| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL092-759 | A. BUILDING: ______<br>B. WING ______ | 05/31/2022 |

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|---|---|
| **DESTINY FAMILY CARE HOME** | **3509 ALLENDALE DRIVE<br>RALEIGH, NC 27604** |

| (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 |
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| V 000 | INITIAL COMMENTS<br><br>An annual and complaint survey was completed on 5/31/22. The complaint was substantiated (intake #NC00187922). Deficiencies were cited.<br><br>This facility is licensed for the following service category 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.<br><br>This facility is licensed for 6 beds and currently has a census of 6. The survey sample consisted of audits of 3 current clients. | V 000 | | |
| V 105 | 27G .0201 (A) (1-7) Governing Body Policies<br><br>10A NCAC 27G .0201 GOVERNING BODY POLICIES<br>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:<br>(1) delegation of management authority for the operation of the facility and services;<br>(2) criteria for admission;<br>(3) criteria for discharge;<br>(4) admission assessments, including:<br>(A) who will perform the assessment; and<br>(B) time frames for completing assessment.<br>(5) client record management, including:<br>(A) persons authorized to document;<br>(B) transporting records;<br>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;<br>(D) assurance of record accessibility to authorized users at all times; and<br>(E) assurance of confidentiality of records.<br>(6) screenings, which shall include:<br>(A) an assessment of the individual's presenting problem or need;<br>(B) an assessment of whether or not the facility can provide services to address the individual's | V 105 | | |

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| V 105 | Continued From page 1 | V 105 | | |

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;

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| V 105 | Continued From page 2 | V 105 | | |

Continued From page 2

This Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to implement governing body policies regarding the adoption of standards that ensured operational and programmatic performance meeting applicable standards of practice for the disposal of sharps and ensuring the safeguard of client records. The findings are:

A. Review on 5/25/22 of the facility's Security of Records policy revealed:
- "....safeguards against loss, tampering, defacement or use by unauthorized persons. The safeguards enforced provide accessibility to client records to authorized users at all times."
- "...The following safeguards are designed to promote security of client records: 1. all records are maintained in a secure location with locked file and room locked..."
- "...10. Only authorized employees or others authorized by Administrator/Licensee have access to records."

Observation on 5/19/22 during the facility tour between 10:50 am and 12:30 pm revealed:
- 6 client record books under the coffee table in the living area of the basement, out in the open.

Interview on 5/24/22 the Administrator/Licensee reported:
- the client records are stored in the Staff Bedroom downstairs in the basement which is always locked.
- there are two separate "client books," one with the current Medication Administration Records (MAR) and one in the staff bedroom with

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the Face Sheet and Admission Assessment and Doctor's orders.

Interview on 5/19/22 staff #1 reported:
- had only been working at the facility for 3 weeks.
- normally worked at a sister facility owned by the Administrator/Licensee.
- the client record books were normally located under the coffee table in the family room area of the basement.
- was not aware of two different client books, she had only ever seen one.

Interview on 5/20/22 staff #2 reported:
- "client books" were kept in the Medicine Room at all times.
- she was not aware of two client record books, only one record book.

Interview on 5/19/22 the Qualified Professional (QP) reported:
- client record books should not be in the family room area which is open to anyone, they should be locked in the Medicine Room.
- the facility had a policy to address the securement of client records and staff had been trained on the policy.

B. Review on 5/25/22 of the facility's Medication Waste Disposal policy revealed:
- "...Sharps, including contaminated needles, scalpels, plastic slides, broken glass and capillary tubes, ends of dental wires, and other contaminated objects that can penetrate the skin are regulated medical waste, and must be:
a. Packaged in a biohazard-labeled (fluorescent orange or orange-red with letters or symbols in contrasting color) or a red container that is rigid, closeable, puncture-resistant and leak proof

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(when in an upright position); b. Sharps containers must be located close to the work areas, and replaced before overfilled..."

Observation on 5/19/22 during the facility tour between 10:50 am and 12:30 pm and 5/23/22 between 10:30 am and 4:00 pm revealed:
- accu-check guide test strips and lancets, both used and unused were sitting out in the open on the end table in the family room.
- no sharps containers provided by facility staff

Interview on 5/19/22 client #2 reported:
- had tested her blood sugar that morning, the test strips and lancets were hers.
- usually disposed of the lancets in the kitchen trash can.

Interview on 5/19/22 staff #1 reported:
- had not seen a sharps container at the facility.
- the clients disposed of their lancets in an empty, plastic coffee creamer bottle or sometimes client #2 threw the lancets in the trash can in the kitchen.

Interview on 5/20/22 staff #2 reported:
- clients #1 and #2 checked their blood sugars in the family room area in the basement.
- had not seen a sharps container, they used a plastic coffee creamer container to dispose of the lancets.

Interview on 5/19/22 the QP reported:
- client #1 should be disposing of the lancets in the approved sharps container.
- the facility had several sharps containers in the Medicine Room.

Interview on 5/24/22 the Administrator/Licensee

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reported:
- clients #1 and #2 checked their blood sugars upstairs.
- the facility had a container for the lancets.
- they had a red sharps container for disposal.
- provided the sharps container, she did not know why the staff would be using a coffee creamer bottle.

This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1 rule violation and must be corrected within 23 days.

V 108 27G .0202 (F-I) Personnel Requirements V 108

10A NCAC 27G .0202 PERSONNEL REQUIREMENTS
(f) Continuing education shall be documented.
(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:
(1) general organizational orientation;
(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;
(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and
(4) training in infectious diseases and bloodborne pathogens.
(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained

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to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.
(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure 2 of 2 paraprofessional staff (#1, #2) were trained to meet the mh/dd/sa needs of the clients. The findings are:

Review on 5/23/22 of staff #1's personnel record revealed:
- hire date of: 2/22/19
- no client specific treatment plan training
- no diabetic training

Review on 5/23/22 of staff #2's personnel record revealed:
- hire date of: 2/22/19
- no client specific treatment plan training
- no diabetic training

Review on 5/19/22 of client #1's record revealed:
- Admission date: 3/22/21
- Diagnoses: Anemia Unspecified, Schizoaffective disorder unspecified, Hypertension (HTN), Diabetes type 2, Hyperlipidemia, Myocardial infarction, Chronic

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diastolic heart failure, Bilateral primary osteoarthritis of hip
- Treatment plan dated: 1/10/22

Review on 5/19/22 of client #2's record revealed:
- Admission date: 6/23/18
- Diagnoses: Schizoaffective disorder, Asthma, Diabetes Mellitus and History of Cerebrovascular
- Treatment plan dated: 1/24/22
- Blood sugar results dated 2/27/22-5/24/22 which ranged from 300-500 on 7 occasions
- no documentation of medical response or coordination with the physician regarding any of the 7 elevated blood sugars

Review on 5/19/22 of client #5's record revealed:
- Admission date: 2/15/15
- Diagnoses: Schizophrenia, Hyperlipidemia, Gastroesophageal Reflux Disease (GERD)
- Treatment plan dated: 1/6/22

Interview on 5/27/22 staff #1 reported:
- unaware of any medical interventions for client #2 when her blood sugars were between 300-500
- her only knowledge of a medical intervention was to call 911 if client #2's blood sugar was over 500
- the Qualified Professional (QP) taught her the diabetes training, she did not remember when
- had not had any training on the clients' treatment plans
- was unable to identify any goals of any of the clients from their treatment plans
- "just supported each client the best way she could"

Interview on 5/27/22 staff #2 reported:
- unaware of any treatment plan training by the QP

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| V 108 | Continued From page 8<br>- unable to provide an example of any of the goals for any of the clients<br>- "assisted [client #2] with learning her numbers, she doesn't know her numbers real good."<br>- received diabetes training under a facility staff person years ago<br>- if client #2's blood sugar "gets high, between 360-370, I will give 12 units of Humalog, if it's over 500, I'll call 911."<br>- they don't call or notify the physician of elevated blood sugars, they just call 911 if it's over 500.<br>- if 911 is called, the Emergency Medical Treatment (EMT) squad would assess the client and take her to the hospital, then the facility would notify the physician and schedule a follow up appointment<br><br>Interview on 5/27/22 the QP reported:<br>- was responsible for staff training on the treatment plans<br>- staff #1 had had treatment plan training, not during her current shift, but in the past.<br>- staff #1 was familiar with the facility and knew all the clients<br>- unaware of a doctor's order for medical response to elevated blood sugars<br>- thought there was an understanding that staff would alert the Administrator/Licensee and the doctor for blood sugar levels over 400, if over 500 call 911.<br><br>Interview on 5/27/22 the Administrator/Licensee reported:<br>- she and the QP provided training for staff #1 on treatment planning<br>- the QP is responsible for training the staff on treatment planning<br>- unaware of the medical interventions for | V 108 | | |

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| V 108 | Continued From page 9<br>blood sugars between 300-500, over 500 call 911.<br>- she makes the physician aware of sugar levels when the client goes to their appointments.<br><br>This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1 rule violation and must be corrected within 23 days. | V 108 | | |
| V 112 | 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(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.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(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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This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to develop and implement treatment plan strategies as well as goals to meet the needs for 2 of 3 audited clients (#1 and #2). The findings are:

