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WOMEN AND CHILDREN FIRST	**12 TUPPER ROAD RIDGECREST, NC 28770**

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 9/2/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .4300 Therapeutic Community. This facility is licensed for 65 and currently has a census of 36. The survey sample consisted of audits of 5 current clients.	V 000		
V 106	27G .0201 (A) (8-18) (B) 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: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for	V 106		

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facility areas including special client activity areas; and
(18) client grievance policy, including procedures for review and disposition of client grievances.
(b) Minutes of the governing body shall be permanently maintained.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to implement their medical preparedness policy to be utilized in a medical emergency. The findings are:

Review on 8/31/22 of Client #7's record revealed:
-Date of admission: 5/6/22;
-Diagnoses: Cannabis Use Disorder (D/O) severe, Amphetamine Use D/O, severe, Major Depressive D/O, recurrent, and severe, and Post Traumatic Stress Disorder;
-no medical issues noted from admission;
-consent for treatment signed on 5/6/22 "to be referred to the nearest emergency room and be transported by emergency personnel in the event of an emergency."

Review on 8/30/22 of the House Manager (HM) #1's staff record revealed:
-Date of Hire: 12/20/21;
-Job Title: House Manager:
-"Performance Responsibilities:
 1. Responsible for ensuring that patients receive all appropriate services;
 3. Provides residents with appropriate paperwork for referrals to ...medical appointments
...

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5. Coordinates transportation ...
9. Along with the Administrative Director ...assures implementation of ...client safety."

Review on 8/30/22 of the Counselor's staff record revealed:
-Date of Hire: 11/1/21;
-Job Title: Admissions Assistant;
-Counselor since June 2022.

Review from 8/30/22 to 9/1/22 of facility incident reports revealed:
-8/20/22, at 9:00pm, "[Client #12] was in the smoke pit and had a seizure ...911 was called ...Paramedics came and checked her vitals, made sure she was stable, and gave her choice to go to the hospital;"
- 8/21/22, "[Client #7] was transported to the Emergency Department (ED) at 9am after [Client #6] reported to the office that she appeared disoriented and could not talk ....[FIRST] (Women and Children FIRST) transported to ED where she was admitted to the hospital for surgery ... blood clot on brain and mild stroke."
-attached to the incident report were written client statements of what happened on 8/21/22, entitled "Resident Clean Up Reports" and Client #7's most recent medical appointment.

Review on 9/1/22 of Client #6's written statement, entitled, "Resident Clean Up Report" dated 8/23/22 revealed:
- 8/21/22 at the smoke pit, "she (Client #7) looked over at me (Client #6)...and in a slurred or groggy voice asked me...for one of those (a cigarette)....and she had trouble striking the lighter;
-[Client #7] was trying to speak but couldn't..she looked disoriented and scared...she began to cry;
-[Client #12] ran to get [HM #1]...and we (Client

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#6, #12) told [HM#1] that something was definitely wrong, possibly a stroke, ...and [HM #1] told [Client #9] to go get a van, pull around and get her (Client #7);
-we, (Client #'s 6, 8, & 9) rushed her (Client #7) to the local emergency room (ER);
-the attending (physician) immediately came...went to an exam room...and a stroke team came in and started an IV and took her for an ultrasound and scan of her head;
-the surgeon asked me (Client #6) if she (Client #7) had any family in the area... because [Client #7] had a stroke and had a large blood clot on brain that required emergency surgery..and they were doing it immediately;
-he said he (surgeon) was giving consent as her physician to do the life-saving procedure...and immediately took her to surgery;
-they successfully removed the clot ...and they wouldn't know the extent of the damage until she was out of the ICU (intensive care unit);
-around 3-4pm, [Counselor] and [staff driver] came to the hospital to pick me (Client#6) up."

Review on 9/1/22 of Client #9's written statement, entitled, "Resident Clean Up Report" dated 8/23/22 revealed:
-"when I came back from my morning run on Sunday [Client #7] had made her way to the smoke pit, when I tried speaking to her (Client #7) ...she couldn't respond;
-I (Client #9) could only see tears in her eyes ...we got her to the hospital as quickly as we could ...the right side of her face seemed off;
-once we got her to the hospital, they immediately checked her out ...asking her to smile and she was unable to ...they took her back right away."

