

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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	<p><b>INITIAL COMMENTS</b></p> <p>An Annual, Follow Up and Complaint Survey was completed on March 14, 2022. The complaint was unsubstantiated (intake #NC00186427). Deficiencies were cited.</p> <p>This facility is licensed for the following service Category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 108	<p><b>27G .0202 (F-I) Personnel Requirements</b></p> <p><b>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</b></p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <p>(1) general organizational orientation;</p> <p>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;</p> <p>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and</p> <p>(4) training in infectious diseases and bloodborne pathogens.</p> <p>(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,</p>	V 108	<p><i>Documented in OP file.</i></p> <p><i>Request OP file</i></p> <p><i>Quarterly trainings</i></p> <p><b>RECEIVED</b></p> <p><b>MAY 06 2022</b></p> <p><b>DHSR-MH Licensure Sect</b></p>	<p><i>each month + quarterly</i></p>

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Felicia N Onuora*

TITLE

*Administrator*

(X6) DATE

*05/03/22*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---


NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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 108	<p>Continued From page 1</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain a file that included trainings in cardiopulmonary resuscitation (CPR)/First Aid for 1 of 1 Professional staff (Qualified Professional). The findings are:</p> <p>Review on 3/14/22 of the Qualified Professional's personnel record revealed:</p> <ul style="list-style-type: none"> <li>- Hired: 2/24/18</li> <li>- No training in CPR/First Aid in the record</li> </ul> <p>Interview on 3/14/22 the Administrator stated:</p> <ul style="list-style-type: none"> <li>- When the Qualified Professional (QP) was hired, she already was trained in CPR/First Aid.</li> <li>- She would have the QP submit a current CPR/First Aid or take the required courses.</li> </ul>	V 108	<p><i>IN PROCESS (QP)</i></p> <p><i>Completed</i></p>	<p><i>4/28/22</i></p>
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>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</p>	V 112	<p><i>Plans are completed updated by due dates</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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	<p>Continued From page 2</p> <p>legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <ol style="list-style-type: none"> <li>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</li> <li>(2) strategies;</li> <li>(3) staff responsible;</li> <li>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</li> <li>(5) basis for evaluation or assessment of outcome achievement; and</li> <li>(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.</li> </ol> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to assure treatment plans were at least reviewed annually for 1 of 3 audited clients (#6). The findings are:</p> <p>Review on 3/10/22 of client #6's record revealed:</p> <ul style="list-style-type: none"> <li>- Admitted: 8/1/13</li> <li>- Diagnoses: Schizophrenia, Diabetes Type 2, Gastroesophageal Reflux Disease and Hyperlipidemia</li> <li>- Treatment plan dated 3/19/20 with goals to decrease his active mental health symptoms by</li> </ul>	V 112	<p><i>Plans are completed, signed and put in client book by due date</i></p> <p><i>goals are updated/ revised as warranted; and deemed necessary.</i></p> 	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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	<p>Continued From page 3</p> <p>taking meds, improve his health to lose weight by engaging in physical activities, maintain personal hygiene and personal care by taking a shower on a daily and basic utilize of his unsupervised time in order to access the community as well as his day program.</p> <ul style="list-style-type: none"> <li>- No update or revisions noted</li> </ul> <p>Interview on 3/14/22 the Qualified Professional (QP) stated:</p> <ul style="list-style-type: none"> <li>- She worked at the facility 4 years.</li> <li>- Her duties included update of the treatment plans.</li> <li>- To her knowledge all clients treatment plans were up to date.</li> <li>- She needed to follow up to see why his treatment plan was not at the group home.</li> </ul> <p>Interview on 3/14/22 the Administrator stated:</p> <ul style="list-style-type: none"> <li>- She would follow up with the QP to check the status of the client's treatment plans.</li> </ul>	V 112	<p><i>Client treatment plans are updated, revised as needed and warranted, and deemed necessary.</i></p> <p><i>Goals are person-centered.</i></p>	
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(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.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(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.</p> <p>(d) Each facility shall have basic first aid supplies</p>	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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	<p>Continued From page 4 accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure disaster drills were completed on each shift quarterly. The findings are:</p> <p>Review on 3/11/22 of the facility's Fire &amp; Disaster Drill Logs revealed:</p> <ul style="list-style-type: none"> <li>- There were no fire or disaster drills documented between October 2021-March 2022</li> </ul> <p>Interview on 3/11/22 staff #2 stated:</p> <ul style="list-style-type: none"> <li>- She had only worked at the group home for the past 4 days.</li> <li>- She was a fill in staff as staff #1 was away on leave.</li> <li>- Normally, documents regarding drills were kept in a notebook in the staff office or near the client records</li> <li>- She could not locate the drill notebooks that contained any drills past October 2017.</li> </ul> <p>Interview on 3/11/22 3 of 3 clients stated:</p> <ul style="list-style-type: none"> <li>- It had been a while since they practiced any type of drill.</li> <li>- None of the clients were able to estimate how long it had been since they had participated in a drill.</li> </ul> <p>Interview on 3/14/22 staff #1 stated:</p> <ul style="list-style-type: none"> <li>- She was the only staff who worked at the group home since October 2021.</li> <li>- She had not completed a drill since her time of hire.</li> </ul> <p>Interview on 3/14/22 the Qualified Professional</p>	V 114	completed	4/1/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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 5 stated: - She thought she observed 2021-2022 drills in a notebook at the home.  Interview on 3/14/22 the Administrator stated: - She was not aware drills had not been completed nor that the current notebook could not be found at the group home.	V 114	<i>Completed and noted in notebook 4/1/22</i>	
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification  G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.  This Rule is not met as evidenced by: Based on record review and interview, the governing body failed to accessed the Health Care Personnel Registry (HCPR) prior to hiring one of three staff (#3). The findings are:  Review on 3/14/22 of staff #3's personnel records revealed: - Hired: - No evidence HCPR had been accessed for staff #3  Interview on 3/14/22 the Administrator stated:	V 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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 131	Continued From page 6  - The Qualified Professional (QP) was responsible to securing a HCPR check on staff - The QP indicated she had not accessed the HCPR before - As the Administrator, she would assure the HCPR was done and show the QP how to do that.	V 131		
V 133	G.S. 122C-80 Criminal History Record Check  G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making	V 133	<i>New staff criminal history completed and entered into client file</i>	<i>3/17/22</i>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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 133	<p>Continued From page 7</p> <p>the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a 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</p>	V 133	<p><i>Completed and entered into client file</i></p>	<p><i>3/17/22</i></p>