A. Review on 5/19/22 of client #1's record revealed:
- Admission date: 3/22/21
- Diagnoses: Anemia Unspecified, Schizoaffective disorder unspecified, Hypertension (HTN), Diabetes type 2, Hyperlipidemia, Myocardial infarction, Chronic diastolic heart failure, Bilateral primary osteoarthritis of hip
- Treatment Plan dated 1/10/22 revealed:
- "...Goal 1: maintain psychiatric/medical stability. Goal 2: unable to self direct, limited ability to self direct. Requires monitoring and reminders to complete activities. Goal 3: increased anxiety around thoughts/feelings and perceptions, unable to differentiate reality.."
- Supervision Assessment dated 1/10/22 revealed: "...moves about the neighborhood or community with continual staff supervision requiring staff to be within audible, visual, and/or physical proximity of the individual..."
- "...due to limited mobility, community access is restricted. [client #1] must be accompanied by someone else when in the community...
- "....is not recommended that she be approved for unsupervised time in the home or community

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at this time..."
- no goals/strategies to address elopement, pan handling, solicitation of neighbors or strangers for money, cigarettes, candy/cookies or rides
- no goals/strategies to address numerous police intervention
- no goals/intervention to address client's absence from the facility on 2/26/22 and subsequent missing person report

B. Review on 5/19/22 of client #2's record revealed:
- Admission date: 6/23/18
- Diagnoses: Schizoaffective disorder, Asthma, Diabetes Mellitus, History of Cerebrovascular accident (CVA), hypertension, Gastroesophageal Reflux Disease (GERD)
- Treatment Plan dated: 1/24/22 revealed:
- "...Goal 1: needs to maintain optimal health, Goal 2: Increase independent and daily living skills, Goal 3: Symptom Management, Goal 4: behaviors interfere daily living activities..."
- Supervision Assessment dated 2/2/22 revealed: "...moves about the neighborhood or community with continual staff supervision requiring staff to be within audible, visual, and/or physical proximity of the individual..."
- "...her history of leaving without notification in other housing placements, she is not being approved for unsupervised time in the community..."
- no goals/strategies to address elopement, pan handling, solicitation of neighbors or strangers for money, cigarettes, candy/cookies or rides

Refer to V367 regarding details of incidents that occurred at the facility regarding clients #1 and #2
- 7 police calls to the facility

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| V 112 | Continued From page 12<br>- police call log history<br>- staff logs of "walk offs" from the facility<br><br>Review on 5/26/22 of an activity log kept by a person in the community revealed:<br>- 28 documented incidents of client #1 and #2 panhandling and soliciting neighbors/community members for money/food/cookies/rides<br>"....March 30, 2022<br>[client #1] at the corner of [intersecting street] and Allendale (Street) flagging down people driving by at 2:30 (pm)<br><br>April 2, 2022<br>[client #1] got money from visitors at Allendale. 3:15 (pm)<br><br>April 5, 2022<br>[client #2] waving at people to stop. A woman did stop and [client #2] got in the car 1:45 (pm)<br><br>April 13, 2022<br>[client #1 and #2] flagging down drivers on corner of Allendale and [intersecting street] trying to get money from the men cutting down limbs at [neighbor's house] 10:20 (am)<br><br>April 16, 2022<br>[client #2] on the corner of Allendale 11:10 (am)<br><br>April 17, 2022<br>[client #1] [one street over from the facility] and [intersecting street] flagging down cars at noon<br>[client #1] flagging down cars at corner of [intersecting street] and Allendale at 1:00 (pm)<br>Incident at group home. 3 police responded.<br>[client #1] threw a knife at caregiver 1:30 (pm)<br><br>April 19, 2022<br>[client #2] asked [a woman] if she could use her | V 112 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|
| DESTINY FAMILY CARE HOME | 3509 ALLENDALE DRIVE RALEIGH, NC 27604 |

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|---|---|---|---|---|
| V 112 | Continued From page 13<br>phone 10:05 (am)<br><br>April 20, 2022<br>[client #1] walking up and down Allendale trying to flag down cars 1:40 (pm)<br><br>April 29, 2022<br>[client #2] at the corner of [intersecting street] and Allendale flagging down cars around 10:00 (am)<br>[client #2] back at the corner of [intersecting street] and Allendale flagging down cars around 4:00 (pm)<br><br>April 30, 2022<br>[client #2] on the corner of Allendale and [intersecting street] flagging down cars 11:15 (am)<br><br>May 3, 2022<br>[client #2] on the corner at [intersecting street] flagging down cars 10:15 (am)<br><br>May 4, 2022<br>[client #2] at the corner of [intersecting street] and Allendale flagging down cars 10:10 (am)<br>Also asked [a man] for $10<br><br>May 5, 2022<br>[client #2] at the corner of [intersecting street] and Allendale waving at cars and begging. 2:45 (pm)<br><br>May 6, 2022<br>[client #2] at the corner of Ingram and Allendale waving at cars and begging. 8:50 (pm)<br><br>May 7, 2022<br>[client #2] at the corner of [intersecting street] and Allendale to beg. 12:35 (pm)<br>[client #2] at the corner of [intersecting street] and | V 112 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 112 | Continued From page 14 | V 112 | | |

Allendale to wave down cars. 6:45 (pm)

May 8, 2022
[client #2] trying to flag down cars at the corner of [intersecting street] and Allendale 10:20 (am)
[client #2] still at the corner. A car had stopped. 11:30 (am)

May 9, 2022
[client #1 and #2] on the corner. [client #1] was on her way back with a caregiver but [client #2] stayed to beg. 10:40 (am)

May 10, 2022
[client #2] on the corner of [intersecting street] and Allendale waving down cars. Neighbor told her she could take walks but not beg. [client t#2] told her to leave her alone in an angry voice. The neighbor told her she would call the police if she continued. 9:30 (am) to 12:00 (pm)
Police arrived at the group home around noon, but neighbor had not called them

May 11, 2022
[client #2] on the corner at waving down cars 9:30 (am)
[client #2] still waving down cars closer to the school at 12:00 (pm)

May 15, 2022
[client #1] was at the corner. 1:10 (pm) to 2:15 (pm)"

Interview on 5/27/22 staff #1 reported:
- was not aware of any goals or strategies on client #1 or #2's treatment plans
- only knew to inform the Administrator/Licensee of the behaviors

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 112 | Continued From page 15 | V 112 | | |

Interview on 5/27/22 staff #2 reported:
- unaware of any goals or strategies for client #1 or #2 to address the above behaviors
- informed the Administrator/Licensee of the behaviors
- the Qualified Professional (QP) was aware of the behaviors because she had a meeting with the clients in 2021 and discouraged the behaviors
- the Administrator/Licensee had told her that she was looking for another placement for client #1 as she did not follow the rules

Interview on 5/27/22 the QP reported:
- was unaware of client #1 and #2's behaviors
- was responsible for treatment plan development, but could not develop the plan as she was not aware of the behaviors/incidents
- would revise the treatment plans and train the staff on strategies to address the behaviors
- would facilitate a meeting with the client guardians, and Assertive Community Treatment teams to discuss strategies as well as supports

Interview on 5/25/22 the Administrator/Licensee reported:
- the QP was responsible for treatment plan development
- was aware of client #1 and #2's behaviors
- client #1 was being discharged to a higher level of care
- client #1 did not follow the rules and only did what she wanted
- the incident on 2/26/22 of client #1 missing for over 5 hours and a missing person report filed never happened so that would not be in client #1's treatment plan

This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1

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| V 112 | Continued From page 16<br>rule violation and must be corrected within 23 days. | V 112 | | |
| V 113 | 27G .0206 Client Records<br><br>10A NCAC 27G .0206 CLIENT RECORDS<br>(a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:<br>(1) an identification face sheet which includes:<br>(A) name (last, first, middle, maiden);<br>(B) client record number;<br>(C) date of birth;<br>(D) race, gender and marital status;<br>(E) admission date;<br>(F) discharge date;<br>(2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;<br>(3) documentation of the screening and assessment;<br>(4) treatment/habilitation or service plan;<br>(5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;<br>(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;<br>(7) documentation of services provided;<br>(8) documentation of progress toward outcomes;<br>(9) if applicable:<br>(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);<br>(B) medication orders;<br>(C) orders and copies of lab tests; and | V 113 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 113 | Continued From page 17 | V 113 | | |

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(D) documentation of medication and administration errors and adverse drug reactions.
(b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to assure an identification face sheet and documentation of the screening and assessment was maintained in the record for 2 of 3 audited clients (#5 and #2). The findings are:

Review on 5/23/19 of client #2's record revealed:
- Admission date: 6/23/18
- Diagnoses: Schizoaffective disorder, Asthma, Diabetes Mellitus, History of Cerebrovascular accident (CVA), hypertension, Gastroesophageal Reflux Disease (GERD)
- no identification face sheet
- no documentation of the screening and assessment

Review on 5/23/19 of client #5's record revealed:
- Admission date: 2/15/15
- Diagnoses: Schizophrenia, Hyperlipidemia, GERD
- no identification face sheet
- no documentation of the screening and assessment

Interview on 5/27/22 the Qualified Professional (QP) reported:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| V 113 | Continued From page 18<br>- she was responsible for the admission assessments in the client records<br>- she was not aware that the client records were missing the assessments or the face sheets<br><br>Interview on 5/24/22 the Administrator/Licensee reported:<br>- the QP was responsible for the client records and the admission assessments<br>- she was not aware that any client records were missing any documentation<br>- there was another client record kept in the staff bedroom with the face sheet, the admission assessments and the physician orders<br><br>Interview on 5/27/22 staff #1 reported:<br>- there was only one client record for each client<br><br>Interview on 5/27/22 staff #2 reported:<br>- there was only one client record for each client | V 113 | | |
| V 114 | 27G .0207 Emergency Plans and Supplies<br><br>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES<br>(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.<br>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.<br>(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.<br>(d) Each facility shall have basic first aid supplies | V 114 | | |

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| V 114 | Continued From page 19 | V 114 | | |

accessible for use.

