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V 000	INITIAL COMMENTS An annual survey was completed on July 22, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency. This facility is licensed for 8 and currently has a census of 7. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's	V 105		

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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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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on observation & interview the facility failed to delegate management of authority for the operation of the facility. The findings are: Observation & interview on 7/15/22 at 10:52am revealed: - client #4 opened the facility's door - he was the only one at the facility - the Program Director (PD) had been out sick since 7/13/22 - he gave staff #1 and staff #2's personal contact information During interview on 7/15/22 at 10:54am with staff #1 reported: - had appointments all day and could not meet - informed to contact the PD or staff #3 - the PD was available even though she was not at the facility During interview on 7/15/22 at 11:10am staff #1 reported: - he contacted the PD & she was supposed to make contact During interview on 7/15/22 at 1:10pm staff #1 reported: - had appointments & the PD was supposed to make contact - he would reach back out to the PD During interview on 7/15/22 at 1:14pm the PD reported: - 3 staff worked at the facility which included her - staff #1 had appointments all day	V 105		

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V 105	Continued From page 3 - staff #2 & #3 were off work - she had been out of work since 7/13/22 & could not return until her physician released her - there were no other staff to assist with the survey - they needed to hire more staff	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 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	V 108		

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V 108	Continued From page 4 clients. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 3 of 4 current staff' (#1, #2 & Program Director) & 1 of 1 former staff (FS#4) had current first aid and cardiopulmonary resuscitation (CPR). The findings are: Review on 7/22/22 of staff #1's personnel record revealed: - no signed job description - first aid/CPR expired February 2020 Review on 7/20/22 of staff #2's personnel record revealed: - date of hire: 9/18/15 - first aid/CPR expired 1/14/22 Review on 7/22/22 of FS#4's personnel record revealed: - date of hire: 2/28/22 - no date of separation - no documentation of first aid/CPR Review on 7/20/22 of the Program Director (PD)'s personnel record revealed: - date of hire: 2001 - first aid/CPR expired 1/14/22 During interview on 7/20/22 the PD reported: - she was responsible for ensuring staff received trainings - FS#4's last day was 5/30/22 - staff worked alone on the shifts	V 108		

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V 108	Continued From page 5 - would schedule staff for first aid/CPR this weekend	V 108		
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 accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facilty failed to ensure fire and disaster drills were completed quarterly and repeated on each shift. The findings are: During interview on 7/20/22 client #2 reported: - admitted October 2021 - he could recall 100% one fire drill being done - does not recall a tornado drill being done - in case of a tornado, he would go inside a room with no windows During interview on 7/20/22 staff #1 reported: - the fire and disaster drill logs were kept at the	V 114		

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V 114	Continued From page 6 facility - he completed fire and disaster drills - for fire drills the clients met across the street - tornado drills the clients got down in the hallway During interview on 7/22/22 staff #3 reported: - had worked at the facility for 4 years - was part time and worked every other Saturday - had not completed any fire or disaster drills During interview on 7/20/22 the Program Director reported: - the fire & disaster drill logs were kept off site at their office - staff #1 completed a fire and disaster drill last week	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 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	V 118		

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V 118	Continued From page 7 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 record review and interview the facility failed to administer medications on the written order of a physician & failed to allow a client to self administer when authorized by a physician for 1 of 3 clients (#5). The findings are: Review on 7/20/22 of client #5's record revealed: - admitted 1/18/22 - diagnosis of severe Alcohol use - no documentation of physician orders Review on 7/20/22 of client #5's May, June & July 2022 MARs revealed the following medications: - Sertraline 50mg (milligrams) bedtime (depression) - Naltrexone 50mg daily (prevent relapse) - Gabapentin 600mg three times a day (seizure) (7am, 3pm & 10pm) - Mirtazapine 30mg bedtime (depression)	V 118		

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V 118	Continued From page 8 During interview on 7/20/22 staff #1 reported: - client #5 was not at the facility for the 3pm medication due to his work schedule - the Gabapentin was placed in a Ziploc bag in the morning & given to him to take to work - he self administered the medication - he was not sure if there was a self administration order During interview on 7/20/22 the Program Director reported: - she could not locate the self administration order for client #5 - would follow up with client #5's physician for self administration order & the physician orders for the medications	V 118		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance	V 290		

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V 290	Continued From page 9 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 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 interview the facility failed to ensure a minimum of one staff remained on the premises. The findings are: Record review on 7/20/22 of the clients' records revealed: - 3 audited clients: #2, #5 & #6 - admission dates between 10/14/21 & 6/15/22 - diagnoses of Methamphetamine, Alcohol, Opiates and Cannabis Disorders	V 290		

