STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL064-125	A. BUILDING: _____ B. WING _____	R 05/04/2022

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DANIELS FAMILY CARE, INC	237 WESTVIEW PARK DRIVE ROCKY MOUNT, NC 27804

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 5/04/22. The complaint was unsubstantiated (NC001874777). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 4 and currently has a census of 4. 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		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record review, observation and interview the facility failed to develop and implement strategies and goals to meet the needs for 1 of 3 audited clients (#4). The findings are:

Review on 5/3/22 of client #4's record revealed:
-Admitted 1/20/22
-Diagnoses: Autism, Intermittent Explosive Disorder, Intellectual Disability Severe, Obstructive Sleep Apnea and Localization related symptomatic Epilepsy with complex partial seizures
-FL2 dated 4/14/22 revealed client #4 "wears Continuous Positive Airway Pressure (CPAP) machine nightly for sleep apnea."
-Treatment plan dated 7/1/2021 had no strategies to address the CPAP machine that client #4 refused to wear at night while sleeping

Observation on 5/3/22 at 1:15pm the CPAP machine was under a table on the floor in staff's room in a case zipped closed.

Interview on 5/3/22 staff #1 stated:
-Client # 4 had not worn the CPAP machine that she is aware of
-She had tried one time with assisting client #4 with putting on the CPAP machine and he refused
-She had not attempted to put the CPAP machine

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V 112	Continued From page 2 on client #4 again on any night she had worked, she worked Thursday-Tuesday weekly -She was not aware of what to do when he refused to wear the CPAP machine -The group home that client #4 came from stated he had not worn the CPAP machine while he lived at that home Interview on 5/4/22 the group home Director stated: -Client #4 won't wear the CPAP machine -Was told that client #4 didn't wear the CPAP machine while he was at the hospital before being admitted into the group home -Had attempted to put the CPAP machine on client #4, but client #4 refused to wear the CPAP machine -The Qualified Professional had planned on talking with the doctor to ask about discontinuing the machine -Client #4 hadn't had any problems with sleeping through the night	V 112		
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.	V 121		

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V 121	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 3 audited clients (#1) had a drug regimen review completed every six months. The findings are: Review on 5/3/22 of client #1's record revealed: -Admitted 8/23/08 - Diagnoses: Schizophrenia, Intermittent Explosive Disorder and Mild Intellectual Disorder - Drug regimen review dated: 2019 - Physician's order dated 8/27/21: -Haldol 10 milligram (mg), take 1 tablet by mouth in the morning (schizophrenia) - Risperidone 2mg, take 1 tablet by mouth in the morning (schizophrenia) -Zoloft 100mg, take 1 tablet by mouth in the morning (major depressive disorder) -Cogentin 1 mg, take 1 tablet by mouth 2 times per day (parkinson's disease) -Tergretol 100mg, chew 3 tablets by mouth in the morning, 3pm and at 6pm (bipolar) Interview on 5/4/22 the group home Director stated: -He had not had anyone in the home to complete a drug regimen review since the pandemic -Currently he was switching pharmacies and would schedule for the drug regimen review to be completed This deficiency has been cited 3 times since the original cite on 2/20/20 and must be corrected within 30 days.	V 121		

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V 290	Continued From page 4	V 290		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or 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	V 290		

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V 290	Continued From page 5 duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 2 of 3 audited clients (#1 & #2) were capable of remaining in the home or community without supervision. The findings are: Review on 5/3/22 of client #1's record revealed: -Admitted 8/23/08 -Diagnoses: Schizophrenia, Intermittent Explosive Disorder, Mild Intellectual Disorder -FL2 dated 5/7/21 "unsupervised time for church services and functions" -No documentation of an assessment for unsupervised time in the home or community Interview on 5/3/21 client #1 stated: -He had unsupervised time in the home and community -He had gone to church on several days a week with other church members in the community, without staff supervision and sometimes walked to the store without staff supervision Review on 5/3/22 of client #2's record revealed: -Admitted 3/19/13 -Diagnoses: Impulse Control Disorder, History of Attention Deficit Hyperactive Disorder, Learning Disorder, Mild Mental Retardation and Vitamin D deficiency	V 290		