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to complete fire and disaster drills at least quarterly. The findings are:

Observation on 5/23/22 between 11:00 am and 12:00 pm of a simulated fire drill by Division of Health Service Regulation (DHSR) Construction revealed:
- no clients reacted to the fire alarm.
- client #2 was asleep on the couch in the upstairs family room
- client #1 was on the deck outside the facility smoking and did not evacuate to the designated area (mailbox).
- staff #1 encouraged clients to exit the facility during the drill but none of the clients responded.

Observation on 5/23/22 of a leak in the basement ceiling between 11:00 am and 12:00 pm during inspection by DHSR Construction revealed:
- water in the upstairs shower leaked through the floor and into the ceiling of the basement below
- the water leaked into the smoke alarm on the wall adjacent to the leak, causing the alarm to signal
- no clients reacted to the fire alarm signal during the second fire alarm.

Review on 5/23/22 of the facility's fire and disaster drill logs from January 2022-May 2022 revealed:
- drills completed only for January 2022-May 2022.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 114 | Continued From page 20 | V 114 | | |

- no disaster drills
- all drill log entries described all clients as responsive to the drill and evacuated the facility and assembled at the mailbox
- three drills signed by staff #2
- two drills signed by the Administrator/Licensee
- all drill log documentation was written in the same handwriting and signed in the same handwriting.

Interview on 5/23/22 client #1 reported:
- ambulated with the use of a walker
- "we aren't too good with that (participating in drills)."
- "the smoke detectors are broken. The alarm goes off at night."
- they did the drills twice a week. "We try to do 3 times a month."
- they had never done a disaster drill.
- she had never seen the Administrator/Licensee do a drill.

Interview on 5/23/22 client #2 reported:
- ambulated with the use of a walker
- was asleep today during the drill, but she knew to go to the mailbox.
- doesn't go out every time because the alarm is broken and goes off in the night. She doesn't want to get out of bed in the night.
- they did tornado drills in the past but she forgot what she was supposed to do during a tornado drill.

Interview on 5/24/22 client #5 reported:
- they do fire drills once a month.
- knew to meet at the mailbox in the event of a fire.
- for a tornado, "all the clients meet in the upstairs bathroom, or hallway and cover their

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heads"
- the last tornado drill was done on 5/22/22, before that, it was last year when they did a tornado drill
- staff #2 did the fire drills
- had never seen the Administrator/Licensee do a drill
- the fire alarm went off intermittently all the time, "something was wrong with it so we don't usually respond to it."
- the fire alarm had been doing this for years.
- the Administrator/Licensee had someone come out and "fix" the fire alarm system, but "it still went off at all kinds of crazy times."

Interview on 5/19/22 the Qualified Professional (QP) reported:
- the facility completed fire/disaster drills every month to ensure they were being done quarterly and on each shift.

Interview on 5/19/22 staff #1 reported:
- they did fire/disaster drills every week and each shift.
- did not know where the fire/disaster log book was located in the facility.
- had been working at the facility for only 3 weeks, she normally worked at a sister facility.
- the ceiling in the basement had leaked since January or February of 2022.
- thought the Administrator/Licensee had someone fix the leak

Interview on 5/20/22 staff #2 reported:
- drills were done once a week for awhile, then once every two weeks.
- for a disaster drill she would simulate that something had happened with another resident and see if the other residents can get the phone, or call 911.

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| V 114 | Continued From page 22<br>- would perform a drill one time in the morning and then during the evening. She did not do any drills during night. "We have clients that do not do well if woken up during the night."<br>- had not ever done a tornado drill.<br>- the leak in the basement ceiling occurred in January of 2022.<br>- the Administrator/Licensee had someone look at the ceiling and fix it. They just had to replace the ceiling tiles.<br><br>Interview on 5/25/22 the Administrator/Licensee reported:<br>- fire drills was performed every month, and a disaster drill was done quarterly.<br>- they did the last disaster drill in December, January and March. Staff #2 did the drills.<br>- was not aware of any issues with the fire alarm going off intermittently or during the night.<br>- would have someone look at the fire alarm system and fix the issue.<br><br>This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1 rule violation and must be corrected within 23 days. | V 114 | | |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the | V 118 | | |

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client's physician.
(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.
(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:
(A) client's name;
(B) name, strength, and quantity of the drug;
(C) instructions for administering the drug;
(D) date and time the drug is administered; and
(E) name or initials of person administering the drug.
(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to assure 1 of 2 paraprofessional staff (#1) competency to administer medications as well as assure the medication administered was recorded immediately after administration affecting 3 of 3 audited clients (#1, #2 and #5). The findings are:

Review on 5/19/22 of client #1's record revealed:
- Admission date: 3/22/21
- Diagnoses: Anemia Unspecified,

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Schizoaffective disorder unspecified, Hypertension (HTN), Diabetes type 2, Hyperlipidemia, Myocardial infarction, Chronic diastolic heart failure, Bilateral primary osteoarthritis of hip

Review on 5/19/22 of client #2's record revealed:
- Admission date: 6/23/18
- Diagnoses: Schizoaffective disorder, Asthma, Diabetes Mellitus, History of Cerebrovascular accident (CVA), hypertension, Gastroesophageal Reflux Disease (GERD)

Review on 5/19/22 of client #5's record revealed:
- Admission date: 2/15/15
- Diagnoses: Schizophrenia, Hyperlipidemia, GERD

Review on 5/23/22 of staff #1's personnel record revealed:
- hire date of: 2/22/19
- medication administration training: 2/22/19

A. Failure to administer medications correctly leaving them unattended:

Observation on 5/19/22 between 10:50 am and 12 noon revealed 5 clients (#1, #2, #3, #4, #5) at home with staff #1. Two plastic pill containers with medications inside each cup were on the dining table labeled with client #1 and #5's names. One plastic shopping bag on the back of a dining room chair contained inhalers for clients #1 and #2.

Review on 5/19/22 of client #1's Medication Administration Record (MAR) dated May 2022 for morning medicatons revealed:
Myrbetriq ER 50 millgram (mg) tablet, 1 daily (overactive bladder)
QC Vitamin E softgel 400 IU (international unit)

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100, 1 daily (supplement)
Vitamin B 1 100 mg, 1 daily (supplement)
Multivitamin, 1 daily (supplement)
Loratadine 10 mg, 1 every morning (allergies)
Ferrous sulfate 325 mg, 1 twice a day (anemia)
Hydralazine 50 mg, 1 and 1/2 three times a day (hypertension)
Prednisone 20 mg, 2 tablets for 10 days (steroid)
Aripiprazole 5 mg, 1 daily (schizophrenia)
Omeprazole dr 20 mg, 1 every morning (GERD)
Furosemide 40 mg, 1 daily (diuretic)
Amlodipine-Benazepril 10-20mg, 1 daily (hypertension)
Albuterol Sulfate HFA, inhale 2 puff by every 4 hours as needed (asthma)

Review on 5/19/22 of client #5's MAR dated May 2022 for morning medicatons revealed: :
Docusate Sodium 100 mg softgel, 1 twice a day (laxative)
Low-Ogestrel, 1 daily (contraceptive)
Cetirizine HCL 10 mg, 1 every morning (allergies)
Propranolol 20 mg, 1 twice a day (hypertension)
Carbamazepine 100 mg 1 three times a day (seizures)
Benztropine Mes 0.5 mg 1 twice a day (side effects)
Hydroxyzine HCL 25 mg 1 in the am (anxiety)
Paliperidone ER 9 mg, 1 every morning (antipsychotic)
Vyvanse 50 mg capsule 1 every morning (Attention deficit disorder)

Review on 5/19/22 of client #2's MAR dated May 2022 for inhalers revealed:
ProAir HFA, inhale 2 puffs as needed every 4-5 hours (asthma), Fluticasone Propionate, instill 1-2 sprays in each nostril once daily prn (as needed) (congestion or runny nose)

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Interview on 5/23/22 client #1 reported:
- medications were administered in the basement out of the Medication Room
- staff #1 administered medications one by one.
- staff #1 put the medicine in the plastic cup and "watched to make sure you" take it.

Interview on 5/23/22 client #2 reported:
- staff #1 called clients individually to the Medication Room, gave them their medications at the closet (Medication Room)
- the pills were in a cup.
- she used to get her medicine upstairs at breakfast
- staff #2 would put medications in the cup and put it by each person's chair. (breakfast and dinner)
- other client's medication cups would be sitting by their place at the dining table.
- clients #1, #5 and #3 were going out so their medicine was always upstairs by their breakfast.

Interviews between 5/19/22 and 5/24/22 client #5 reported:
- she did not feel well on 5/19/22 so she did not eat breakfast and therefore did not take her morning medications
- gets her medications upstairs, recanted and stated she got her medications downstairs.
- sometimes the medication was left out by their breakfast.