Review on 9/1/22 of email forwards dated 8/21/22 at 9:05 am and 11:06 am from HM #1 to the Case

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Manager, men and women's facility medical staff, the Administrative Director (AD) and the Executive Director (ED) revealed:
-"[Client #7] was sent to the ER (emergency room) today 8/21/22 at 9:00AM ... Veteran [Client #12] came into the office and said that [Client #7] was acting disoriented and couldn't talk ...I sent LT (long term) [Client #6] with her as a strength (peer support) ..."
-"[Client #6] just called with an update on [Client #7] ...[Client #7] has had a mild stroke and has a blood clot on her brain and they are taking her for emergency surgery right now ...They say the surgery can take anywhere from 45 minutes to 2 hours ...[Client #6] said that she will stay at the hospital till the surgery is complete ...I will send an update as soon as I have one."

Review on 9/1/22 of the facility's "Emergency Procedures Checklist" revealed:
-written procedures for 16 different types of emergencies that could occur at the facility including, medical emergency, natural disaster, missing consumer, and bomb threat etc., with corresponding color codes for each;
-"Code Blue" is for Medical Emergency with 11 steps to be followed by staff:
-"Step 1. Respond immediately;
-Step 2. First staff member on the scene assumes control of the facility's initial response. Call for help;
-Step 3. Announce Code BLUE, a medical emergency is occurring in the facility ...staff respond immediately;
-Step 4. Implement the Incident Command System (ICS) by assigning the most qualified staff member on duty at the time to assume the ICS Commander position ...the ICS commander position sets the incident response objectives, strategies, and priorities;

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-Step 5. All consumers are considered to be a full code unless consumer has do not resuscitate (DNR) ...DNR does not allow withholding of ...basic first aid;
-Step 6. Assess the consumers condition;
-Step 7. If the consumer appears to be in crisis, call 911 immediately;
-Step 8. Stay with the consumer and provide care to the level of your training;
-Step 9. When additional staff arrive, assign the following duties ...gather consumer emergency information, Face sheet, DNR status, Medication Administration Record (MAR), and insurance cards ...notify Administrative Director if they are not already on the premises;
-Step 10. Upon the arrival of emergency medical personnel, present any medical charts and DNR orders if applicable;
-Step 11. Provide emergency personnel with a concise, factual account of events and all treatment efforts."

Interview on 8/31/22 with Client #6 revealed:
-she saw Client #7 at the "smoke pit" in the morning with her head down;
-Client #7 "wasn't really responding ...had trouble lighting a lighter"
-she and other residents asked Client #7 if she was OK and she couldn't really speak so they went inside to get HM #1;
-"no one could get her to respond" so they "immediately took her to the emergency room"
-HM #1 told Client #9 to get the van and take Client #7 to the emergency room;
-HM #1 told her to go with Client #7 to the hospital; she sat next to Client #7 in the van;
-Client # 9 drove the van and Client #8 sat in the front seat;
-there was no staff person in the van with them;
-she waited at the hospital with Client #7; she

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didn't know anything about Client #7's medical history
-the doctor informed her that Client #7 had a blood clot on her brain and needed emergency surgery;
-the doctor signed the medical consent for surgery;
-she called the facility about 45 minutes later, and told HM #1 that Client #7 had a blood clot and was in surgery;
-she thought they would send her to the hospital initially and a staff person would relieve her;
-there were no facility staff at the hospital with her or Client #7 until the Staff Driver and the Counselor came to pick her up at approximately 4:00pm.

Interview on 9/1/22 with Client #8 revealed:
-has been at the facility since 8/8/22;
-she went outside to smoke, and Client #7 came out to the smoke pit; another girl was trying to ask her if Client #7 was "ok;" Client #7 wasn't responding;
-"we took her (Client #7) to the ER"
-she sat in the front seat next to Client #9 who was driving; "any time a female leaves the facility, it's part of the rules to have someone else go with you"
-has not heard codes being called ..."there was another emergency when (Client #11) had a seizure."

