STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R-C 05/24/2022

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ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 05/24/22. The complaints were substantiated (Intake #'s NC00188487, NC00188447 & NC00187845). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 3 current clients and 2 former 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	V 105		

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V 105	Continued From page 1 can provide services to address the individual's needs; and (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	V 105		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to implement written policy when a client was discharged. The findings are:

Review on 5/17/22 of Former Client (FC) #5's record revealed:
- Admitted: 10/23/20
- Discharged: 4/5/22
- Diagnosis: Schizophrenia disorder, bipolar type

Review on 5/17/22 of FC #5's discharge summary dated 4/4/22 revealed:
- Date of transfer/discharge 4/5/22
- "Emergency treatment team meeting was held on 4/4/22 to discuss the immediate discharge that's going to be effective on 4/5/22...the team discussed his continued drug use and his non-compliance with the rules. The decision was made for him to be discharged to the shelter on 4/5/22."
- No services or referrals for continued treatment.
- No documentation about FC #5 stating that he wanted to be discharged from the facility.

Review on 5/17/22 of the facility's discharge criteria/policy revealed:
- "...#4. Ann's Adult Mental Health Facility assists residents regarding their discharge by (b.) Providing referrals to other community services and agencies.
- #5. A written discharge summary includes, at a minimum...(g.) Recommendations for services/treatment/supports...

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V 105	Continued From page 3 - #6. If a resident repeatedly does not follow policies and procedures and it is determined needs cannot be met, the QP (Qualified Professional) c. Assists in the coordination of care for the resident in obtaining appropriate services... - #8. [Facility] makes every effort to provide the resident and legally responsible person at least 30 calendar days notice of discharge... - #9. (b) Notifies appropriate employees and referring agency... - #11. If a resident request discharge for other than medical reason a two-week notice period is required..." Interview on 5/12/22 the Local Management Entity's (LME) Care Coordinator reported: - Facility never called LME to discuss FC #5 being discharged. - The LME wasn't notified until several days after FC #5 was already discharged. - Discharge summary wasn't received until 4/15/22 after several requests. - The facility never told her the name of the shelter FC #5 was taken to and was told to look up shelters. - The facility told her that they went through the court to IVC (Involuntary Commit) FC #5 but the court deemed him not a harm to himself or others. - Since he didn't have a care manager assigned to him, the LME was not a part of the treatment meetings but had previously told the Chief Operating Officer (COO) that if they were having problems with a client that didn't have a care manager or to discharge a client, to call the access line and speak with a clinician for assistance. - She asked the COO for a name of whom she spoke with at the LME but never received a	V 105		

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V 105	Continued From page 4 response. Interview on 5/18/22 FC #5's brother reported: - He didn't know that FC #5 could be discharged that way. - He thought the facility would have to find another home for FC #5 because it was sort of "abrupt." - He didn't okay the shelter, they just told him that's what was going to happen so he didn't question it. - The facility never told him what shelter FC #5 was going to. - The facility never told him that they tried looking for another home. - The facility never gave him the option to make arrangements. - "It all happened so fast." Interview on 5/20/22 the Qualified Professional (QP) reported: - They had an emergency meeting for FC #5 the day before his actual discharge that included his brother. - FC #5 had not been following any rules and didn't want to listen to staff. - They notified the LME but FC #5 is his own guardian. - They dropped FC #5 off at the men's shelter downtown. - They normally give a 30-day notice but FC #5 wanted to be discharged. Interview on 5/17/22 & 5/24/22 the COO reported: - FC #5 was his own guardian. - They followed the discharge policy. - A discharge summary was completed and sent to the LME. - They tried to call and get help from the state and the LME.	V 105		

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V 105	Continued From page 5 - "What are we supposed to do if a client want to be discharged."	V 105		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (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.	V 110		

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V 110	Continued From page 6	V 110		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that 1 of 3 audited staff (#4) demonstrated knowledge, skills and abilities required by the population served. The findings are:

Review on 5/17/22 of staff #4's record revealed:
- Hire date 11/7/17
- Title: House Manager

Review on 5/17/22 of client #4's record revealed:
- Admitted 1/11/22
- Diagnoses: Schizophrenia, Post Traumatic Stress Disorder (PTSD) and Cocaine use disorder/cannabis use disorder

Review on 5/17/22 of client #4's treatment plan dated 1/5/22 revealed:
- Staff will accompany her on all scheduled appointments and advocate on her behalf.
- Staff will inform her that she is required to stay with staff always during appointments and community outings.
- Staff is required to go outside and monitor her while she smokes a cigarette.