Interviews between 5/19/22 and 5/24/22 staff #1 reported:
- medications are normally administered in the basement at the Medication Room.
- medications were on the table last Thursday (5/19/22)
- she had carried the medications upstairs on

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5/19/22 because client #5 did not feel well and had asked her to bring the medications upstairs
- client #1 "was being slow" that morning (5/19/22) and that was why she took the inhalers upstairs
- her normal medication administration process is to call each client to the Medication Room one at a time and dispense the medication, observe that they took the medication and sign off on the MAR

Interview on 5/20/22 staff #2 reported:
- she was the primary staff assigned to the facility
- she was considered "live in" staff
- she had worked at the facility for 3 years
- she administered medications in the basement out of the Medication Room. One person at a time.
- she put the pills in the plastic cup. She observed them take the medications. Then she signed the MAR.
- client #4 did not do well on the steps to and from the basement, so she would take her the medications upstairs.
- client #4 is the only one she does that for.

Interviews between 5/19/22 and 5/27/22 the Qualified Professional (QP) reported:
- she visited the facility once or twice a month
- the Administrator/Licensee monitored the medication process and oversight of the medication administration with the staff
- she was unaware of the practice of the medications set out at the table and clients left without supervision while the medications were on the table

Interviews between 5/24/22 and 5/27/22 the Administrator/Licensee reported:

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- she visited the facility 3-4 times a week
- the staff administer the medication out of the Medication Room and per doctor order's.
- sometimes for client #4, they take it upstairs as she cannot come downstairs.
- she was unaware of the staff leaving the clients medications beside their breakfast at the dining room table
- " It's not advisable to do that. You cannot leave someone's medication on the table as someone could get someone else's medications."
- unaware staff were taking a shopping bag upstairs with the clients' medication in the shopping bag

B. MAR not signed after administration

Observation on 5/19/22 between 10:50 am and 12 noon revealed:
- medications for clients #1, #2 and #5 were left out on the table for morning medication
- at 11:55am, clients #1 and #5 took their medications which had been left out on the table
- MAR books were located downstairs for all clients
- staff #1 did not sign off on the MAR immediately after clients #1 and #5 took their medication

Review on 5/19//22 at 2:30pm of client #1's May 2022 MAR revealed:
- all morning medications had been initialed

Review on 5/19//22 at 2:30pm of client #2's May 2022 MAR revealed:
- all morning medications had been initialed

Review on 5/19//22 at 2:30pm of client #5's May 2022 MAR revealed:
- all morning medications had been initialed

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Interview on 5/19/22 staff #1 reported:
- she signed off on the MAR because the clients still took the medications just not in the morning
- she was in a "fluster" as state surveyors were on site

C. Failure to administer medications as ordered:

Review on 5/19/22 of client #2's March 2022-May 2002 MARs revealed:
- Albuterol Sulfate inhalation solution 0.083% 2/5mg/3 millileter (ml), Inhale contents of one vial via nebulizer 4 times daily as needed for cough for wheezing or shortness of breath (asthma)
- initialed on 3/7/22-3/31/22 every night
- initialed 4/11/22-4/16/22 and 4/20/22-29/22

Observation on 5/19/22 from 10:50 am and 12 noon during the facility tour revealed:
- nebulizer machine on bedside table of client #2

Interview on 5/19/22 staff #1 reported:
- no one in the home had a nebulizer machine
- upon seeing the nebulizer on client #2's bedside table, "it's a nebulizer, I guess she do have a nebulizer machine."

Interview on 5/20/22 staff #2 reported:
- no one in the home had a nebulizer machine

Interview on 5/24/22 the Administrator/Licensee reported:
- unaware of anyone in the home with a nebulizer machine

Interview on 5/23/22 client #2 reported:
- she had a nebulizer machine

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- she used it when she was coughing a lot
- sometimes she put the liquid medicine in the machine and sometimes the staff did it

D. Failure to document Blood Glucose checks:

Record review on 5/24/22 of client #2's blood glucose log dated 1/5/22-5/24/22 revealed:
- no blood glucose check times recorded from 1/5/22-4/26/22 for any of the 4 times per day checked.
- recorded blood glucose times for only morning checks from 4/27/22-5/24/22.
- no times for afternoon, evening or night

Record review on 5/24/22 of client #1's blood glucose log dated 1/5/22-5/24/22 revealed:
- no blood glucose check times recorded from 1/5/22-5/3/22 for any of the times checked.

Interview on 5/24/22 the Administrator/Licensee reported:
- the clients check their own blood glucose levels and show the staff, the staff then log the reading on the blood glucose log
- the clients do not self administer their insulin, staff administer the insulin
- both of the staff had training in diabetes

Review on 5/27/22 of the facility's Plan of Protection dated 5/27/22 and signed by the QP revealed:

"What immediate action will the facility take to ensure the safety of the consumers in your care?

The current staff person will be relieved of duty as soon as a replacement can be brought in. Until that time the administrator or QP will administer medications. This staff person will not be able to

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work in this facility. The full time staff returns on Monday, May 30, 202. She will be reinserviced on medication administration, storage, following Dr's orders and understanding client's medication & medical needs within 24 hours of returning to work. This training will be conducted by a licensed professional, RN [Registered Nurse], pharmacist etc... "

"Describe your plans to make sure the above happens.

The QP will complete the medication administration responsibilities for tonight. The administrator will ensure that all staff members receive medication administration training on at least a quarterly basis. No staff person will work unless trained within 24 hours of hire and regular updates are completed by a licensed professional. "

Six clients resided at the facility. Diagnoses ranged from Schizoaffective disorder, Schizophrenia, Hypertension (HTN), Diabetes type 2, Hyperlipemia, Myocardial infarction, Chronic diastolic heart failure, Bilateral primary osteoarthritis of hip, Anemia, Asthma, Diabetes Mellitus, History of cerebrovascular accident (CVA) and Gastroesophageal Reflux Disease (GERD). Clients were left unsupervised with medications such as Aripiprazole, Carbamazepine, Benztropine, Hydroxyzine HCL, Paliperidone, and Vyvanse left out on the dining room table. Staff #1 who was hired on 2/22/19 as a full-time live in staff at a sister facility and fill in staff for the facility, left the medications for two clients in the medication containers without supervision. Five clients were in the home during that time with access to the medication. Clients reported that staff routinely left the medications in

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| | containers sitting on the dining table next to each client's chair with the clients' names on them for the clients to take during their breakfast. Although staff #1 had medication administration training, she failed to administer medications individually to each client, left medication unsupervised and had not assured client #1, and #5's MAR was accurate. Medications used in the treatment of asthma for clients #1 and #2 were left in a plastic shopping bag on the back of the dining chair unsupervised. Staff #1 failed to administer the medications or ensure the MAR for the inhalers was accurate. Client #2 had an order for a nebulizer machine and neither the Administrator, staff #1 or staff #2 were aware that client #2 used the nebulizer as needed. Client #2 had a diagnosis of asthma, and could not have used the machine without the staff providing the solution to put in the machine. Despite having initialed that the treatment had been given in March and April, staff were unaware of the nebulizer and the order to be used when needed. Staff #1 and #2 were both trained in diabetes management, although there is no documentation of diabetes management training in their respective personnel files. Blood glucose logs were not being maintained to reflect the times of the accu checks per physician orders. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day. | | | |
| V 289 | 27G .5601 Supervised Living - Scope | V 289 | | |
| | 10A NCAC 27G .5601 SCOPE | | | |

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| V 289 | Continued From page 33<br>(a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.<br>(b) A supervised living facility shall be licensed if the facility serves either:<br>(1) one or more minor clients; or<br>(2) two or more adult clients.<br>Minor and adult clients shall not reside in the same facility.<br>(c) Each supervised living facility shall be licensed to serve a specific population as designated below:<br>(1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses;<br>(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;<br>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;<br>(4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;<br>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or<br>(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is | V 289 | | |

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mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).

This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to operate within the scope of the program affecting three of three audited clients (#1, #2 and #5). The findings are:

A. Cross reference: 10A NCAC 27G .0201 Governing Body Policies (v105). Based on observation, record review and interview, the facility failed to implement governing body policies regarding the adoption of standards that ensured operational and programmatic performance meeting applicable standards of practice for the disposal of sharps and ensuring the safeguard of client records.

B. Cross reference: 10A NCAC 27G .0202

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Personnel Requirements (v108). Based on record review and interview the facility failed to ensure 2 of 2 paraprofessional staff (#1, #2) were trained to meet the mh/dd/sa needs of the clients.

C. Cross reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (v112). Based on record review and interviews, the facility failed to develop and implement treatment plan strategies as well as goals to meet the needs for 2 of 3 audited clients (#1 and #2).

D. Cross reference: 10A NCAC 27G .0207 Emergency Plans and Supplies (v114). Based on observation, record review and interview the facility failed to complete fire and disaster drills at least quarterly.

E. Cross reference: 10A NCAC 27G .5602 Supervised Living for Adults with Mental Illness-Staff (v290). Based on observation, record review, and interviews, the facility failed to ensure 2 of 3 audited clients (#1 and #2) were capable of remaining in the home or community without supervision.

F. Cross reference: 10A NCAC 27G .5603 Supervised Living for Adults with Mental Illness -Operations (v291). Based on record review and interviews the facility failed to coordinate with other qualified professionals who were responsible for the treatment/habilitation of 1 of 3 audited clients (#2).

G. Cross reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (v366). Based on record review and interview the facility failed to implement their incident reporting policy.