Interview on 9/1/22 with Client #9 revealed:
-had been at the facility for 4 months;
-noticed the day before Client #7 was taken to the hospital that her eye wasn't moving; she wasn't sure if Client #7 asked to go to the hospital the day before;
-on the morning (8/21/22) that Client #7 was taken to the hospital, Client #7's "face looked

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droopy and looked like she had a stroke" ...said "do you want to go to the hospital;"
-went to get the van; drove the van to the hospital with Client #7, Client #8 and Client #6;
-"don't think [Staff Driver] would have taken her;"
-HM #1 and the Counselor were at the facility on date of incident; "it was a Sunday ...I do remember her [Counselor] being here ...her and [HM #1] came out to the smoke pit;"
-"a staff member should have gone with us instead of sending 3 clients ....she was in bad shape;"
-she did not have medical training as a client driver;
-had not heard Code Blue or Code Green called over the intercom.

Interview on 9/1/22 with the HM #1 revealed:
-was in the office 2-3 weeks ago when a client came in to tell her something was wrong with Client #7;
-she went out to see Client #7; Client #7 couldn't speak;
-Client #9 was "right there" (near Client #7) so she told her to get the van and take Client #7 to the hospital;
-HM #1 made the decision to send Client #7 by facility van and not call EMS (emergency medical services);
-called the men's house to make sure they could get a vehicle;
-sent a "client driver" (Client #9) to take Client #7 to the hospital because it took EMS so long to arrive the night before;
-the previous night, another client had what appeared to be a seizure; she called EMS and it took them approximately 45 minutes to arrive;
-she sent an "indigent letter" which was sent with a client when they had a doctor visits; the letter had reasons for the doctor visit, MARs;

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-the incident with the seizure was the first time she had to call EMS;
-had "probably" seen the emergency procedures policy; "don't know anything about code blues"
-after Client #7 left the facility, she sent an initial email to the Case Manager, the men and women's facility medical staff, the AD and the ED; she sent additional emails to the same staff with updates on Client #7's condition;
-was not by herself on the weekend; other staff lived on campus, but she was the "only one up"
-"[Counselor] lives here and [Admission's Assistant] too ...[staff driver] and myself"
-if there was a problem, she could call the Counselor or the Admission's Assistant.

Interview on 9/1/22 with HM #2 revealed:
-hired as the HM when she graduated from the program in May 2021;
-HM #3 did most of her training;
-she had not seen the facility's emergency checklist before;
-she was trained in fire and disaster drills and when to call EMS.

Interview on 9/1/22 with HM #3 revealed:
-spoke with the ED today; there was an emergency policy; "we do know the procedures to follow for an emergency and calling 911;"
-the ED will bring her the policy and they will keep a written copy in the house manager's office.

Interview on 8/31/22 with the Counselor revealed:
-had been in the clinical role for 3 months; was previously the Admission's Assistant at the facility for a year;
-lived at the facility;
-on the morning that Client #7 was taken to the ER, "girls came running in from outside ...[Client #7] couldn't form two words together;"

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-EMS was not called to take Client #7 to ER because the night before, it took approximately 45 minutes for EMS to arrive when another client appeared to be having seizure;
-Client #9 was "right there so we had her drive them;"
-for medical emergencies, "depends on what kind of emergency; if seizure, call an ambulance, if cut or scrape, drive them to the ER."

Interview on 9/1/22 with the AD revealed:
-had been the AD for 3 months; prior to becoming the AD, she was over the admissions process for the men and women's program;
-on weekends, there was one house manager per shift in the house; there were usually five staff on property (lived on site);
-received a phone call when Client #7 was on her way to the hospital and email updates from HM #1;
-the emergency policy "is not realistic ...most of our staff don't have it memorized;"
-"have not had a medical situation that severe ...it did need to be EMS ....to come and make that decision ...due to liability ...something could have happened in transport;"
-a client had a seizure the night before Client #7 was taken to the hospital; EMS was called to the facility to evaluate her (Client #11) and cleared her;
-was working on a document addressing medical emergencies and will post in medical office and house manager's office.