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V 290	Continued From page 6 -FL2 dated 5/7/21 "up to 2 hours down time" Interview on 5/3/21 client #2 stated: -He had "down time" unsupervised time in the home and in the community. -He walked to the store and had stayed at home alone when the staff and housemates went out to the store or for a ride. Interview on 5/3/21 staff #1 stated: -Was aware that client #1 and client #2 had unsupervised time in the home and in the community -Unsure of how many hours client #1 was supposed to have "maybe 2 hours" -Unsure of how many hours client #2 was supposed to have "2 hours" -Client #1 attended church on Sunday's, Wednesday's and Friday's every week with church members. -Client #2 sometimes had walked to the store but would not be gone long. Interview on 5/4/21 the grou home Director stated: -Client #1 had unsupervised time between 2-4 hours in which client #1 would go to church on Sunday, Bible study on Wednesday and Church on Friday night with church members that wwere not group home staff. -Client #2 had unsupervised time, he would walk to the store without staff or stay in the home when there was an outing he didn't want to participate in. -There was no assessment, it was put on the FL2 This deficiency has been cited 3 times since the original cite on 2/20/20 and must be corrected within 30 days.	V 290		

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V 512	Continued From page 7	V 512		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on interview and record review 1 of 2 staff (group home Director) verbally abused 2 of 3 audited clients (#1 & #2). The findings are: Review on 5/3/22 of Client #1's record revealed: - Admitted 8/23/08 - Diagnoses: Schizophrenia, Intermittent Explosive Disorder and Mild Intellectual Disorder	V 512		

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V 512	Continued From page 8 Review on 5/3/22 of Client #2's record revealed: - Admitted 3/19/13 - Diagnoses: Impulse Control Disorder, History of Attention Deficit Hyperactive Disorder, Learning Disorder, Mild Mental Retardation and Vitamin D deficiency Review on 5/3/22 of the Director's personnel record revealed: -Hired 9/05/09 -Training in Mental Retardation/Intellectual Development Disabilities (IDD) of person centered thinking, IDD overview and Clients Rights dated 8/9/21 Interview on 5/3/22 Client #1 stated: -"Things had not been going so well." -The group home Director had been "yelling...a lot lately...he might be going through something" -One time while in the bedroom looking out of the window the group home Director yelled "you're being weird why are you looking out of the window watching the neighbor", that "made me feel bad because I was only watching the man attach a trailer to his truck" -"That made me feel like I shouldn't look out of the windows in my bedroom, Do you think looking out of a window was weird?" -The group home Director said "to all of us" that live at the home "you will never make it without me and he knows they want to move out but he will never let us move." -He was concerned about an incident that happened that morning (May 3, 2022) while he was with his community service worker and in the lobby of the day program. -He called the group home Director and he was yelling over the phone "why are you calling my phone you don't call my phone" and then he hung up the phone when "I tried to explain why I was	V 512		

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V 512	Continued From page 9	V 512		

calling."
-He called the group home Director's phone at the request of his community service worker to coordinate the pick up place for a doctor's appointment that he had scheduled that morning.
-When the group home Director arrived at the day program to pick him up for his doctor's appointment, he yelled at him "Where is your worker, where is your worker" and when she came around the corner he "was yelling at her and that made me feel bad, made me feel like I had gotten her yelled at and she wouldn't want to be my worker anymore."

Interview on 5/3/22 client #2 stated:
-The group home Director had done a lot of "yelling and fussing" at the group home lately
-Didn't remember the date but the group home Director had said "to me I don't have anywhere else to go, he had a home to go to"
-The group home Director "doesn't respect my feelings or respect me as a man."
-"I don't have anywhere else to live right now, no family and that makes me sad."
-The group home Director likes to have the last word, "he tried to provoke everyone and he always wanted to be right about everything."
-The group home Director shouldn't be able to talk to us "any type of way."

Interview on 5/3/22 the Day Program Associate Professional (DPAP) stated:
-She was aware that Client #1 and Client #2 had complained about how the group home Director yelled and talked to them
-May 3, 2022 was the first time that the yelling was witnessed
-The group home Director came into the lobby of the day program where Client #1 was waiting and walked up to Client #1 very close and yelled