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V 290	Continued From page 10 - varying unsupervised times between 4 and 9 hours a day in the home and community for employment reasons During interview on 7/22/22 client #2 reported: - there were no staff after 10:30pm - lights out for clients at 10:30pm - an automatic alarm came on at 11pm - clients do not have the code to the alarm system - he was the contact person during the day if clients needed anything, however, was not contacted for any reason During interview on 7/20/22 client #5 reported: - staff #1 & #2 worked at the facility - staff arrived at the facility around 5pm and left at 10:30pm - there were no overnight staff During interview on 7/15/22 & 7/20/22 staff #1 reported: - had worked at the facility since 2015 - worked from 2pm - 10:30pm on Friday and Saturdays & 5pm - 10:30pm weekdays - he and staff #2 alternated days - client #2 was the live-in contact person - management was looking for overnight staff but it had been difficult - on 7/15/22 he agreed to stay overnight until permanent staff was hired - on 7/20/22 the live-in staff quit one day this week & planned to meet with management to negotiate terms for the overnight staff position During interview on 7/22/22 staff #3 reported: - worked every other Saturday from 1:30pm - 10:30pm - had a live-in staff but passed away in October 2021	V 290		

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V 290	Continued From page 11 - hired (Former Staff) FS#4 but he quit 2 - 3 months ago - he had not worked in the last 2 - 3 weeks - no staff relieved him at 10:30pm - he completed a bed check prior to his departure at 10:30pm - an automated alarm came on after he left - the clients were responsible and interested in the program During interview on 7/15/22, 7/20/22 & 7/22/22 the Program Director (PD) reported: - it was difficult to find live-in staff since the death of a FS in October 2021 - FS#4 quit in May 2022 - all the clients had unsupervised time during the day due to employment - on 7/22/22 staff #1 did not work out as the overnight staff During interview on 7/22/22 the Executive Director reported: - worked daily from 8am- 5pm - it had been difficult to find overnight staff for the facility - was his idea for a responsible client to be a "contact person" until FS#4 could be replaced - client #1 was to notify management for reasons like: unannounced visitors, sickness & injuries Review on 7/15/22 of the Plan of Protection dated 7/15/22 written by the Program Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? There will be staff overnight 7 days a week starting 7/15/22. Describe your plans to make sure the above happens. [PD] will have staff available for the night shift until someone permanent can be hired."	V 290		

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V 290	Continued From page 12 Review on 7/25/22 of the Plan of Protection dated 7/22/22 written by the Executive Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The Executive Director will work with the Program Manager to identify a qualified staff person to occupy the back room overnight. This action will begin 7/22/22 and the qualified staff person will remain in the position temporarily until a permanent replacement is hired and trained. Describe your plans to make sure the above happens. The Executive Director will work with the Program Manager to ensure a qualified staff person is identified today and is in place on 7/22/22. The Program Manager will make a visit to the facility on 7/22/22 to ensure this occurs." Clients were admitted to the facility with diagnoses of Methamphetamine, Alcohol & Opiate Disorders. There was no overnight staff for at least 5 months between October 2021 & July 2022. Staff arrived at varying hours during the day, however their shift ended at 10:30pm in which they left the facility. Client #1 was left in charge of himself & 6 others, in case of any emergencies with no staff supervision. Due to the failure to have clients supervised overnight for at least 5 months, this deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. Administrative penalty of $3,000 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 290		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int.	V 536		

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V 536	Continued From page 13 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior;	V 536		

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V 536	Continued From page 14 (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-015	A. BUILDING: _____ B. WING _____	07/22/2022

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V 536	Continued From page 15 (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time.	V 536		

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V 536	Continued From page 16 (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 3 of 4 current staff' (#1, #2 & Program Director) & 1 of 1 former staff (FS#4) had alternatives to restrictive interventions refresher training on an annual basis. The findings are: Review on 7/22/22 of staff #1's personnel record revealed: - no signed job description - alternatives to restrictive intervention expired 2/28/19 Review on 7/20/22 of staff #2's personnel record revealed: - date of hire: 9/18/15 - alternatives to restrictive intervention expired 3/31/21 Review on 7/22/22 of former staff #4's personnel record revealed:	V 536		

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V 536	Continued From page 17 - date of hire: 2/28/22 - no documentation of alternatives to restrictive intervention Review on 7/20/22 of the Program Director (PD)'s personnel record revealed: - date of hire: 2001 - alternatives to restrictive intervention expired 3/6/20 During interview on 7/20/22 the PD reported: - she was responsible for ensuring staff received training for alternatives to restrictive intervention - she would get staff scheduled for alternatives to restrictive intervention	V 536		