STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-083	A. BUILDING: _____ B. WING _____	R 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS DDA GROUP HOME	838 ROSS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on 4/13/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 8 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-083	A. BUILDING: _____ B. WING _____	R 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS DDA GROUP HOME	838 ROSS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility the facility failed to schedule a review of a plan at least annually affecting one of three clients (#3). The findings are: Review on 4/12/22 of client #3's record revealed: -Admission date of 10/29/12. -Diagnoses of Intellectual and Developmental Disability-Unspecified, Schizophrenia, Dementia, Obstructive Sleep Apnea and Psoriasis. -Person Centered Plan (PCP) dated 9/7/20. -There was no documentation that client #3 had a plan completed for 2021. Interview on 4/13/22 with the Manager revealed: -He didn't realize the PCP for client #3 was not current. -He confirmed the facility failed to schedule a review of a plan at least annually for client #3.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-083	A. BUILDING: _____ B. WING _____	R 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS DDA GROUP HOME	838 ROSS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 2 (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 conduct fire and disaster drills under conditions that simulate emergencies. The findings are: Review on 4/13/22 of the facility's fire drill log revealed: -3/14/22-9:30 pm -11/10/21-5:30 pm -7/14/21-11 pm -6/16/21-6:45 am -There was no documentation of 8am-8pm staff doing a drill during the 1st quarter of 2022. -There was no documentation of 8pm-8am staff doing a drill during the 4th quarter of 2021. -There was no documentation of 8am-8pm staff doing a drill during the 3rd quarter of 2021. -There was no documentation of 8am-8pm staff doing a drill during the 2nd quarter of 2021. Review on 4/13/22 of the facility's disaster drill log revealed: -4/14/21- 4 pm -There was no documentation of 8am-8pm and/or 8pm-8am staff doing a drill during the 1st quarter of 2022. -There was no documentation of the 8am-8pm and/or 8pm-8am staff doing a drill during the 4th quarter of 2021.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-083	A. BUILDING: _____ B. WING _____	R 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS DDA GROUP HOME	838 ROSS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 3 -There was no documentation of the 8am-8pm and/or 8pm-8am staff doing a drill during the 3rd quarter of 2021. -There was no documentation of the 8am-8pm and/or 8pm-8am staff doing a drill during the 2nd quarter of 2021 Interview on 4/12/22 with client #1 revealed: -He thought staff did fire and disaster drills with them. -He thought the drills were done monthly. Interview on 4/12//22 with client #2 revealed: -He thought they did fire and disaster drills with staff. -He was not sure how often staff conducted the fire and disaster drills with them. Interview on 4/12//22 with client #3 revealed: -He thought staff conducted fire and disaster drills with them. -He was not sure how often the fire and disaster drills were conducted. Interview on 4/13/22 with the Manager revealed: -The group home had two shifts. He worked the 8am-8pm shift. Another staff worked the 8pm-8am shift. -The last surveyor told him he was supposed to be doing fire and disaster drills quarterly. -He didn't realize they were supposed to be doing the fire and disaster drills on both shifts. -He confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-083	A. BUILDING: _____ B. WING _____	R 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS DDA GROUP HOME	838 ROSS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 121	Continued From page 4	V 121		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to obtain drug reviews every six months for three of three clients (#1, #2 and #3) who received psychotropic drugs. The findings are: a. Review on 4/12/22 of client #1's record revealed: -Admission date of 11/30/12. -Diagnoses of Paranoid Schizophrenia, Moderate Intellectual and Developmental Disability, Intermittent Explosive Disorder and History of Fetal Alcohol Syndrome. Review on 4/13/22 of physician's orders revealed: -Order dated 4/16/21 for Sertraline HCL 100 milligrams (mg), one tablet daily; Risperidone 3 mg, one tablet twice daily; Trazodone 50 mg, one	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-083	A. BUILDING: _____ B. WING _____	R 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS DDA GROUP HOME	838 ROSS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 121	Continued From page 5	V 121		

tablet three times daily; Trazodone 50 mg, 2 tablets at bedtime; Divalproex Sodium ER 500 mg, two tablets at bedtime and Buspar HCL 15 mg, two tablets twice daily.

Review on 4/13/22 of the Medication Administration Record (MAR) revealed:
-April 2022-Staff documented client #1 was administered the above medications 4/1 thru 4/12.