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V 512	Continued From page 10 "Where is your worker, go get her and get her out here." Interview on 5/3/22 the Day Program Qualified Professional (DPQP) stated: -Client #1 had complained in the past but this had been the only time it was witnessed -She did not visually see the group home Director come into the lobby but heard him in her office which is approximately 100 feet away from the lobby The group home Director was in the lobby of the day program with Client #1, Client #2 and the community service worker, he became "very aggressive, waving his hands/fingers" in the community service worker's face, the community service worker was short and the group home Director was taller and he was standing over her moving his hands and "the situation escalated other clients and staff began to walk up to the lobby to see what was going on" -She had to intervene between the community service worker and the group home Director. She asked the group home Director to leave the premises. Interview on 5/3/22 the Community Service Worker stated: -Had been working with Client #1 for 3 or 4 months, had taken him to the school and at the day program helped him with his goals -Worked with Client #1 to advocate for himself, was aware that Client #1 had called his care coordinator to make a complaint of how the group home Director had been talking to him -The morning of May 3, 2022, Client #1 had a scheduling conflict with his going to school and his doctor's appointment. "I had called [group home Director] twice that morning and received no answer. I asked [Client #1] to call from his	V 512		

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V 512	Continued From page 11 phone to see if he would answer a call from him. When [group home Director] answered the phone "I could hear him yelling... we were sitting in the car, [Client #1] was in the passenger seat and I was in the driver seat." -Client #1 had attempted to explain why he called and that was when group home Director hung up the phone on client #1 before he could explain. -When the group home Director arrived at the day program to pick up the clients for their doctor's appointments, "I was in the room next door to the lobby. Heard the [group home Director] yelling at Client #1 where is your worker, go get her and get her out here. " -"I walked into the lobby and [group home Director] began yelling that [Client #1] was manipulative and you don't know [Client #1]." -The group home Director then became "very aggressive and intimating waving his fingers in my face" while Client #1 and Client #2 were present. -When Client #1 came back to work after his appointment he kept apologizing for "getting me yelled at" -Client #1 acted as if "he had done something wrong, maybe he was embarrassed or just felt bad" Interview on 5/4/22 the group home Director stated: -Client #1 had lived at the group home since it had open 14 years ago and Client #2 had lived in the home for 9 years -He had not yelled at the clients, he had talked to them in a firm voice -Client #1 had been "coached by former staff" to make complaints about the group home -The morning of May 3, 2022 Client #1 did call his phone and "Yes I hung up on him. [Client #1] was manipulative and he will call over and over for no	V 512		

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V 512	Continued From page 12 reason. I had hung up on him before because he doesn't want anything." -He had not yelled at Client #1 to get his community service worker, he walked up to the window and asked the receptionist could he speak with the community service worker. -He didn't know why the community service worker "got so upset and has blown this situation up" -He had "never" told any client they didn't have anywhere else to go -He had not talked with Client #1 about the May 3, 2022 incident at the day program and no other client had mentioned it. Review on 5/4/22 of the Plan of Protection dated 5/4/22 written by the Qualified Professional (QP) revealed: -"What immediate action will the facility take to ensure the safety of consumers in your care? group home Director will be taken out of staffing until he receives and satisfactorily complete an in-service/training on Effective Communication and Participant Rights on 5/4/2022 with the Qualified Professional and pass with 85% on the test to be considered for passing. He will also need to continue to demonstrate competency with regard to understanding human/client rights for the individuals that he support on a consistent basis. Describe you plans to make sure the above happens. The group home Director will attend and complete the training on 5/4/22. He will meet with the QP to revise his current supervision plan to reflect monthly supervision instead of bimonthly supervision and to include basic understanding of human/client rights. QP will interview persons served weekly for a month by phone or during routine home visits to ensure that they are	V 512		

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DANIELS FAMILY CARE, INC	237 WESTVIEW PARK DRIVE ROCKY MOUNT, NC 27804

(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 512	Continued From page 13 treating being treated appropriately and that their rights are not being violated." Client #1 and Client #2 had diagnoses to include Schizophrenia, Intermittent Explosive Disorder, Mild Intellectual Disorder, Impulse Control Disorder, History of Attention Deficit Hyperactive Disorder and Learning Disorder. Client #1 reported to the Local Management Entity of how rudely the group home Director had spoken to him. Client #1 also had concerns about the way the group home Director was yelling at him and his housemates. The Day Program Qualified Professional witnessed and had to intervene in an incident where the group home Director was asked to leave the day program due to his aggressive and intimidating behaviors. Client #1 reported his feelings were hurt and feeling guilty when the group home Director yelled at his community service worker. Client #2 reported how he wasn't respected as a man by the group home Director and how he felt as if he was being provoked by the group home Director. This deficiency constitutes a Type A1 rule violation for serious abuse and must be corrected within 23 days. An administrative penalty of $2000.00 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 512		