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H. Cross reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (v367). Based on record review and interview the facility failed to submit level II incident reports within 72 hours to the Local Managed Entity/Managed Care Organization (LME/MCO).

I. Cross reference: 10A NCAC 27F .0103 Health, Hygiene and Grooming (v540). Based on observation, record review and interview, the facility failed to ensure each client had the right to dignity and privacy in the provision of personal health, and hygiene affecting 2 of 3 audited clients (#1 and #2).

J. Cross reference: 10A NCAC 27G .0303 Location and Exterior Requirements (v736). Based on observation and interview, the facility failed to maintain the facility in a safe, clean, attractive and orderly manner.

K. Cross reference: 10A NCAC 27G .0303 (d) Pest Control (v738). Based on observation and interviews, the facility failed to ensure the facility was free of insects and rodents.

Review on 5/27/22 of the facility's Plan of Protection dated 5/27/22 and signed by the Qualified Professional (QP) revealed:

"What immediate action will the facility take to ensure the safety of the consumers in your care?

The current staff is going to be relieved as soon as a replacement is identified. The administrator will ensure that this happens within the next 24 hours.
V105 The [Qualified Professional] QP and

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administrator will confer tonight regarding governing body policies on standards of practice regarding record storage, having appropriate disposal for biohazard waste, privacy and confidentiality of client information. The QP will retrain staff on confidentiality, record storage and access and ensure that a sharps container is purchased tonight and will instruct clients on how to dispose of their lancets, pin tops, etc. appropriately.
V107 The administrator will ensure that all employees have completed personnel records, including all trainings, [Health Care Personnel Registry] HCPR check, criminal background checks, etc. Because the administrator works directly with the clients, she will complete all trainings as required for direct care staff.
V108 The QP will reinservice the full time staff on treatment plans prior to the beginning of her shift on Monday, May 30, 2022. The administrator will schedule diabetes training with a licensed professional to be completed as quickly as their scheduled will allow.
V111 The QP will reassess the 2 clients and update the treatment plans within 24 hours. The update will be shared with the client and full time staff when she returns and any other incoming staff upon hire.
V112 The supervision assessments are kept in the records and reviewed regularly with staff. The QP will now keep documentation of these reviews in the individual personnel file for clients.
V114 The QP has reinserviced the administrator as of 5/25 and again on 5/27/22 on disaster drills. This is expected to be completed no less than monthly on varying shifts. QP will monitor.
V290 QP will conduct weekly training and review on supervision assessments with staff for the next 30 days. Any staff person who is not willfully ignoring or not following the treatment plan will be

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removed and disciplinary action will be taken, up to and including termination.
V291 The administrator does the appointments for clients. It will be her responsibility to in-services staff on any changes upon return from appointments. Additionally, it will be her responsibility to contact the QP to inform the QP of any changes to that client's treatment. It will be the responsibility of the administrator to contact the medical professional when there are consistent refusal to complete blood sugar checks or when the blood sugar levels fall within the guidelines of the instructions provided by the healthcare professional.
V366 & 367 It shall be the responsibility of the person witnessing or becoming aware of a reportable incident (leaving without notification, injury, police involvement, hospitalization, death, allegations of abuse, neglect or exploitation etc..) to report it directly to the QP in a timely manner. The QP will then follow up on any needed information, conduct investigations when appropriate and enter information into IRIS within 24 hours, 72 hours or complete the investigation within 5 days.
V540 The QP met with the staff and the 2 clients and discussed the concern about the need for privacy when completing toileting, grooming, hygiene activities. The administrator will ensure that the portable toilets are removed from the room. Both individuals have access to a bathroom directly outside of the room that they are able to use.
V736 The administrator has contracted with a contractor who initiated the repairs on yesterday, May 26, 2022. The administrator will provide the contractor with the list of areas needing immediate attention. QP met with him briefly to discuss those areas needing immediately attention this week. All work will be completed by

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23 days. This will include the ceiling in the downstairs hallway, the leak was addressed yesterday, the vegetation growing outside the home, repairing door jambs , etc.. The administrator addressed the cleanliness (or lack of) of the rooms with the residents earlier in the week. She will conduct weekly inspection of rooms to ensure that the staff are assisting the clients as needed to ensure a clean and safe environment.
V738 The administrator has contracted with Terminix. They are scheduled to exterminate on Thursday, June 2, 2022."

"Describe your plans to make sure the above happens.
The administrator will follow up immediately on requests for repairs. She will conduct weekly inspections to ensure this is done. The QP will reassess all clients and will do monthly treatment team meetings over the next 90 days to ensure staff fully understand what their responsibilities are. Documentation and signature from the employee acknowledging that the training has taken place and they fully understand will be kept on file."

Review on 5/31/22 of the facility's amended Plan of Protection dated 5/31/22 and signed by the QP revealed:

"What immediate action will the facility take to ensure the safety of the consumers in your care? Please remove any reference to tag v107. "

Six clients resided at the facility. Diagnoses included Schizoaffective disorder, Schizophrenia, Hypertension (HTN), Diabetes type 2, Hyperlipemia, Myocardial infarction, Chronic

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diastolic heart failure, Bilateral primary osteoarthritis of hip, Anemia, Asthma, Diabetes Mellitus, History of cerebrovascular accident (CVA) and Gastroesophageal Reflux Disease (GERD).

Clients #1 and #2 engaged in behavior such as walking off from the facility unsupervised, panhandling and soliciting neighbors and community members for money, cigarettes, cookies and rides. These behaviors resulted in 7 incidents of police intervention. Staff failed to notify the QP of the frequency and degree of these behaviors, which resulted in a lack of supports and no treatment plan goals/interventions being implemented to address the behaviors. Clients #1 and #2 were assessed and deemed inappropriate for community unsupervised time due to their health issues and behaviors. Staff #1 was unaware that the clients were deemed inappropriate for unsupervised time in the community as she was not trained on the client treatment plans when she assumed her shift. When staff continued to allow client #1 and #2 to engage in these behaviors, and failed to communicate to the QP, clients #1 and #2 were placed at risk. Client #2 eloped from the facility on 2/26/22 for over 5 hours and missed her 2 pm Hydralazine medication. Police intervention was required to locate and return the client to the facility, but staff did not call for assistance until over 5 hours later. The QP was unaware of the incident, and therefore did not update client #2's treatment plan to address the elopement issue. The facility failed to ensure that incident reports were made for the above mentioned incidents or that internal investigations were completed.

Staff #1 and staff #2 were hired in 2019. Staff #2 was the primary staff assigned to the facility. Staff

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#1 was considered fill in staff and had been at the facility for 3 weeks while staff #1 took time off. Both staff lacked training in treatment planning and strategy implementation. Neither of the staff could identify any of the clients' treatment goals or the staff role in the client's progression toward each goal. Client records were left out in the open of the basement family room area, exposing all confidential client information.

Clients #1 and #2 were both diabetic and prescribed insulin. Staff were unable to articulate medical interventions for elevated blood glucose levels. Staff #1 and staff #2 had different perceptions on how to treat the two clients in the event their respective blood sugar levels were high and the facility did not have physician orders to follow until 5/26/22 to instruct the staff accordingly. Client #2 had 7 incidents of elevated blood sugars with no physician contact and therefore no coordination of care.

Due to a leak from the shower into the basement ceiling, the facilty smoke alarm was triggered intermittently and would sound off at all times of the day and night. The clients had become desensitized to the alarm and no longer reacted and failed to exit the facility. This posed a safety issue for the 6 clients of the facility. No disaster drills were documented and the clients were unaware of procedures to respond to a disaster if one should occur. Additional safety concerns were found in the facility in the form of expired fire extinguishers, plastic coffee cans being used as cigarette dispensaries and plastic coffee creamer bottles being used as a sharps disposal box for blood glucose lancets. Door frames were split and did not allow doors to lock or shut properly, light bulbs were out, ceiling fans and light fixtures were hung too low and were a safety hazard. The

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facility was assessed with a roach infestation and had not had any treatments scheduled. Clients and staff had observed a mouse in the facility, but no effort was made to address the rodent issue.

Client #1 and #2 shared a bedroom. They both had individual bedside commodes in the room, but the room was not equipped to afford either client with privacy as there was no partition or curtain.

The Administrator/Licensee visited the facility between 3-4 times a week to pick up and drop off clients from various appointments. While she was responsible for incident reports, the physical environment of the facility, and staff medication administration and medication reviews, she was frequently engaged with a client at an appointment and unable to maintain those responsibilities. Staff communicated incidents directly to the Administrator/Licensee and assumed she would notify the QP of any issues, but the QP was not made aware and unable to report incidents or develop goals/interventions to address issues. The QP was responsible for the training of the staff in treatment planning and progress toward goals. She indicated she had completed this training with the staff, however staff were unable on interview to communicate any goals/strategies for any of the clients. This collective lack of services such as care, habilitation, for clients demonstrated by staff #1 and #2, the QP and the Administrator constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2.000 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.

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| V 290 | 27G .5602 Supervised Living - Staff | V 290 | | |

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 duty shall be trained in alcohol and other drug

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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 observation, record review, and interviews, the facility failed to ensure 2 of 3 audited clients (#1 and #2) were capable of remaining in the home or community without supervision. The findings are:

Review on 5/19/22 of client #1's record revealed:
- Admission date: 3/22/21
- Diagnoses: Anemia Unspecified, Schizoaffective disorder unspecified, Hypertension (HTN), Diabetes type 2, Hyperlipidemia, Myocardial infarction, Chronic diastolic heart failure, Bilateral primary osteoarthritis of hip
- Supervision Assessment dated 1/10/22 revealed: "...moves about the neighborhood or community with continual staff supervison requiring staff to be within audible, visual, and/or physcial proximity of the individual..."
- "...due to limited mobility, community access is restricted. [client #1] must be accompanied by someone else when in the community...
- "....is not recommended that she be approved for unsupervised time in the home or community at this time..."