Review on 5/17/22 of the facility's elopement policy & procedures revealed:
- "Notify the police after 30 minutes have passed after the elopement."

Review on 5/18/22 of the police call service log/report for this facility location revealed:
- Date/Time reported 4/17/22 10:30am
- "The subject (client #4) left the group home...on 4/16/22 with a [rideshare] driver on her way to the [local medical center]. The subject has

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not yet returned and is not in any area hospitals."
- Person Narrative "[Client #4] left yesterday after her on call nurse got her a [rideshare] to go to [local medical center] for some leg pain. That was at 2:47pm and she has not come back yet. I did not contact [rideshare] to find out who the driver was or anything like that.....she has schizophrenia but she doesn't have anything like dementia."

Review on 5/17/22 of the facility's incident report dated 4/17/22 revealed:
- "The client never called staff when she was ready to be picked up. Staff called [local medical center] but they were closed today."

Review on 5/17/22 of the Medical Center's website revealed the facility's hours of operation are Sunday - Sunday 8am - 8pm.

Interview on 5/19/22 & 5/23/22 Staff #4 reported:
- No longer worked for this group home
- Stopped working at this group home on 4/1/22 fulltime
- Never put a client in a rideshare before this incident
- Only did what the nurse from 911 told her to do
- Couldn't remember if she called anyone in management about putting client #4 in the rideshare but thought she called the QP (Qualified Professional).
- Didn't remember what the QP said about putting client #4 in the rideshare or what time she called her.
- Sent an email to management either the same day or the next day after client #4 didn't return back to the facility.
- Thought she remembered calling 911 the next morning

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- Wasn't sure how it all went. It was hard for her to remember the details surrounding client #4 getting in the rideshare, when she called to check on client at the local medical center and when she informed management.

Interview on 5/20/22 the Emergency Service Worker stated:
- There was a call to Emergency Services on 4/16/22.
- There was a new dispatch procedure that was implemented on 3/01/2022.
- The new procedure would re-route non-emergency calls to the nurse navigation line.
- The new procedure would not send a ride share service to pick up anyone. Sending a ride share service was not on the flow chart of what was to happen.
- There was no way to trace or get specific information on this call due to it being re-routed to the nurse navigation line.

Interview on 5/20/22 with the medical records staff at the local medical center reported:
- If client had been seen at any of their facilities, it would be in their system.
- She did not have client #4 being seen in any of their facilities on 4/16/22 or 4/17/22.

Interview on 5/23/22 the Qualified Professional (QP) reported:
- Was on vacation when the incident with client #4 occurred.
- They would normally not put clients in a rideshare vehicle alone.
- The way this happened was not their policy and if she was not on vacation, this would not have happened.
- Was taken "aback" by this incident.
- Staff #4 told her that she was following the

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instructions of the nurse.
- Told staff #4 that someone would have taken her to the hospital because they did have a transportation unit.
- To her knowledge, she didn't think anyone was called for guidance when client #4 was put in a ride share.
- Cannot verify that client #4 actually went to the local medical center.
- Told staff #4 that she should have still followed the protocol but the QP said that the staff's "attitude was that [client #4] was going to elope anyway."
- "At the end of the day we are still responsible for the clients even if they are going to elope."
- Client #4 returned to the facility on Sunday, 4/18/22.
- Staff #4 was taken off of the schedule for a few days.
- Not sure if staff #4 has been back to the group home.

Interview on 5/24/22 the Chief Operating Officer (COO) reported:
- Did not find out about the incident with client #4 until everyone else found out by email which she believed was 4/17/22.
- Her response when she saw the email was "wait, what."
- If staff #4 had followed the elopement protocol, "we wouldn't be here."
- She spoke with staff #4 and was told that the 911 worker called the rideshare.
- She was not able to get any contact information for the 911worker from staff #4.
- Staff #4 did not say why she waited until the next day to call 911 to report client #4 missing when client #4 had not returned from the local medical center.
- Staff #4 was suspended for a week but it

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V 110	Continued From page 10 lasted longer. - Staff #4 had been filling in at this facility since coming back from suspension. Review on 5/24/22 of the Plan of Protection dated 5/24/22 written by the Qualified Professional revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Staff will be trained on the elopement policy on a continuous basis. Staff will sign the agenda after each training. Describe your plans to make sure the above happens. -The training will happen during supervisions and the staff will sign the agenda after each training and supervision." Client #4 had diagnoses of Schizophrenia, PTSD and Cocaine use disorder/cannabis use disorder. Client #4 had a history of elopement. Client #4 would leave the facility for days at a time. She did not have any unsupervised time according to her treatment plan. On 4/16/22, staff #4 allowed client #3 to get in a rideshare without supervision to go to the local medical center. Staff #4 stated that she was following the orders of 911 although the facility had never done this before with their clients. Client #4 left the facility around 2:47pm and staff #4 did not call to check on client #4 until after the medical center closed which was 8:00pm. Staff #4 did not report client #4 missing until the next morning nor did she notify any management when she didn't get in touch with the client the evening before. This deficiency constitutes an Imposed Type B rule violation which is detrimental to the health, safety and welfare of the clients. An administrative penalty of $200.00 per day is imposed for failure to correct within 45 days.	V 110		