Interview on 9/1/22 with the ED revealed:
-most house managers were in that role when they were a client; HM #3 was the senior house manager and most responsible for selecting new HM;
-HM #3 trains the house managers on fire and

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safety drills and the "policy is essentially similar for missing client, weather event, smell of gas ...;"
-can't say if HM's #1 or #2 have seen the emergency policy;
-he was called and emailed on the day Client #7 was taken to the ER;
-if a client is identified as a driver while they are here (have a license), they run their MVR (motor vehicle record) and driving was their job while they were a client;
-wasn't aware that EMS was called for a client having a seizure the night before Client #7 was driven to the hospital.

Review on 9/2/22 of the Plan of Protection written by the Executive Director and dated 9/2/22 revealed:

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

[Executive Director] and [Administrative Director] will review the emergency procedure plan with the staff on duty 9/2/22 and ensure that all staff are properly trained on emergency procedures, including emergency medical procedures. Staff will be informed to contact EMS (Emergency Medical Services) by calling 911 in the event that there is an emergency incident at the facility that requires transportation to a medical provider. Training will take place to ensure clients are not placed in transportation situations when staff is not present.

Describe your plans to make sure the above happens.

[Executive Director] and [Administrative Director] will review the emergency plan with staff on duty 9/2/22 and ensure that the staff on duty between

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V 106	Continued From page 11 9/3/22 and 9/5/22 are aware of the emergency procedures and to call 911 in the event of an incident that requires transportation to a medical provider. Staff-wide training will be conducted on 9/6/22 on the emergency procedure plan and checklist. Any staff unable to be present on 9/6/22 will be trained at the early possible time, and before they are on duty for the next shift. All staff will be informed and trained on how to contact EMS in an emergency situation." Women and Children FIRST is licensed as a therapeutic community that serves women with substance use disorders that promotes employment, recovery, and life skills through a structured living environment with peer supports. This program also serves women as an alternative to incarceration. Client #7 had a medical emergency on 8/21/22, where she was observed by clients and staff not able to talk, her face was drooping, and appeared to be having a stroke. House Manager #1 had three current clients transport Client #7 to a local emergency room without staff, instead of calling 911. At the hospital, Client #7 was assessed and taken into emergency surgery for a blood clot on her brain. There was no staff present at the hospital with Client #7 until the following day on 8/22/22. Client #7 was still at the hospital at the time of exit on 9/2/22. The emergency procedures checklist was not being utilized by the facility and the house managers have not seen or been trained on the facility's written procedures to follow in the event of a medical emergency. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An Administrative penalty of $6,000.00 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	V 106		

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V 106	Continued From page 12 facility is out of compliance beyond the 23rd day.	V 106		
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 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.	V 118		

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This Rule is not met as evidenced by:
Based on record reviews, observation, and interviews, the facility failed to administer medications only on the written order of a physician, follow the written order of a physician, and keep the MAR current affecting 3 of 5 audited clients (Clients #1, #2 and #4). The findings are:

Review on 8/30/22 of Client #1's record revealed:
-Date of admission: 3/21/22;
-Diagnoses: Opioid Use Disorder (D/O), severe, heroin; Methamphetamine Use D/O, severe; Tobacco Use D/O, moderate; Bipolar I D/O, current or most recent episode manic, moderate; Adjustment D/O w/Mixed Anxiety and Depressed Mood and a rule out for Post-Traumatic Stress Disorder.

Review on 8/30/22 of Client #2's record revealed:
-Date of admission: 5/18/22;
-Diagnoses: Opioid Use D/O, severe; Cocaine Use D/O, severe, in early remission, in controlled environment; Amphetamine Use D/O, severe, in early remission, in controlled environment; Tobacco Use D/O, moderate; Post-Traumatic Stress D/O (PTSD).

Review on 8/30/22 of Client #4's record revealed:
-Date of admission: 5/31/22;
-Diagnoses: Amphetamine Substance Abuse D/O, Severe Methamphetamine, in early remission; Tobacco Use D/O, moderate.

