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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE-BLACKLEY FELLOWSHIP HOME	110 SOUTH LAYTON AVENUE DUNN, NC 28334

(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 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		

DHSR - Mental Health
AUG 17 2022
Lic. & Cert. Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia White, CADC | TITLE: Program Director | (X6) DATE: 8-8-22

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

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 8, 2022

Patricia Hite, Program Director
Program Resource Institute, Inc.
PO Box 747
Lillington, NC 27546

Re: Annual Survey completed July 22, 2022
Elmore-Blackley Fellowship Home, 110 South Layton Avenue, Dunn, NC 28334
MHL #043-015
E-mail Address: pathite@embarqmail.com, tedcfitz@aol.com

Dear Ms. Hite:

Thank you for the cooperation and courtesy extended during the Annual survey completed July 22, 2022 survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Type A1 rule violation is cited for 10A NCAC 27G .5602 Staff (V290).
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Type A1 violation must be ***corrected*** within 23 days from the exit date of the survey, which is August 14, 2022. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against Program Resource Institute, Inc. for each day the deficiency remains out of compliance.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is September 20, 2022.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Renee Kowalski at (919) 552-6847.

Sincerely,

Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR_Letters@sandhillscenter.org
Pam Pridgen, Administrative Supervisor

Division of Health Service Regulation
Mental Health Licensure and Certification Section
Rule Violation and Client/Staff Identifier List

Facility Name: Elmore-Blackley Fellowship Home MHL Number: 043-015
Exit Date: 7/22/22 Surveyor: Rhonda Smith

EXIT PARTICIPANTS: [redacted] (Program Director) & [redacted] (Executive Director)

COVID NOTIFICATION: In the event a COVID positive case is identified within 48 hours of a DHSR survey – the provider or DHSR should notify the other entity to prevent possible continued exposures.

Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0201 GOVERNING BODY POLICIES (V105) standard

Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108) standard

Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (V114) standard

Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118) standard

Rule Violation/Tag #/Citation Level: 10A NCAC 27G .5602 STAFF (V290) (Type A)

Rule Violation/Tag #/Citation Level: 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (V536) standard

Client & Staff Identifier List
(Indicate staff title or number beside each name)

[redacted]

CITATION LEVEL: Number of days from survey exit for citation correction
Standard = 60 days **Recite** – standard = 30 days **Type A** = 23 days **Type B** = 45 days
Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date

Facility Name: Elmore-Blackley Fellowship Home, 110 South Layton Avenue, Dunn, NC 28334
MHL #043-015

Provider Contact Person for Follow-up: [redacted] Program Director

Phone: 910-892-6017 Fax: 910-892-6020 Email: [redacted]

Re: Annual Survey completed July 22, 2022

PLAN OF CORRECTION: 10A NCAC 27G .0201 Governing Body Policies Date Corrected: 8/16/22

- (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.) Client's charts have been noted to include they are capable of remaining in the facility without supervision and this will be reviewed at a minimum annually for clients in need of additional time at the facility. Program Director will continue to collaborate with referring agencies to assure client is capable of remaining in the home or community without supervision prior to admittance.
- Clients have been advised unless they are expecting a visitor to only allow staff to answer the door. Annual and State inspections will be facilitated by staff only. Staff on call can arrive at the facility within 30 minutes once contacted. Contact information is posted on the front door of facility.
- Program Director [redacted] will monitor the situation to ensure contact information will be in place and staff available on call to assist 24/7.
- Monitoring will occur daily.

PLAN OF CORRECTION: 10A NCAC 27G .0202 Personnel Requirements Date Corrected: 8/16/22

- First Aid and CPR training took place on 8/5/22 all staff attended with the exception of Hameed Shareef referenced as Staff #3. Staff person will not work until training has been completed. NCI National Crisis Intervention Plus was offered and all staff attended. Trainings have been documented and in staff files.
- Online calendar will include trainings to schedule.
- Monitoring will take place monthly by Program Director Patricia Hite.

PLAN OF CORRECTION: 10A NCAC 27G .0207 Emergency Plans and Supplies Date Corrected: 8/22/22

- Fire and Disaster Drill Log is on site in Director's office. Drills are entered quarterly as conducted on each shift. All staff are trained on conducting drills.
- Posted schedule for quarterly drills and reminder note will be added to staff time sheets for quarterly drills. Initial drill guidance will be given to new staff at orientation.