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V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal 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:	V 366		

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V 366	Continued From page 12 (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The 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	V 366		

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LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;
(E) the client's legal guardian, as applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to develop and implement written policies governing their response to incidents as required. The findings are:

A. Review on 5/17/22 Client #2's record revealed:
- Admitted: 5/5/21
- Diagnoses: Schizoaffective Disorder, Bipolar type, Anxiety Disorder, Unspecified and Dyslipidemia

Review on 5/17/22 of the facility's follow up documentation form for Client #2 revealed:
- 4/1/22 Police knocked on the door and "asked if [client #2] lived at the home. Staff said yes and he then stated that the client was down

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	MHL092-669	A. BUILDING: _____ B. WING _____	R-C 05/24/2022

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V 366	Continued From page 14 the road being seen by Emergency Medical Service (EMS) due to him not knowing where he lived and was knocking on other people's doors asking was this his group home. Staff then asked the officer to bring him to the home." - No documentation of there response to the incident Interview on 5/19/22 the Chief Operations Officer (COO): - Aware the police brought the client to the home - Had not completed any further investigations of the incidents, "the police brought him back we did not call them" This deficiency constitutes a re-cited deficiency and must be corrected within 30 days	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:	V 367		

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V 367	Continued From page 15 (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C	V 367		

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V 367	Continued From page 16 .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report Level II incidents within 72 hours affecting 2 of 3 audited clients (#2, #4). The findings are: A.Review on 5/18/22 of the Incident Response Improvement System (IRIS) revealed: - No reports for this facility or for client #2	V 367		

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V 367	Continued From page 17 Review on 5/17/22 Client #2's record revealed: - Admitted: 5/5/21 - Diagnoses: Schizoaffective Disorder, Bipolar type, Anxiety Disorder and Unspecified and Dyslipidemia Review on 5/18/22 of the facility's follow up documentation form for client #2 revealed: - 4/1/22 client #2 was brought back to the house by a police officer B.Review on 5/17/22 Client #4's record revealed: - Admitted: 1/11/22 - Diagnoses: Schizophrenia, Post Traumatic Stress Disorder and Cocaine use disorder/cannabis use disorder Review on 5/17/22 of the facility's incident report for client #4 revealed: - No incident report for 4/28/22's elopement Review on 5/18/22 of the IRIS revealed: - No reports entered for 4/17/22 for client #4 Review on 5/18/22 of the police call service log/report for this facility location revealed: - 4/17/22 at 10:30 am missing person for client #4 - 4/28/22 at 11:43 am missing person for client #4 Interview on 5/17/22 staff #1 stated: - He completed the facility incident reports - Facility incident reports were taken to the office weekly - He does not input incidents into IRIS Interview on 5/19/22 & 5/23/22 the Qualified Professional (QP) reported: - Not responsible for completing IRIS reports	V 367		

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V 367	Continued From page 18 - The Mental Health Manager was responsible for the input of IRIS reports Interview on 5/19/22 the Chief Operations Officer/Chief Financial Officer - There was no incident report completed for the 4/1/22 incident, "they didn't call the police, the police came to the house" - Level II and III incident reports were entered into IRIS Mental Health Manager was unavailable for interview during the dates of the survey 5/17/22-5/23/22. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days	V 367		
V 542	27F .0105(a-c) Client Rights - Client's Personal Funds 10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS (a) This Rule applies to any 24-hour facility which typically provides residential services to individual clients for more than 30 days. (b) Each competent adult client and each minor above the age of 16 shall be assisted and encouraged to maintain or invest his money in a personal fund account other than at the facility. This shall include, but need not be limited to, investment of funds in interest-bearing accounts. (c) If funds are managed for a client by a facility employee, management of the funds shall occur in accordance with policy and procedures that: (1) assure to the client the right to deposit and withdraw money; (2) regulate the receipt and distribution of funds in a personal fund account;	V 542		