Review on 8/30/22 of physician orders for Client #1 revealed:
-Buprenorphine (opioid maintenance therapy) 2mg (milligram), dissolve 1 tablet under tongue

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once daily for 5 days ordered 6/27/22;
-Buprenorphine 2mg, dissolve 1 tablet under tongue twice daily for 7 days ordered 7/8/22;
-Buprenorphine 2mg dissolve 1 tablet under tongue every morning; dissolve 2 tablets under tongue every evening for 14 days ordered 7/15/22;
-Buprenorphine 2mg, dissolve 2 tablets under tongue BID (twice daily) for 14 days ordered 7/29/22 and 8/26/22;
-Buprenorphine: for next 14 days, take 1 2mg tablet and ½ of 8mg tablet BID for total daily dose of 12mg; when out of 8mg tablets, take 3 2mg tablets BID for total daily dose of 12mg ordered 8/26/22;
-Bupropion (smoking cessation), 300mg one tablet every morning.

Review on 8/30/22 of Client #1's MARs dated 6/1/22-8/29/22 revealed:
-there was no dosage documented on the June MAR for Buprenorphine, place one tablet under tongue and allow to dissolve once daily for 5 days documented as administered from 6/28/22-6/30/22.
-there was no dosage documented on the July MAR for Buprenorphine, one tablet under tongue and allow to dissolve once daily for 5 days; the administration instructions for "once daily for 5 days" was crossed out and replaced with "twice daily for 7 days;"
-the Buprenorphine with the changed administration instructions was administered once daily for 9 days (7/1/22-7/8/22, 7/15/22) and twice daily for 6 days (7/9/22-7/14/22)
-Buprenorphine 2mg dissolve 1 tablet under tongue every morning; dissolve 2 tablets under tongue every evening for 14 days was documented as administered for 16 days from 7/16/22-7/31/22

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-the following medications were administered without a written physician order:
-Furosemide (edema), 20mg, one tablet daily for 14 days administered 8/12/22-8/26/22
-Clindamycin 1-5% (acne), apply to affected area BID (twice daily) administered 7/26/22-8/30/22
-Buprenorphine 2mg, dissolve 1 tablet under tongue BID administered 8/1/22-8/30/22.
-Buprenorphine 8mg, dissolve ½ tablet under tongue BID administered 8/12/22-8/30.

Observation at 11:55am on 8/31/22 of Client #1's medications revealed:
-Buprenorphine 2mg, take one 2mg tablet and one half (8mg) for 14 days; when out of 8mg, take 3 2 mg tablets twice daily for total of 12 mg, dispensed 8/26/22;
-Buprenorphine 8mg, dissolve ½ tablet under tongue BID dispensed on 8/12/22;
-Clindamycin 1-5%, apply to affected area BID dispensed 8/11/22;
-Bupropion, 300mg one tablet every morning dispensed 7/2922.

Review on 8/30/22 of Client #2's MARs dated 6/1/22-8/29/22 revealed:
-Junel (birth control), 1mg/20mcg (microgram), one tablet daily was administered 7/28/22-8/29/22 without a written physician order.

Review on 8/30/22 of Client #4's MARs dated 6/1/22-8/29/22 revealed:
-Methocarbamol (muscle spasms) 500mg, 2 tablets PRN (as needed) for 7 days administered on 7/21/22 and 7/22/22 without a written physician order.

Interview on 8/31/22 with Client #1 revealed:
-if she needed to see a doctor, she put in a request to the House Manager (HM) #1; she is

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the medical case manager;
-has had no problems with her medications;
-sometimes [local medical provider] "will put a medication on the orders but not call it in to the pharmacy;"
-was "trying to taper off Subutex" (buprenorphine).

Interview on 8/31/22 with Client #2 revealed:
-the HM #1 was "put in the medicine position ... there wasn't really any training;"
-one time she ran out of medication (Buspirone); the doctor wrote it for once a day but she was taking it three times daily;
-she did her part with putting in the request for refill; she was out of it for two days but had no side effects.

Interviews on 8/31/22 and 9/1/22 with the HM #1 revealed:
-she had been in the role of medical case manager since the 3rd week of July 2022;
-knew the process but was still learning the paperwork;
-the medical case manager at the men's house was training her on how to do "prescription refills, flow and MAR sheets, how to recognize proposals, who we work with, who to call;"
-typed the MARs each month;
-when clients were admitted, she hand wrote the MAR and then typed it the following month;
-if a new prescription was added during the month, she handwrote it on the MAR;
-Client #1 started on buprenorphine 3 months after she was admitted; the dosage changed frequently;
-Client #1's insurance did not cover the 8 mg of buprenorphine; once she finished the current supply of the 8mg tablets, the doctor wrote an order to take 3, 2mg tablets twice daily for a total

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of 12mg;
-Client #1's Furosemide was started as a daily pill at the last doctor visit but the doctor did not call in the prescription after the visit; the prescription was filled yesterday and she will pick it up from the pharmacy today.

