Division of Health Service Regulation

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY FAMILY CARE HOME	3509 ALLENDALE DRIVE 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
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 5/31/22. The complaint was substantiated (intake #NC00187922). Deficiencies were cited. This facility is licensed for the following service category 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 beds and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000	V105 Governing Body Policies The facility QP has inserviced all staff and the administrator on standards of practice in the area of protecting client's information, ensuring that client information/records are appropriately stored to ensure confidential information is only accessible to the applicable employees of Destiny Family Care Homes. The facility has also ensured that the staff are aware of where the sharps containers are available in the medication room. Should there be a reason to check someone's blood sugar away from the designated area in a situation deemed to be an emergency the staff person is responsible for making sure that the sharps container is with them and available to disposed of contaminated items immediately.	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's	V 105		

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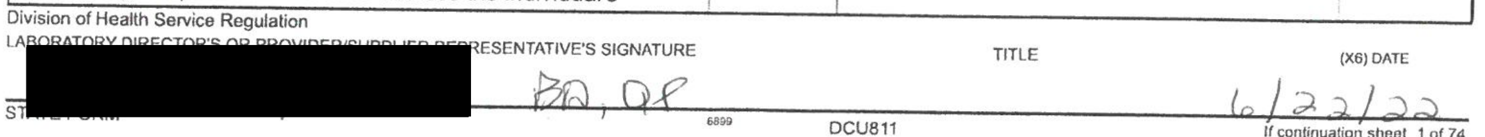

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V 105	Continued From page 1 needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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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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V 105	Continued From page 4 (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	V 105		

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V 105	Continued From page 5 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 105		
V 108	27G .0202 (F-I) Personnel Requirements 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	V 108	V108 Personnel Requirements The facility has ensured that the staff have been trained by an RN on diabetes care and protocols. There are no emergency interventions required for blood sugars under 400. Staff were inserviced on this by the RN and by the QP. There have been staff changes in the home specifically as a result of lack of knowledge of previous training and staff not adhering to training requirements in this home. The staff have always been trained on how to support clients as well as V	

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V 108	Continued From page 6 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	V 108	108 continued: each client's active treatment needs and the meaning of supervised living. If a staff person does not follow the training provided they will be subject to disciplinary action, up to and including termination.	

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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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- unable to provide an example of any of the goals for any of the clients
- "assisted [client #2] with learning her numbers, she doesn't know her numbers real good."
- received diabetes training under a facility staff person years ago
- 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."
- they don't call or notify the physician of elevated blood sugars, they just call 911 if it's over 500.
- 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

Interview on 5/27/22 the QP reported:
- was responsible for staff training on the treatment plans
- staff #1 had had treatment plan training, not during her current shift, but in the past.
- staff #1 was familiar with the facility and knew all the clients
- unaware of a doctor's order for medical response to elevated blood sugars
- 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.

Interview on 5/27/22 the Administrator/Licensee reported:
- she and the QP provided training for staff #1 on treatment planning
- the QP is responsible for training the staff on treatment planning
- unaware of the medical interventions for

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V 108	Continued From page 9 blood sugars between 300-500, over 500 call 911. - she makes the physician aware of sugar levels when the client goes to their appointments. 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	V112 Assessment/Treatment Plan The QP has reassessed clients #1 and #2. Treatment plans have been updated to reflect additional needs or concerns. All staff have been inserviced on the updated goals. Behavioral concerns that had not been addressed are now addressed. One of the two clients has been discharged since the survey. Staff have also been advised that ALL client behaviors are to be reported directly to the QP. Any challenging behaviors will be addressed with administrator and QP. Any client who fails to follow rules of the facility, place themselves in danger, panhandles, engages in any other dangerous or illegal activity may be discharged for unwillingness to comply with treatment plan, keep themselves safe or repeated violations/offenses. The QP and the administrator have discussed this at length and QP will document all meetings where these concerns are discussed.	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 10 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	V 112	Staff can discuss behavioral concerns with the administrator but each staff person witnessing or having a concern about any client has the responsibility to report the concerns to the QP. Failure to do so may result in disciplinary action. The QP has always made herself available to V112 continued: the staff at all times, 24/7 for emergencies. This has not changed. Treatment goals should always reflect current needs but information has to be shared appropriately and in a timely manner. ALL staff and the administrator have been re-inserviced on this protocol, which is not new.	