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V 542	Continued From page 19 (3) provide for the receipt of deposits made by friends, relatives or others; (4) provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account; (5) assure that a client's personal funds will be kept separate from any operating funds of the facility; (6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client or legally responsible person upon or subsequent to admission of the client; (7) provide for the issuance of receipts to persons depositing or withdrawing funds; and (8) provide the client with a quarterly accounting of his personal fund account. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to manage and maintain records of client personal funds as required and provide quarterly accounting of clients' personal fund accounts, affecting 3 of 3 audited current clients (#1,#2 #4) and 1 of 2 former client (FC) (FC#7). The findings are: A. Review on 5/17/22 of Client #1's record revealed: - Admitted: 10/26/21 - Diagnoses: Schizoaffective disorder, bipolar type, Mild Intellectual Disability and Cocaine Use Disorder Review on 05/17/22 of the facility's financial forms for Client #1 revealed: - May 2022: Amount Deducted was blank	V 542		

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V 542	Continued From page 20 Starting Balance $66.00 "Amount Resident Received" was blank Client signature and staff signature on 5/1/22 Interview on 5/17/22 Client #1 reported: - He signed the paper that he got his money but he didn't get his money. B. Review on 5/17/22 of Client #2's record revealed: - Admitted: 5/5/21 - Diagnoses: Schizoaffective Disorder, Bipolar type and Anxiety Disorder, unspecified and dyslipidemia Review on 5/19/22 of the facility's financial forms for Client #2 revealed: - March: Amount Deducted was blank Starting Balance $66.00 "Amount Resident Received" was blank Client signature and staff signature on 3/1/22 - April: Amount Deducted was blank Starting Balance $0 "Amount Resident Received" $66.00 Client signature and staff signature on 4/4/22 C. Review on 5/17/22 Client #4's record revealed: - Admitted: 1/11/22 - Diagnoses: Schizophrenia, Post Traumatic Stress Disorder and Cocaine use disorder/cannabis use disorder Review on 5/19/22 of the facility's financial forms for client #4 revealed: - March 2022: Amount Deducted was blank Starting Balance $66.00 "Amount Resident Received" was blank Client signature and staff signature on 3/1/22 D. Review on 5/17/22 FC #7's record revealed:	V 542		

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V 542	Continued From page 21 - Admitted: 4/20/20 - Diagnoses: Schizoaffective Disorder, Bipolar type and Intellectual Developmental Disability, unspecified type Review on 5/19/22 of the facility's financial forms for FC #7 revealed: - March: Amount Deducted was blank Starting Balance $66.00, "Amount Resident Received" was blank Client signature and staff signature on 3/1/22 - April : Amount Deducted was blank Starting Balance $0 "Amount Resident Received" $50.00 Client signature and staff signature on 4/4/22 - April: Amount Deducted was blank Starting Balance $63.00 "Amount Resident Received" $63.00 Client signature and staff signature on 4/4/22 Interview on 5/19/22 client #4 reported: - She never received any money from the facility. - She brought her cigarettes with money the facility gave her. Interview on 5/19/22 staff #1 stated: - Every client received $66.00 a month - The money is brought to the home by the Mental Health Manager (MHM) - Receipts and the money are kept in the safe in the facility but no one had a key at the facility - The MHM kept the key to the safe and would come to the facility to distribute the money. The staff on shift would complete the paperwork and allow the client to sign for the money received. Interview on 5/19/22 the Qualified Professional (QP) stated: - They don't reconcile receipts monthly	V 542		

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V 542	Continued From page 22 - They don't keep each individual receipt for every single purchase - Once the client received their money, they spent it on what they wanted and no record was kept. - A record is kept for copays in the office by the Mental Health Manager and the Chief Operations Officer/Chief Financial Officer COO/CFO - They had never had bank statements before, and it hadn't been an issue. - The COO/CFO is responsible for paying clients co-pays and accounts along with the MHM	V 542		
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 interview and observation, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 5/19/22 at 1:38pm revealed the following: Kitchen: - Floor had two spots where the laminate was peeling up Bathroom:	V 736		

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V 736	Continued From page 23 - Floor had two tiles missing. - Missing light bulb in light fixture. Client #1's room: - Light fixture plate/cover by the door was missing - Exposed wires from the wall phone wires Basement: - Several steps going down into the basement were wobbly Interview on 5/19/22 staff #1 reported: - He would email maintenance request to the office and they (office staff) would get in touch with maintenance man, he would come out and fix what was on the request Interview on 5/23/22 the Chief Operations Officer/Chief Financial Officer stated: - Maintenance was working on repairs, they have been busy. [This deficiency has been cited five times since the original cite on 1/6/20 and must be corrected within 30 days.]	V 736		