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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 133	<p>Continued From page 8</p> <p>business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>(1) The level and seriousness of the crime.</li> <li>(2) The date of the crime.</li> <li>(3) The age of the person at the time of the conviction.</li> <li>(4) The circumstances surrounding the commission of the crime, if known.</li> <li>(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.</li> <li>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.</li> <li>(7) The subsequent commission by the person of a relevant offense.</li> </ol> <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>(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.</li> </ol>	V 133	<p><i>complete</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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 133	<p>Continued From page 9</p> <p>(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.</p> <p>(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related</p>	V 133	<p>(Continued)</p> <p>Complete at hire</p>	3/17/22
-------	--	-------	--	---------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mh1092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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 133	<p>Continued From page 10</p> <p>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.</p> <p>(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.</p> <p>(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:</p> <p>(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.</p> <p>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete a statewide criminal background check within seven days of</p>	V 133	<p>completed 3/17/2022</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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 133	<p>Continued From page 11</p> <p>employment for one of two paraprofessional staff (#1) The findings are:</p> <p>Review on 3/14/22 of staff #2's personnel record revealed:</p> <ul style="list-style-type: none"> <li>- Hired: 11/2021</li> <li>- No statewide criminal record check.</li> </ul> <p>Interview on 3/14/22 the Administrator/Registered Nurse stated:</p> <ul style="list-style-type: none"> <li>- The Qualified Professional (QP) was responsible to securing a criminal record check prior to hiring staff.</li> <li>- The QP indicated she had not conducted a criminal background check before.</li> </ul>	V 133	<p><i>completed 3/17/2021</i></p>	
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview the facility was not maintained in a safe, clean and attractive manner. The findings are:</p> <p>Observation on 3/10/22 between 10:00 AM- 11:00 AM revealed the following:</p> <ul style="list-style-type: none"> <li>- Kitchen: Inside of refrigerator dirty with brown stains inside</li> </ul>	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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	<p>Continued From page 12</p> <p>Newspapers in front of and underneath the refrigerator</p> <ul style="list-style-type: none"> <li>- Client #1's bedroom: <ul style="list-style-type: none"> <li>Bed leaning forward</li> </ul> </li> <li>- Bedroom occupied by clients #6 and #2: <ul style="list-style-type: none"> <li>Strong urine odor smell</li> </ul> </li> <li>- Bathroom utilized by client #3: <ul style="list-style-type: none"> <li>No covering over light fixture</li> <li>Cabinet doors off hinge not able to close fully</li> <li>Towel rack broken -one anchor of three piece hardware set for the rack remained on the wall.</li> </ul> </li> </ul> <p>Interview on 3/10/22 staff #2 stated:</p> <ul style="list-style-type: none"> <li>- Normally worked at another facility.</li> <li>- Worked at this facility as a fill in for three days prior to this interview.</li> <li>- Was not sure why the newspaper was in front of refrigerator, thought light fixture covering was taken down to replace bulb and was aware of the strong urine smell due to incontinence issues.</li> </ul> <p>Interview on 3/10/22 client #3 stated:</p> <ul style="list-style-type: none"> <li>- He did not recall what happened to the light fixture covering.</li> <li>- He was not sure how long the light fixture did not have a covering.</li> <li>- The newspaper was placed under the refrigerator because the refrigerator was uneven.</li> </ul> <p>Interview on 3/14/22 staff #1 stated:</p> <ul style="list-style-type: none"> <li>- She started working at the facility in November 2022.</li> <li>- Newspaper was placed under the refrigerator to keep it balanced.</li> <li>- No sure how long the newspaper had been there.</li> <li>- Reminders were needed to keep clients #2</li> </ul>	V 736	<p>Removed</p> <p>Cleaned</p> <p>Fixed</p>	<p>3/17/22</p> <p>3/17/22</p> <p>3/21/22</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl092-607</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLESSED HOME, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7005 BRECKEN RIDGE AVENUE RALEIGH, NC 27615</b>
--	---