Review on 5/19/22 of client #2's record revealed:
- Admission date: 6/23/18
- Diagnoses: Schizoaffective disorder, Asthma,

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Diabetes Mellitus, History of Cerebrovascular accident (CVA), hypertension, Gastroesophageal Reflux Disease (GERD)
- Supervision Assessment dated 2/2/22 revealed: "...moves about the neighborhood or community with continual staff supervison requiring staff to be within audible, visual, and/or physcial proximity of the individual..."
- "...her history of leaving without notification in other housing placements, she is not being approved for unsupervised time in the community..."

Refer to V112 regarding client #1 and #2 panhandling, and soliciting neighbors/community members for money/food/cookies/rides

Observation on 5/19/22 at 10:20 am on arrival of facility revealed:
- client #1 entered a cab
- staff #1 outside the facility watched client #1 enter the cab

Interviews between 5/19/22 and 5/24/22 staff #1 reported:
- was "fill in" staff at this facility
- had been there 3 weeks and primarily worked at a sister facility
- was considered "live in" staff
- was aware that clients #1 and #2 walked away from the facility and asked the neighbors for cigarettes and rides to the store
- was aware that client #1 and #2 called for cabs to go to the store
- had never called a cab for client #1 and #2
- thought client #1 and #2 had an hour of unsupervised time in the community
- thought they had unspervised time because the clients left the facility, so she assumed they had the unsupervised time

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- had been keeping a log of her own accord of "walk off" incidents since April 2022.

Review on 5/23/22 of staff #1's "walk off log"book revealed:
- 7 incidents from 4/30/22-5/22/22 of clients #1 and #2 walking off from the facility
- 2 incidents of client #1 getting into a cab

Interview on 5/20/22 staff #2 reported:
- was the primary staff assigned to the facility.
- was considered "live in staff"
- normally worked 3 weeks and was off 2 weeks, but lately she always worked longer if the Administrator/Licensee needed her to work over
- had recently taken some time off and had not worked in the facility for 3 weeks
- was aware of clients #1 and #2 walking away from the facility, they had done this numerous times
- did not believe any of the clients in the facility had unsupervised time in the community
- clients #1-#2 would say that they were going to get "exercise" and slip away and "panhandle" on the corner of the street
- had informed the Administrator/Licensee of the clients' recent behaviors of taking a cab or getting rides from strangers
- had kept a log of incidents of the two clients walking off from the facility
- did not have the log book with her to share the incidents
- the Administrator/Licensee had talked to the clients about their behaviors

Interviews between 5/19/22 and 5/27/22 the Qualifed Professional (QP) reported:
- unaware of the above mentioned incidents.
- staff had not communicated with her regarding any of the above incidents.

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| V 290 | Continued From page 47<br>- neither client #1 or #2 had any unsupervised time in the community<br>- did not know why staff #1 assumed they had unsupervised time, or why staff #1 allowed them to take cabs<br>- staff had contacted the Administrator/Licensee and believed the Administrator/Licensee had communicated with her.<br><br>Interview on 5/25/22 the Administrator/Licensee reported:<br>- unaware why staff #1 thought the clients had unsupervised time<br>- was aware of client #1 and client #2 walking around the neighborhood and that the staff had reported the clients were asking for money/cigarettes and rides, getting cabs but she had not witnessed this behavior.<br>- client #1 did not follow any of the facility rules<br><br>This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1 rule violation and must be corrected within 23 days. | V 290 | | |
| V 291 | 27G .5603 Supervised Living - Operations<br><br>10A NCAC 27G .5603 OPERATIONS<br>(a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.<br>(b) Service Coordination. Coordination shall be maintained between the facility operator and the | V 291 | | |

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qualified professionals who are responsible for treatment/habilitation or case management.
(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.
(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.

This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to coordinate with other qualified professionals who were responsible for the treatment/habilitation of 1 of 3 audited clients (#2). The findings are:

Review on 5/19/22 of client #2's record revealed:
- Admission date: 6/23/18
- Diagnoses: Schizoaffective disorder, Asthma, Diabetes Mellitus, History of Cerebrovascular accident (CVA), hypertension, Gastroesophageal Reflux Disease (GERD)
- Medication Administration Record (MAR) dated 3/1/22-5/31/22: Accu-Check Guide Test Strip, use as directed to check blood sugar three times daily.

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- Blood Glucose log dated 2/27/22-5/24/22: 7 entries of blood sugar levels between 300-500 on the following dates:
  2/7/22 360
  4/27/22 500
  4/12/22 HI (high)
  4/14/22 500
  4/24/22 301
  5/1/22 361
  5/23/22 397
- no documentation of medical response or coordination with the physician regarding any of the 7 elevated blood sugars
- no physician visit since 12/1/21
- physician order dated 5/26/22 revealed: "...if glucose under 70 give 1/2 cup juice or soda, or 4-5 crackers or hard candy then recheck glucose in 15 min to an hour. If glucose 'HI' or over 500 call MD [medical doctor] . If weekend, take to the ER [emergency room]."

Review on 5/27/22 of client #2's physician note dated 12/1/21 revealed:
- "...her glucose readings are now avg [average] 100-200's..."

Interview on 5/27/22 staff #1 reported:
- unaware of any medical interventions for client #2 when her blood sugars were between 300-500
- her only knowledge of a medical intervention was to call 911 client #2's blood sugar was over 500
- the Qualified Professional (QP) taught her the diabetes training, she did not remember when

Interview on 5/27/22 staff #2 reported:
- if client #2's blood sugar "gets high, between 360-370, she will give 12 units of Humalog, if it's over 500 call 911."

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DESTINY FAMILY CARE HOME | 3509 ALLENDALE DRIVE RALEIGH, NC 27604 |

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| V 291 | Continued From page 50<br>- they don't call or notify the physician of elevated blood sugars, they just call 911 if it's over 500.<br>- if 911 is called, the Emergency Medical Treatment (EMT) squad would assess the client and take her to the hospital, then the facility would notify the physician and schedule a follow up appointment<br><br>Interview on 5/27/22 the QP reported:<br>- unaware of a doctor order for medical response to elevated blood sugars, but thought there was an understanding to alert the Administrator/Licensee for blood sugar levels over 400 call the doctor, and over 500 call 911.<br><br>Interview on 5/27/22 the Administrator/Licensee reported:<br>- unaware of the medical interventions for blood sugars between 300-500, over 500 call 911.<br>- she makes the physician aware of sugar levels when the client goes to their appointments.<br><br>This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1 rule violation and must be corrected within 23 days. | V 291 | | |
| V 366 | 27G .0603 Incident Response Requirments<br><br>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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: | V 366 | | |

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| V 366 | Continued From page 51<br>(1) attending to the health and safety needs of individuals involved in the incident;<br>(2) determining the cause of the incident;<br>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;<br>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;<br>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;<br>(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<br>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.<br>(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.<br>(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:<br>(1) immediately securing the client record by:<br>(A) obtaining the client record;<br>(B) making a photocopy;<br>(C) certifying the copy's completeness; and<br>(D) transferring the copy to an internal review team;<br>(2) convening a meeting of an internal | V 366 | | |

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| V 366 | Continued From page 52<br>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:<br>(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;<br>(B) gather other information needed;<br>(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<br>(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and<br>(3) immediately notifying the following:<br>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;<br>(B) the LME where the client resides, if different; | V 366 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;
(E) the client's legal guardian, as applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to implement their incident reporting policy.
The findings are:

Refer to V367 regarding details of incidents that occurred at the facility
- 7 police calls to the facility

Review on 5/19/22 of facility records revealed no documentation that the facility had responded to the 7 police calls by addressing the following:
- the clients health and safety needs
- determining the cause of the incidents
- developing and implementing corrective measures
- developing and implementing measures to prevent similar incidents from occurring again
- assigning staff to be responsible for implementation of the corrections
- adhering to confidentiality requirements
- maintaining documentation regarding these response measures

Interview on 5/19/22 staff #1 reported:

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- not aware of any incidents that had occurred in the last 6 months
- thought there was a facility incident log but did not know where the log book was kept

Interviews between 5/19/22 and 5/27/22 the Qualified Professional (QP) reported:
- not aware of the police calls
- staff had not communicated with her when incidents occurred, they contacted the Administrator/Licensee and assumed the Administrator/Licensee had communicated with her
- unaware of the location of the facility incident log book
- she was responsible for submitting Level II and Level III reports
- the staff and the Administrator/Licensee were responsible for submitting Level I incident reports

Interview on 5/19/22 the Administrator/Licensee reported:
- aware of the police calls
- did not submit Incident Response Improvement System (IRIS) reports as the police came and went
- had not completed any further investigations of the incidents
- responsible for investigating incidents and submitting in the incident response improvement system
- there was a facility incident log book and she would submit the incident log entries for the past 6 months

Record request for incident log entries and investigative reports made on 5/19/22, 5/23/22, 5/25/22 and 5/27/22.
- no incident log entries were submitted prior to survey exit on 5/31/22.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 366 | Continued From page 55<br>- no investigative reports were submitted prior to survey exit on 5/31/22.<br><br>This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1 rule violation and must be corrected within 23 days. | V 366 | | |
| V 367 | 27G .0604 Incident Reporting Requirements<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and<br>(6) other individuals or authorities notified or responding. | V 367 | | |

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(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 .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;

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(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 review and interview the facility failed to submit level II incident reports within 72 hours to the Local Managed Entity/Managed Care Organization (LME/MCO). The findings are:

Review on 5/19/22 of the North Carolina Incident Response Improvement System between 12/1/21 and 5/19/22 revealed:
- no level II incident reports

Review on 5/20/22 of the local police records revealed:
- the police were called to the facility 7 times between 12/1/22 and 5/19/22.
- "...2/25/22 clients communicating threats, 2/26/22 request for service, 2/26/22 missing person, 3/18/22 clients begging, 3/28/22 talk with officer, 4/4/22 talk with officer, 4/17/22

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disturbance resulting in police report..."
- "...Offense Incident Report dated 4/17/22: one female caretaker (staff #2) and one female subject (client #1) were involved in a verbal altercation. The caretaker alleged that the subject threw a knife at her.."

