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
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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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V 291	Continued From page 50 - 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: - 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. Interview on 5/27/22 the Administrator/Licensee reported: - unaware of the medical interventions for 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 291		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:	V 366		

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V 366	Continued From page 51 (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal	V 366	V 366 Incident Response Requriements It is the responsibility of the QP to complete level 2 and 3 incidents in IRIS within 72 hours of their occurrence. The QP will train administrator and/or other designated staff on how to complete incident reports in the absence of the QP. Training on reporting procedures/protocols have taken place for direct care staff and administrator. Training included required notification to the QP, description of levels of incident, how to complete incident reports and providing all pertinent information when reporting an incident.	

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review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:

(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;

(B) gather other information needed;

(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and

(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and

(3) immediately notifying the following:

(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;

(B) the LME where the client resides, if different;

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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.

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V 366	Continued From page 55 - no investigative reports were submitted prior to survey exit on 5/31/22. 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 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding.	V 367	V 367 Incident Reporting Requirements: Staff are required to contact the QP and administrator for any incident which involves behaviors, med errors, leaving without notifications, presence of weapons, threats, injuries, substance abuse, suicide attempts/gestures/threats, treatment, etc.. All level 2 & 3 incident reports are to be entered into IRIS by the QP. When an incident occurs it is the responsibility of the group home staff to notify QP immediately. The QP will respond by obtaining information, conducting an investigation (if necessary) and entering the information into IRIS within 72 hours. All staff have been inserviced on this procedure. Training will continue monthly at meeting.	

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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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times
- the QP had talked with them about the behavior in 2021
- clients #1-#2 would say that they were going to get "exercise" and slip away and "panhandle" on the corner of the street
- client #1 threw a knife or "silverware" at her in April 2022.
- contacted the PD and the police responded but she did not press charges.
- the police had talked to the clients and warned them they could be charged for panhandling.
- unaware of client #1 missing on 2/26/22 as she was not working that day
- had informed the Administrator/Licensee of the clients recent behaviors
- 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
- the Administrator/Licensee had considered discharge of client #1, but had not found a placement
- had not told the QP about the incidents this year because she thought the Administrator/Licensee would tell her

Interviews between 5/19/22 and 5/27/22 the QP reported:
- unaware of the above mentioned incidents.
- staff had not communicated with her regarding any of the above incidents.
- staff had contacted the Administrator/Licensee and believed the Administrator/Licensee had communicated with her.
- had she known of the degree of client #1 and

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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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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 367	Continued From page 62 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 10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING (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: (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to shave at least daily; (3) opportunity to obtain the services of a barber or a beautician; and (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. (b) Bathtubs or showers and toilets which ensure individual privacy shall be available. (c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available. This Rule is not met as evidenced by: 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	V540 Health, Hygiene & Grooming The QP has discussed the concerns about privacy with all clients, staff and administrator. At no time should a client in a double occupancy room have a bedside commode in that room if there is not a separating wall. In this case both clients were able to use the bathroom and we discussed their individual needs. The bedside commodes have been removed. QP has requested that the facility staff notify the QP when new equipment of any sort is prescribed for a client. At this time we can discuss concerns, barriers, etc.. for the use of that equipment.	

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V 540	Continued From page 63 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	V 540		

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V 540	Continued From page 64	V 540		

- preferred to not use the bathroom across the hall from her room as her roommate (client #1) got feces on the toilet
- they don't have any privacy in the room, there is no curtain between the beds or bedside commode

Interview on 5/19/22 staff #1 reported:
- did not know why client #2 had the bedside commode
- client #1 had had her bedside commode for only a few weeks

Interview on 5/20/22 staff #2 reported:
- client #2 had her bedside commode ever since she had been working at the facility, approximately 3 years
- did not know why client #2 needed the commode since the basement bathroom was right across the hall from client #1-#2's bedroom
- 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
- was aware there was no curtain or partition in the room for privacy

Interview on 5/24/22 the Qualified Professional (QP) reported:
- unaware why either client #1 or #2 needed a bedside commode
- there was no way to accommodate privacy in their rooms, there was no partition
- the basement bathroom was across the hall from their bedroom, the clients used that bathroom in the past
- had told the Administrator/Licensee that if a client had a bedside commode, they must be in a single occupancy room
- can only make recommendations to the Administrator/Licensee regarding the physical set

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V 540	Continued From page 65 up of the facility Interview on 5/24/22 the Administrator/Licensee reported: - believed that client #2 got her bedside commode in 2020 - did not know why the clients needed the bedside commodes - client #1 had just received her bedside commode - did not know why the clients could not use the basement hall bathroom - there was no partition or curtain in client #1 or #2's bedroom to ensure privacy 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 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on 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 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.	V 736	V736 Facility and Grounds Maintenance The administrator has contracted with a contractor to make the needed repairs in the home. The areas downstairs including the ceiling has been repaired or replaced after the leak was addressed. There are no exposed wires, smoke detector was replaced, sink and toilets were repaired, replaced, etc. The bedrooms have been cleaned and ceiling fans removed, dressers replaced, areas needing repair have been repaired, covers have been placed on light fixtures, light fixtures have bulbs, fixtures in bathrooms have been repaired or replaced, client rooms were cleaned by clients and the cleaning service. Clients & staff have been inserviced on	

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V 738	Continued From page 71 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	V 738	V738 Pest Control The facility contacts with a professional extermination company. An assessment of the facility's needs was completed and the extermination has been completed. Going forward the company will conduct quarterly inspections or more frequently if pests are seen.	

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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	V 736	V736 continued: individual responsibility to keep their living environment clean and neat and free of odor at all times, tables have been repaired and reposition to remove the possibility of someone being injured by the low hanging chandelier, ash trays have been purchased for outside smoking in the designated areas, trash has been placed for pick up and extermination has been 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	V 736		

the facility
- had reported the mouse to the Administrator
- had not seen any other containers to dispose of the cigarettes outside the facility, so she used plastic coffee cans
- the Administrator/Licensee was the person responsible for repairs for the facility
- the Administrator/Licensee came to the facility 2-3 times a week to take clients to doctor appointments.
- the Administrator/Licensee was not at the facility long when she came

Interviews between 5/20/22 and 5/27/22 staff #2 reported:
- the basement ceiling had leaked around January 2022.
- thought the Administrator/Licensee had had someone fix the leak.
- the smoke alarm had gone off intermittently since January 2022
- had informed the Administrator/Licensee of the fire alarm and someone came to look at the alarm

Interviews between 5/19/22 and 5/24/22 the Qualified Professional (QP) reported:
- came to the facility once or twice a month
- the facility Administrator/Licensee was responsible for facility repairs
- when she visited the facility, she did tour the facility for the purpose of engaging with the clients
- was not focused on the physical environment during the facility tour
- was not aware of the fire alarm system going off intermittently

Interviews between 5/24/22 and 5/27/22 the Administrator/Licensee reported:
- was aware that the facility had roaches and

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V 736	Continued From page 70 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 736		
V 738	27G .0303(d) Pest Control 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	V 738		

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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	V 738		

- the facility did not have a "rat problem, there was no rat."
- did not know why people said there was a "rat."
- the facility had requested treatment from the pest control company, but she did not know when they were scheduled.

Interview on 5/23/22 with the pest control company customer service manager reported:
- they had done an evaluation on the facility on 5/7/22.
- they assessed the facility had a roach infestation.
- they left treatment plan recommendations with staff #1 to give to the Administrator/Licensee .
- they had not been contacted for service/treatment since their visit on 5/7/22.

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.