Interview on 9/1/22 with the Administrative Director (AD) revealed:
-HM #1 was new to her role in medical; she is still in that process for training; working with [staff] who runs the medical department with the men's program.

Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.

This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

V 736 — 27G .0303(c) Facility and Grounds Maintenance — V 736

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 was not maintained in a safe, clean, and orderly manner. The findings are:

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V 736	Continued From page 18 Observation of the facility on 8/30/22 between 2:30pm and 3:00pm revealed: -in the kitchen, there was a patched floor tile in front of the refrigerator that was crumbling, making the floor uneven; -moisture and mildew spots appeared above a client shower downstairs in the facility; -there was a cracked mirror above the sink in a client bedroom downstairs; -the wall in a client bedroom downstairs needed to be repainted from where pictures had been ripped off the wall. Interviews from 8/30/22 to 9/2/22 with the Executive Director revealed: -there had been ongoing facility improvements being made and the tile in the kitchen would be repaired within in the next month.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on record review, observation, and interviews the facility failed to maintain the water temperature between 100-116 degrees Fahrenheit. The findings are:	V 752		

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V 752	Continued From page 19 Observation of the facility on 8/30/22 at 2:45PM revealed: -the upstairs art room's bathroom hand sink, room 223, registered at 124 degrees Fahrenheit; -upstairs, room 217's hand sink registered at 130 degrees Fahrenheit; -downstairs, two bedroom hand sinks including room 108, registered at 130 degrees Fahrenheit. Review on 8/30/22 of the local county health department inspection report dated 6/10/22 of the facility revealed: -water temperatures in 7 facility hand sinks were documented above 116 degrees Fahrenheit, ranging from 117 to 120 degrees Fahrenheit. Interviews from 8/30/22 to 9/1/22 with Client #'s 1-4 revealed: -there were no complaints about the water temperature; -they were able to regulate the temperature themselves by hand. Interview on 8/30/22 with the House Manager #2 (HM #2) revealed: -no one had complained about the water temperature; -the county inspector mentioned putting the water temperatures in her report; -there were no facility incidents related to the water being too hot. Observation and interview on 8/30/22 at 3:54PM with the Executive Director (ED) and the Administrative Director (AD) revealed: -the water heater had been set at 120 degrees Fahrenheit and the ED manually lowered it to 110 degrees Fahrenheit in front of surveyors; -the facility would have maintenance staff come	V 752		

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by and re-check the water temperature to make sure it was safe for clients.

Review on 8/31/22 of the Plan of Protection signed by the Administrative Director on 8/31/22 revealed:

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

Presenting Concern: Hot Water Temperature

Immediate Plan of Correction: Staff members [Executive Director] and [Administrative Director] adjusted the temperature on the hot water heater from 120 degrees to 110 degrees on August 30th, 2022 when initially informed of the violation. Our maintenance staff has since checked several times again today to ensure that the temperature is still at 110 degrees.

Describe our plans to make sure the above happens: In addition to the immediate adjustment of the set temperature on the hot water heater, [facility name] maintenance staff will continue to regularly monitor the hot water temperatures in the clients bedrooms and throughout the facility. The maintenance staff will further adjust the set temperature of the hot water heater should it need to be set at a lower setting. Temperature checks will take place daily until a safe and steady temperature is maintained in all rooms."

The women's facility at Women and Children First is a dormitory styled building that has two floors, group rooms, a kitchen and dining room, laundry rooms, and bedrooms with adjoining bathrooms on each level. Three bathroom hand sinks in the facility registered at 130 degrees Fahrenheit

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V 752	Continued From page 21 when initially tested on 8/30/22. Another bathroom hand sink registered at 124 degrees Fahrenheit. The local county health department inspection report dated 6/10/22 noted water temperatures throughout the facility above 116 degrees Fahrenheit. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of 200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 752		