(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	<p>Continued From page 13</p> <p>and #6's bedroom odor free from urine.</p> <ul style="list-style-type: none"> <li>- Not aware of the covering missing.</li> </ul> <p>Interview on 3/14/22 the Qualified Professional stated:</p> <ul style="list-style-type: none"> <li>- Visited the house at least monthly.</li> <li>- Not aware of environmental repairs or replacements needed for the home.</li> </ul> <p>Interview on 3/14/22 the Administrator stated:</p> <ul style="list-style-type: none"> <li>- She was not aware of the environmental issues identified.</li> <li>- She would have someone to make the necessary repairs..</li> </ul> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 736	Completed	3/17/22

Original



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor  
KODY H. KINSLEY • Secretary  
MARK PAYNE • Director, Division of Health Service Regulation

April 7, 2022

Felecia N. Onuorah, Administrator  
Blessed Home, LLC  
3113 Edgetone Drive  
Raleigh, NC 27604

RECEIVED

MAY 06 2022

DHSR-MH Licensure Sect

Re: Annual, Follow Up and Complaint Survey completed March 14, 2022  
Blessed Home, LLC, 7005 Brecken Ridge Avenue, Raleigh, NC 27615  
MHL # 092-607  
E-mail Address: gozonuorah@yahoo.com  
Intake #NC00186427

Dear Ms. Felecia Onuorah:

Thank you for the cooperation and courtesy extended during the Annual, Follow Up and Complaint Survey completed March 14, 2022. The complaint was unsubstantiated.

As a result of the follow up survey, it was determined that none of the deficiencies were in compliance.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

**Type of Deficiencies Found**

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

**Time Frames for Compliance**

- Re-cited standard level deficiency must be **corrected** within 30 days from the exit of the survey, which is April 13, 2022.
- Standard level deficiencies must be **corrected** within 60 days from the exit of the survey, which is May 13, 2022.

**MENTAL HEALTH LICENSURE & CERTIFICATION SECTION**

**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION**

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603  
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718  
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

April 7, 2022  
Blessed Home, LLC  
Blessed Home, LLC

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Renee Kowalski at 919-552-6847.

Sincerely,



India Vaughn-Rhodes  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org  
Pam Pridgen, Administrative Assistant