STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-192	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME, INC	2508 SANDERS ROAD WILLOW SPRINGS, NC 27592

(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 8/31/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 2 current clients and 1 deceased client.	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;	V 113	DHSR - Mental Health SEP 23 2022 Lic. & Cert. Section	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-192	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME, INC	2508 SANDERS ROAD WILLOW SPRINGS, NC 27592

(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 113	Continued From page 1 (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain copies of lab test for 1 of 3 audited clients (#3). The findings are: Review on 8/24/22 of client #3's record revealed: - admitted 5/18/20 - diagnoses of Schizoaffective Disorder, Intellectual Developmental Disorder & Bipolar - physician order dated 5/31/22: Clozapine 50mg 2 1/2 bedtime (schizophrenia) - Clozapine levels were last checked May 2022 During interview on 8/30/22 staff #1 reported: - client #3 had his Clozapine levels checked weekly - the documentation was located in his "my chart" through his physician's office - he was not able to print the labs	V 113	Staff was re oriented to understand that the facility needs a copy of all clients lab record to be on file once the lab result is released from the lab. Staff was oriented to ask for a copy of client's labwork report from pharmacy or doctor's office to file in the client records for reference when the need arises. Administrator or designated staff will review client's record quarterly to ensure compliance.	09\30\22 and on going.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-192	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME, INC	2508 SANDERS ROAD WILLOW SPRINGS, NC 27592

(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 113	Continued From page 2 During interview on 8/31/22 the Licensee reported: - staff will obtain a print out of the Clozapine levels from his physician's office - Clozapine levels will be placed in client #3's record	V 113		
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	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-192	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME, INC	2508 SANDERS ROAD WILLOW SPRINGS, NC 27592

(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 118	Continued From page 3 with a physician. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure medications were administered on the written order of a physician & failed to keep MARs current for 1 of 1 deceased client (DC#6) . The findings are: Review on 8/24/22 of Deceased Client (DC#6)'s record revealed: - admitted 9/14/21 and passed away 7/20/22 - diagnoses of Schizophrenia, Hypertension, Diabetes, Alcohol & Cocaine use - physician order dated 5/2/22: Amlodipine 5mg (milligrams) daily (blood pressure) (BP) - physician consultation dated 6/2/22: "blood pressure still elevated - check BP daily" Review on 8/24/22 of DC#6's May 2022 MARs revealed: - no documentation Amlodipine was administered the entire month of May 2022 - June 2022 blood pressures were checked weekly During interview on 8/30/22 the House Supervisor reported: - she could not locate the May 2022 MAR - she and a former staff reviewed MARs - she did not review MARs a lot at this facility, however, thought the former staff did - the Qualified Professional (QP) also reviewed the MARs	V 118	Staff was inserviced to print out hard copy MAR at the begining of the month. Staff was trained to document on the manual MAR and EMAR system to ensure that medication administration is recorded appropriately. Administrator or qualified designated staff will review client's record quarterly to ensure complaince.	09\30\22 and on going.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-192	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME, INC	2508 SANDERS ROAD WILLOW SPRINGS, NC 27592

(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 118	Continued From page 4 During interview on 8/31/22 the QP reported: - it was not her responsibility to review MARs During interview on 8/31/22 the Licensee reported: - it was she and the HS responsibility to review the MARs - staff will document medications in the EMAR (computerized) system and on the hard copy of the MAR Due to the failure to accurately document medication administration, it could not be determined if a client received their medications as ordered by the physician	V 118		
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;	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-192	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME, INC	2508 SANDERS ROAD WILLOW SPRINGS, NC 27592

(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 5 (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. (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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-192	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME, INC	2508 SANDERS ROAD WILLOW SPRINGS, NC 27592

(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 6 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; (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 ensure a Level II incident report was submitted to the Local Management Entity/Managed Care (LME/MCO) within 72 hours. The findings are: Review on 8/24/22 of Deceased Client (DC#6)'s record revealed: - admitted 9/14/21 and passed away 7/20/22 - diagnoses of Schizophrenia, Hypertension, Diabetes, Alcohol & Cocaine use	V 367	s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-192	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME, INC	2508 SANDERS ROAD WILLOW SPRINGS, NC 27592

(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 7 Review on 8/24/22 of a fax dated 7/21/22 submitted to the Division of Health Service Regulation (DHSR) revealed: - DC#6 passed away with unknown causes in the emergency room During interview on 8/31/22 the Qualified Professional reported: - she submitted a report of death to the DHSR - a representative at DHSR complaint unit informed her she did have to notify the LME/MCO - she would complete a level II incident report today (8/31/22)	V 367	Facility QP completed the level 11 incident report. LME\MCO was notified. QP verbalized understanding of including the MCO in the death reporting list and also completing level 11 incident report in the IRIS regardless of client death location. Administrator or designated supervisor will review incident reporting \ client records quaterly to ensure compliance.	09\30\22 and on going.

ULTIMATE FAMILY CARE HOME INC.
817 SOUTH SECOND STREET
SMITHFIELD, NC 27577
Phone: (919) 880-3144. Fax: (919) 550-2163

September 21, 2022

Dear Ms. Smith,

Please see attached plan of correction for the deficiencies noted from the annual survey conducted on August 31, 2022 at our facility with MHL 051-192

Please feel free to email or call me at [redacted] with any questions.

Sincerely,

Administrator
Ultimate Family Care Home Inc.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

September 12, 2022

Lillian Okoro-Ezuma, Administrator
Ultimate Family Care Home, Inc.
817 South Second Street
Smithfield, NC 27577

Re: Annual Survey completed August 31, 2022
Ultimate Family Care Home, Inc., 2508 Sanders Road, Willow Spring, NC 27592
MHL #051-192
E-mail Address: ultimatehealthcare1@gmail.com

Dear Ms. Okoro-Ezuma:

Thank you for the cooperation and courtesy extended during the Annual survey completed August 31, 2022.

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

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is October 30, 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
MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

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@Alliancebhc.org
DHSRreports@eastpointe.net
Joy Futrell, CEO, Trillium Health Resources LME/MCO
Fonda Gonzales, Director of Quality Management, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Supervisor