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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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- police call log history
- staff logs of "walk offs" from the facility

Review on 5/26/22 of an activity log kept by a person in the community revealed:
- 28 documented incidents of client #1 and #2 panhandling and soliciting neighbors/community members for money/food/cookies/rides
"....March 30, 2022
[client #1] at the corner of [intersecting street] and Allendale (Street) flagging down people driving by at 2:30 (pm)

April 2, 2022
[client #1] got money from visitors at Allendale. 3:15 (pm)

April 5, 2022
[client #2] waving at people to stop. A woman did stop and [client #2] got in the car 1:45 (pm)

April 13, 2022
[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)

April 16, 2022
[client #2] on the corner of Allendale 11:10 (am)

April 17, 2022
[client #1] [one street over from the facility] and [intersecting street] flagging down cars at noon
[client #1] flagging down cars at corner of [intersecting street] and Allendale at 1:00 (pm)
Incident at group home. 3 police responded.
[client #1] threw a knife at caregiver 1:30 (pm)

April 19, 2022
[client #2] asked [a woman] if she could use her

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phone 10:05 (am)

April 20, 2022
[client #1] walking up and down Allendale trying to flag down cars 1:40 (pm)

April 29, 2022
[client #2] at the corner of [intersecting street] and Allendale flagging down cars around 10:00 (am)
[client #2] back at the corner of [intersecting street] and Allendale flagging down cars around 4:00 (pm)

April 30, 2022
[client #2] on the corner of Allendale and [intersecting street] flagging down cars 11:15 (am)

May 3, 2022
[client #2] on the corner at [intersecting street] flagging down cars 10:15 (am)

May 4, 2022
[client #2] at the corner of [intersecting street] and Allendale flagging down cars 10:10 (am)
Also asked [a man] for $10

May 5, 2022
[client #2] at the corner of [intersecting street] and Allendale waving at cars and begging. 2:45 (pm)

May 6, 2022
[client #2] at the corner of Ingram and Allendale waving at cars and begging. 8:50 (pm)

May 7, 2022
[client #2] at the corner of [intersecting street] and Allendale to beg. 12:35 (pm)
[client #2] at the corner of [intersecting street] and

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V 112	Continued From page 14 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	V 112		

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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 rule violation and must be corrected within 23 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (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; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and	V 113	V 113 Client Records Each of the surveyed clients have been a resident in this facility for over a year. The admission assessments were always present during previous surveys for at least 2 of the current survey clients. The QP has discussed the importance of leaving all initial assessments and other appropriate documents (FL2, hospital discharge summaries, physicians orders, PCP, admission assessments, client specific information, etc..) in the records. It is not known who removed the items, but all staff have been inserviced on protocols for removing any information from the records. ALL client records were reviewed. ALL clients have face sheets present in their records. The admission assessments have all been refiled in the clients individual records.	

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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:

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V 113	Continued From page 18 - she was responsible for the admission assessments in the client records - she was not aware that the client records were missing the assessments or the face sheets Interview on 5/24/22 the Administrator/Licensee reported: - the QP was responsible for the client records and the admission assessments - she was not aware that any client records were missing any documentation - there was another client record kept in the staff bedroom with the face sheet, the admission assessments and the physician orders Interview on 5/27/22 staff #1 reported: - there was only one client record for each client Interview on 5/27/22 staff #2 reported: - there was only one client record for each client	V 113		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies	V 114		

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V 114	Continued From page 19 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.	V 114	V114 Emergency Plans and Supplies The QP has inserviced the administrator and the staff on procedures for fire/disaster drills. Both drills will be conducted on a monthly basis. The staff will rotate the schedule to ensure that a drill has been done on each shift within a quarter. This will be reviewed on a monthly basis during the quality assurance review. The reviewing team will consist of the administrator, QP and direct care staff on shift at that time. Any staff person who willingly fails to comply with requirements will be subjected to disciplinary action. The leak in the ceiling on the bottom floor was repaired prior to the survey exit. It no longer leaks, and the alarms are no longer triggered because of the previous leak. Clients and staff have confirmed this.	

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- 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 - 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." - had not ever done a tornado drill. - the leak in the basement ceiling occurred in January of 2022. - the Administrator/Licensee had someone look at the ceiling and fix it. They just had to replace the ceiling tiles. Interview on 5/25/22 the Administrator/Licensee reported: - fire drills was performed every month, and a disaster drill was done quarterly. - they did the last disaster drill in December, January and March. Staff #2 did the drills. - was not aware of any issues with the fire alarm going off intermittently or during the night. - would have someone look at the fire alarm system and fix the issue. 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 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (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. (2) Medications shall be self-administered by clients only when authorized in writing by the	V 118	V118 Medication Requirements Medication training was completed on 6/2/22. Staff, administrator and QP were in attendance. Training focused on medication administration (when, how and where), documentation, medication storage (including insulin), dangers of leaving medications unattended by staff, diabetes care (including protocols to follow for high and low blood sugars). There have been staffing changes at this facility.	

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V 118	Continued From page 23 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,	V 118		