Interview on 5/20/22 with the local Police Sergeant reported:
- a community resident reached out to the police department (PD) with concerns about the clients at the facility.
- "when the weather was warm, there were two residents [client #1] and [client #2] that would come out and pan handle, ask people for rides, and ask people for cigarettes"
- the police initiated neighborhood checks (riding around the neighborhood), in April 2022 of the area.
- he had spoken to the staff a couple of times about the neighborhood concerns regarding the two clients panhandling and asking for rides.
- "the staff appeared unconcerned" and identified the two clients immediately when the behaviors were described to her
- had pulled a call log history report and identified the following incidents at the facility from 1/1/22-5/19/22:
"...4/17/22 involving [client #1] : allegation that [client #1] threw a knife at the staff. Police report was filed at that time, no arrest made, 3/28/22: [client #2] threatened [client #1]. [client #1] called the PD with a complaint against [client #2] threatening her, 3/14/22: [staff #2] reported clients were begging and panhandling in the street. No report filed, 2/26/22: [the Administrator] called at 6pm and reported [client #1] eloped from the facility around noon and had not had any medication or food. A description of [client #1] was provided and an officer found her nearby

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and drove her back to the home. She was fine. No police report filed..."

Interviews between 5/19/22 and 5/24/22 staff #1 reported:
- was "fill in" staff at this facility
- had been there 3 weeks and primarily worked at a sister facility
- was considered "live in" staff
- was aware that clients #1 and #2 walked away from the facility and asked the neighbors for cigarettes and rides to the store
- had never submitted an incident report for these behaviors.
- had never called the police for the clients behaviors
- had told the Administrator/Licensee about the clients' behaviors
- thought the Administrator/Licensee had told the Qualified Professional (QP)
- thought there was a facility incident log book, but she did not know where it was located
- had been keeping a log of her own accord of "walk off" incidents since April 2022.

Review on 5/23/22 of staff #1's "walk off log" book revealed:
- 7 incidents from 4/30/22-5/22/22 of clients #1 and #2 walking off from the facility

Interview on 5/20/22 staff #2 reported:
- was the primary staff assigned to the facility.
- was considered "live in staff"
- normally worked 3 weeks and was off 2 weeks, but lately she always worked longer if the Administrator/Licensee needed her to work over
- had recently taken some time off and had not worked in the facility for 3 weeks
- was aware of clients #1 and #2 walking away from the facility, they had done this numerous

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| V 367 | Continued From page 60<br>times<br>- the QP had talked with them about the behavior in 2021<br>- clients #1-#2 would say that they were going to get "exercise" and slip away and "panhandle" on the corner of the street<br>- client #1 threw a knife or "silverware" at her in April 2022.<br>- contacted the PD and the police responded but she did not press charges.<br>- the police had talked to the clients and warned them they could be charged for panhandling.<br>- unaware of client #1 missing on 2/26/22 as she was not working that day<br>- had informed the Administrator/Licensee of the clients recent behaviors<br>- had kept a log of incidents of the two clients walking off from the facility<br>- did not have the log book with her to share the incidents<br>- the Administrator/Licensee had talked to the clients about their behaviors<br>- the Administrator/Licensee had considered discharge of client #1, but had not found a placement<br>- had not told the QP about the incidents this year because she thought the Administrator/Licensee would tell her<br><br>Interviews between 5/19/22 and 5/27/22 the QP reported:<br>- unaware of the above mentioned incidents.<br>- staff had not communicated with her regarding any of the above incidents.<br>- staff had contacted the Administrator/Licensee and believed the Administrator/Licensee had communicated with her.<br>- had she known of the degree of client #1 and | V 367 | | |

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client #2's behaviors she would have addressed them with their respective Assertive Community Treatment Teams (ACTT) , and possibly had client #1 assessed for Involuntary Committment (IVC) after her aggressive incident with staff #2 on 4/17/22.
- upon learning of the above incidents, she had communicated to all staff that they are to immediately contact her when an incident occurs

Interview on 5/25/22 the Administrator/Licensee reported:
- did not submit any incident reports to the LME/MCO
- was aware of client #1 and client #2 walking around the neighborhood and that the staff had reported the clients were asking for money/cigarettes and rides, but she had not witnessed this behavior.
- the incident on 2/26/22 with client #1 missing from noon to 6pm never happened
- unaware of the incident on 4/17/22 with client #1 throwing a knife at staff #2
- client #1 did not follow any of the facility rules
- did not believe the clients were bothering the neighbors.
- they had done internal incident log entries and investigations, she would submit them for review

Record request for incident log entries and investigative reports made on 5/19/22, 5/23/22, 5/25/22 and 5/27/22.
- no incident log entries were submitted prior to survey exit on 5/31/22.
- no investigative reports were submitted prior to survey exit on 5/31/22.

This deficiency is cross referenced into 10A

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| V 367 | Continued From page 62<br>NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1 rule violation and must be corrected within 23 days. | V 367 | | |
| V 540 | 27F .0103 Client Rights - Health, Hygiene And Grooming<br><br>10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING<br>(a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the:<br>(1) opportunity for a shower or tub bath daily, or more often as needed;<br>(2) opportunity to shave at least daily;<br>(3) opportunity to obtain the services of a barber or a beautician; and<br>(4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil.<br>(b) Bathtubs or showers and toilets which ensure individual privacy shall be available.<br>(c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure each client had the right to dignity and privacy in the | V 540 | | |

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|---|---|---|---|
| | MHL092-759 | A. BUILDING: ______ B. WING ______ | 05/31/2022 |

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| V 540 | Continued From page 63 | V 540 | | |

provision of personal health, and hygiene affecting 2 of 3 audited clients (#1 and #2). The findings are:

Review on 5/19/22 of client #1's record revealed:
- Admission date: 3/22/21
- Diagnoses: Anemia Unspecified, Schizoaffective disorder unspecified, Hypertension (HTN), Diabetes type 2, Hyperlipidemia, Myocardial infarction, Chronic diastolic heart failure, Bilateral primary osteoarthritis of hip
- no physician's order for bedside commode

Review on 5/19/22 of client #2's record revealed:
- Admission date: 6/23/18
- Diagnoses: Schizoaffective disorder, Asthma, Diabetes Mellitus, History of Cerebrovascular accident (CVA), hypertension, Gastroesophageal Reflux Disease (GERD)
- no physician's order for bedside commode

Observation on 5/19/22 between 10:50 am and 12:30 pm during the facility tour revealed:
- 2 bedside commodes present in shared bedroom of client #1 and #2
- no privacy curtain or partition present in the shared bedroom of client #1 and #2

Interview on 5/23/22 client #1 reported:
- had obtained the bedside commode 2 weeks ago
- had been incontinent for over a year and sometimes she had accidents in her bed at night
- did not have any privacy in her room when she used the bedside commode, there was no curtain in the room between the two beds

Interview on 5/23/22 client #2 reported:
- used her bedside commode every night

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| V 540 | Continued From page 64<br>- preferred to not use the bathroom across the hall from her room as her roommate (client #1) got feces on the toilet<br>- they don't have any privacy in the room, there is no curtain between the beds or bedside commode<br><br>Interview on 5/19/22 staff #1 reported:<br>- did not know why client #2 had the bedside commode<br>- client #1 had had her bedside commode for only a few weeks<br><br>Interview on 5/20/22 staff #2 reported:<br>- client #2 had her bedside commode ever since she had been working at the facility, approximately 3 years<br>- did not know why client #2 needed the commode since the basement bathroom was right across the hall from client #1-#2's bedroom<br>- did not know why client #1 had a bedside commode. She didn't have it when she went off shift at the end of April<br>- was aware there was no curtain or partition in the room for privacy<br><br>Interview on 5/24/22 the Qualified Professional (QP) reported:<br>- unaware why either client #1 or #2 needed a bedside commode<br>- there was no way to accommodate privacy in their rooms, there was no partition<br>- the basement bathroom was across the hall from their bedroom, the clients used that bathroom in the past<br>- had told the Administrator/Licensee that if a client had a bedside commode, they must be in a single occupancy room<br>- can only make recommendations to the Administrator/Licensee regarding the physical set | V 540 | | |