Review on 4/13/22 of facility records revealed:
-There was no evidence of a six month psychotropic drug review for client #1.

b. Review on 4/12/22 of client #3's record revealed:
-Admission date of 10/29/12.
-Diagnoses of Intellectual and Developmental Disability-Unspecified, Schizophrenia, Dementia, Obstructive Sleep Apnea and Psoriasis.

Review on 4/13/22 of physician's orders revealed:
-Order dated 7/9/21 for Sertraline HCL 100 mg, two tablets daily; Quetiapine Fumarate 100 mg, one tablet twice daily; Quetiapine Fumarate 400 mg, one tablet at bedtime; Fluphenazine 10 mg, 1 and ½ tablet at bedtime and Trazodone 100 mg, two tablets at bedtime.
Review on 4/13/22 of the MAR revealed:
-April 2022-Staff documented client #3 was administered the above medications 4/1 thru 4/12.

Review of facility records on 4/13/22 revealed:
-There was no evidence of a six month psychotropic drug review for client #3.

Interview on 4/13/22 with the Manager revealed:
-The pharmacist was supposed to come to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-083	A. BUILDING: _____ B. WING _____	R 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS DDA GROUP HOME	838 ROSS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 121	Continued From page 6 home on 4/13/22 and do the psychotropic drug review. -He thought the pharmacist came out last year and did the psychotropic drug reviews. He could not remember the specific date the pharmacist came to the group home last year. -He confirmed there was no documentation of six months psychotropic drug review for clients #1 and #3.	V 121		
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	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-083	A. BUILDING: _____ B. WING _____	R 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS DDA GROUP HOME	838 ROSS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	Continued From page 7 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 reviews and interviews, the facility failed to review the plan annually to ensure a client was capable of remaining in the home and community without supervision affecting one of three clients (#1) and failed to assess client's capability of having unsupervised time in the home and community without staff supervision affecting one of three clients (#2). The findings are: The following is evidence the facility failed to review the plan annually to ensure a client was capable of remaining in the home and community without supervision. a. Review on 4/12/22 of client #1's record revealed: -Admission date of 11/30/12.	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-083	A. BUILDING: _____ B. WING _____	R 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS DDA GROUP HOME	838 ROSS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	Continued From page 8 -Diagnoses of Paranoid Schizophrenia, Moderate Intellectual and Developmental Disability, Intermittent Explosive Disorder and History of Fetal Alcohol Syndrome. -Unsupervised Time Assessment dated 3/7/18. -There was no documentation that client #1's plan was reviewed annually to ensure he was capable of remaining in the home and community without supervision. Interview on 4/12/22 with client #1 revealed: -He had unsupervised time in the home and community without staff. -He walked throughout the neighborhood during his unsupervised time in the community. -He thought he walked around the neighborhood 2-3 days a week. -He also stayed at the group home without staff for about 30 minutes to an hour a few times throughout the week. The following is evidence the facility failed to assess client's capability of having unsupervised time in the home and community without staff supervision b. Review on 4/12/22 of client #2's record revealed: -Admission date of 4/20/20. -Diagnoses of Mild Intellectual and Developmental Disability, Post Traumatic Stress Disorder, Depression and Vitamin D Deficiency. -Person Centered Plan dated 7/2/21-Client #2 can have up to 2 hours of unsupervised time to walk to planned destinations and return within the specified amount of time independently 7 days a week. -There was no documentation that client #2 had been assessed for capability of having unsupervised time in the home and community	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-083	A. BUILDING: _____ B. WING _____	R 04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS DDA GROUP HOME	838 ROSS STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 290	Continued From page 9 without staff supervision. Interview on 4/12/22 with client #2 revealed: -He had unsupervised time in the home and community. -He used his unsupervised time in the community to walk to the park in the neighborhood. He normally stayed at the park 1-2 hours. He wasn't sure how often he went to the park. -He used his unsupervised time at the group home sometimes. He wasn't sure how often he stayed at the group home without staff. Interviews on 4/12/22 and 4/13/22 with the Manager revealed: -Clients #1 and #2 had unsupervised time in the home and community. -He did not realize the Unsupervised Time Assessment for client #1 needed to be reviewed annually. He thought once the unsupervised time was approved they didn't have to look at the unsupervised time again for that client. -He wasn't sure why there was no Unsupervised Time Assessment for client #2. -He confirmed the facility failed to review the plan annually to ensure client #1 was capable of remaining in the home and community without supervision. -He confirmed the facility failed to assess client #2's capability of having unsupervised time in the home and community.	V 290		