dresser was worn. -Bedroom #4: area approximately 2 x 4 feet in size of wall surface damaged above the bed; cob webs inside window frame. -The client bathroom near bedroom #1 and #2 had brown rust discolor about 1 inch on the top of the mirror. -The bathroom shower curtain was torn and had makeshift holes. -The door frame to the right of the kitchen had paint worn around perimeter of the frame. -The client bathroom near bedroom #5 had a broken towel rod. -Bedroom #7: walls were smudged/discolored. -Paint worn off by rear exterior door handle. -Standing water collected outdoors behind the kitchen. Interview on 2/3/22 Home Manager #1 stated the standing water behind the facility was due to a clogged drain that needed to be "snaked" which was needed "from time to time." Interviews on 2/1/22 - 2/9/22 the Executive Director stated: -The Cook was also her maintenance staff. -She also had a former client that helped out with facility maintenance. -There were maintenance forms for staff to complete for needed repairs.	V 736	working on getting all of these deficiencies corrected	

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V 536	Continued From page 53 stated: -She was responsible for coordinating training for all staff. -She was attempting to coordinate annual training for all staff throughout the year but had not done this. 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	NCI training completed along with First AID/ CPR	
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 interview the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 2/3/22 between 11:55 am - 12:30 pm during the facility tour revealed: -The bench outside the facility had 1 missing wood slat and 1 broken wood slat. -The window to the left of the facility's front door was missing the window screen. -Sections of exterior siding of building were missing near entrance. -The common sitting area had paint missing to	V 736	Bench wood thrown away	

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V 736	Continued From page 55 -She was responsible for facility repairs and maintenance; she could authorize expenditures up to $1000 without Board approval.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 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. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the water temperature was maintained between 100-116 degrees Fahrenheit. The findings are: Observation on 2/2/22 between 11:56 am - 1:15 pm revealed the following temperatures above 116 degrees: -Left hallway bathroom sinks were 119 and 125 degrees. -Right hallway bathroom sinks were 138 degrees. -Kitchen sinks were 130 degrees. Interview on 2/2/22 the Executive Director stated: -Clients #1-4 used the hallway bathrooms as well as the kitchen sinks. -She was not aware of water temperature checks being performed or documented. -She was responsible for coordinating any repairs to the facility.	V 752	Hot water heaters have been turned down Will monitor hot water to be no more than 116 degrees Fahrenheit	

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V 752	Continued From page 56 Review on 2/09/22 of Plan of Protection (POP) dated 2/09/22 completed by the Executive Director revealed the following: -"What immediate action will the facility take to ensure the safety of the consumers in your care? "Maintenance has turn down hot water temperature to fall within guidelines of 100 to 116 degrees." -"Describe your plans to make sure the above happens." "Will monitor staff daily to make sure temperature checks are done a recorded with appropriate temperatures which are 100 to 116 degrees per state guidelines." This deficiency constitutes a re-cited deficiency. Four clients whose primary diagnosis were inclusive of Substance Abuse Disorders resided in the facility. Water temperatures were consistent between 119-138 degrees Fahrenheit at water sources utilized by clients. The facility did not have documentation of temperature checks being conducted or recorded. This deficiency constitutes a Type A2 rule violation as clients were placed at substantial risk of serious harm and must be corrected within 23 days. An administrative penalty of $500.00 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 752	water heaters have been turned down monitoring to make sure water is NO more than 116 degrees Fahrenheit	
V 768	27G .0304(d)(4) Non-Client Accommodations 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities	V 768		

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V 768	Continued From page 57 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 2/1/22 of the facility's license revealed a licensed capacity of 16 clients. Observations on 2/3/22 during the facility tour between 11:55 am and 12:30 pm revealed: -7 client bedrooms with 2 beds and 1 bedroom with 1 bed. -1 bed in the office. Interview on 2/3/22 House Manager #1 stated: -Bedroom #8 was for the "sleeping body (overnight sleep staff)." Interview on 1/25/22 - 2/23/22 the Executive Director stated: -The facility had a "sleeping body" at night. -The overnight sleep staff stayed in one of the client bedrooms. -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.	V 768	License has been changed from 16 beds to 14 beds	

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V 768	Continued From page 58 -She understood the facility could not provide accommodations for staff in the 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	Staff / Sleeping bags are no longer taking up Client bed.	