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| V 540 | Continued From page 65<br>up of the facility<br><br>Interview on 5/24/22 the Administrator/Licensee reported:<br>- believed that client #2 got her bedside commode in 2020<br>- did not know why the clients needed the bedside commodes<br>- client #1 had just received her bedside commode<br>- did not know why the clients could not use the basement hall bathroom<br>- there was no partition or curtain in client #1 or #2's bedroom to ensure privacy<br><br>This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1 rule violation and must be corrected within 23 days. | V 540 | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance<br><br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain the facility in a safe, clean, attractive and orderly manner. The findings are: | V 736 | | |

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| V 736 | Continued From page 66 | V 736 | | |

Observation on 5/19/22 between 10:50 am and 12:00 pm and on 5/23/22 between 11:10 am and 12:30 pm during the facility tour and Division of Health Service (DHSR) Construction follow-up survey revealed:

Basement Hallway:
- basement hall ceiling was caved in. Three tiles were caved in above the threshold between the hall and the family room.
- smoke detector near the basement hall celing was missing the cover.
- light bulb and wires hung down from the hall ceiling. One bulb was out
- floor tiles in the basement bathroom were gapping.
- basement bathroom was missing a toilet lid.
- toilet seat had black marks on the seat.
- basement bathroom sink was clogged
- a blanket was rolled up and wedged at the bottom of the staff bedroom door and the floor
- hall closet ceiling tiles were caved in
- the upstairs shower was turned on while the basement tiles were open, water leaked onto the basement floor below
- after 5 minutes of the upstairs shower being ran, and water leaked below, the fire alarm went off

Client #1 and client #2's bedroom:
- ceiling fan had a piece of the light globe hanging down from the fan chain.
- ceiling fans were hung too low for head clearance
- black marks on the floor beside client #2's bed.
- black marks approximately 1-2 inches on client #1's comforter.
- wooden dresser was missing 2nd drawer from the top.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 736 | Continued From page 67 | V 736 | | |

Continued From page 67

- door jam was broken. The wooden door frame was split preventing the door from closing or locking

Basement Family Room:
- center support post in the family room had a broken wooden trim box at the base of the post, open to the outside of the home.
- cigarette butt on the floor near the staircase

Staircase:
- cigarette butt on the stairs.

Upstairs Hallway:
- uncovered light fxture with no cover
- 2 blown lightbulbs.
- two lightbulbs in the bathroom were out
- air return vent cover was dirty and rusted

Client #5 and client #6's bedroom:
- curtain rod was broken on the left side.
- shared toilet had black marks inside the toilet bowl
- shared toilet was not stable on the floor and moved
- shared bathroom sink was clogged
- missing hand towel bar
- missing bar near shower
- black substance in the stand up shower
- bathroom door frame would not lock

Client #3's room:
- mattress was sunken in on the side closest to the door.
- lightbulb out in the ceiling fan/ light
- four bags of trash in the room

Kitchen:
- Black/brown marks on the chair railing.
- grease build up on backsplash behind stove

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| V 736 | Continued From page 68 | V 736 | | |

and on the stove filter.
- 3 cracked floor tiles

Dining room:
- chandelier style light fixture is too low for the room layout and posed a risk for walking into the fixture
- dining room table had two broken legs and was wobbly

3 Fire Extinguishers:
- dated as last serviced in 2019

Home Exterior:
- cigarette butts were disposed in plastic coffee cans
- vegetation growing on the exterior of the home was growing into the power lines
- broken table and trash near the basement patio doors

Interviews between 5/19/22 and 5/24/22 staff #1 reported:
- the basement hallway ceiling leaked water sometimes
- had informed the Administrator/Licensee and thought the leak had been fixed
- had seen roaches in the facility and believed the pest control company was scheduled for service but did not know the date
- the fire alarm system would go off intermittently and during the night
- had informed the Administrator/Licensee and believed the Administrator/Licensee had someone come out and look at the system
- client #1's marks on her comforter were due to her incontinence and client #1 needed to wash her comforter
- had rolled a blanket and placed it underneath the staff bedroom door after she saw a mouse in

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| V 736 | Continued From page 69<br>the facility<br>- had reported the mouse to the Administrator<br>- had not seen any other containers to dispose of the cigarettes outside the facility, so she used plastic coffee cans<br>- the Administrator/Licensee was the person responsible for repairs for the facility<br>- the Administrator/Licensee came to the facility 2-3 times a week to take clients to doctor appointments.<br>- the Administrator/Licensee was not at the facility long when she came<br><br>Interviews between 5/20/22 and 5/27/22 staff #2 reported:<br>- the basement ceiling had leaked around January 2022.<br>- thought the Administrator/Licensee had had someone fix the leak.<br>- the smoke alarm had gone off intermittently since January 2022<br>- had informed the Administrator/Licensee of the fire alarm and someone came to look at the alarm<br><br>Interviews between 5/19/22 and 5/24/22 the Qualified Professional (QP) reported:<br>- came to the facility once or twice a month<br>- the facility Administrator/Licensee was responsible for facility repairs<br>- when she visited the facility, she did tour the facility for the purpose of engaging with the clients<br>- was not focused on the physical environment during the facility tour<br>- was not aware of the fire alarm system going off intermittently<br><br>Interviews between 5/24/22 and 5/27/22 the Administrator/Licensee reported:<br>- was aware that the facility had roaches and | V 736 | | |

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had contacted the pest control company and scheduled service but did not know when it was scheduled
- did not believe there was a mouse in the facility. They had never had a mouse in the facility.
- came by the facility 3-4 times a week
- the facility staff would inform her of issues that needed to be repaired and she would coordinate the repairs.
- was not aware of any issues with the fire alarm system going off intermittently
- had contacted "the handyman" to repair the upstairs shower and replace the ceiling tiles in the basement hallway ceiling
- had not received the Statement of Deficiency Report dated March 9, 2022 from DHSR Construction and was unaware of the previous living environment citations.

This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1 rule violation and must be corrected within 23 days.

V 738 — 27G .0303(d) Pest Control — V 738

10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS
(d) Buildings shall be kept free from insects and rodents.

This Rule is not met as evidenced by:
Based on observation and interviews, the facility

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| V 738 | Continued From page 71 | V 738 | | |

failed to ensure the facility was free of insects and rodents. The findings are:

Observation on 5/19/22 during the facility tour between 10:50 am and 12:30 pm revealed:
- a blanket rolled up at the bottom of the staff bedroom door.
- a live roach in client #2's nebulizer machine located on her nightstand in her bedroom
- the nebulizer machine was inside a cardboard box on client #2's nightstand with the tubing wound inside the box, the roach was observed inside the tubing.
- a live roach on the lampshade of client #2's lamp located on her nightstand in her bedroom.

Observation on 5/31/22 during the facility exit survey at 10:10 am revealed:
- a live winged, hard shelled bug crawling on the floor from the steps to the family room area.

Interview on 5/23/22 Divsion of Health Service Regulation Construction reported:
- the open wooden trim box in the basement at the base of the support post in the family room area was a source of entry for pests and rodents

Interview on 5/23/22 client #1 reported:
- saw the "rat" run from the closet in the basement hall to the hot water heater across the hall from her bedroom "out of the side of my eye"
- the facility had a roach problem "real bad."
- saw them on her person when she laid in her bed
- sometimes they fell from the ceiling tiles

Interview on 5/23/22 client #2 reported:
- saw a "rat" outside her bedroom door the other day.
- the "rat" ran behind the hot water heater

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| V 738 | Continued From page 72 | V 738 | | |

across from her room.
- heard the "rat rustling around in my cookies" that she kept in her bedroom the other night.

Interview on 5/24/22 client #5 reported:
- the facility had a roach problem.
- had seen 2 roaches in the refrigerator on the night of 5/22/22 and 5/23/22.
- had seen roaches "all downstairs and in the kitchen."
- thought the pest control company had come out to treat the facility a month ago.

Interview on 5/19/22 staff #1 reported:
- had put the rolled blanket at the bottom of the staff door because she had seen a mouse run across the floor from the client bedrooms to the hot water heater area.
- had seen roaches in the facility.
- a pest control company had done an evaluation on the facility on 5/7/22.
- the pest control company told her there was a roach infestation and advised a treatment plan.
- informed the Administrator/Licensee of the visit and recommendation for treatment.
- was not aware of when the facility would be treated, she had not been told of the treatment date, but was told that a staff member from the sister facility had scheduled treatment for the facility and the sister facility.

Interview on 5/23/22 the Qualified Professional (QP) reported:
- overheard staff #1 talking about the mouse and the roaches.
- the pest control company was scheduled for treatment but she did not know the date.

Interview between 5/24/22 and 5/27/22 the Administrator/Licensee reported:

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| V 738 | Continued From page 73<br>- the facility did not have a "rat problem, there was no rat."<br>- did not know why people said there was a "rat."<br>- the facility had requested treatment from the pest control company, but she did not know when they were scheduled.<br><br>Interview on 5/23/22 with the pest control company customer service manager reported:<br>- they had done an evaluation on the facility on 5/7/22.<br>- they assessed the facility had a roach infestation.<br>- they left treatment plan recommendations with staff #1 to give to the Administrator/Licensee .<br>- they had not been contacted for service/treatment since their visit on 5/7/22.<br><br>This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living for Adults with Mental Illness-Scope (v289) for a Type A1 rule violation and must be corrected within 23 days. | V 738 | | |