

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-471</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/02/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  
**EASTER SEALS UCP NC RALEIGH GROUP HO**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**1529 BEN LLOYD DRIVE  
RALEIGH, NC 27604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

V 000 INITIAL COMMENTS

An annual survey was completed on 11/2/22. Deficiencies were cited.

This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.

This facility is licensed for 6 beds and currently has a census of 5. This survey sample consisted of audits of 3 current clients.

V 000

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.

V 118

V118 – RN will complete MedAdmin Trainings with Grou Home Manager and staff at Ben Loyd.

Special attention to med closet check list that will include reviewing expired meds,

In addition, steps to be taken when medication is not in the closet as prescribed.

RN added a requirement in the EMAR for staff to document an explanation if a med is unavailable. This addition was communicated to all the GH Managers via email by QM

12/1/22

DHSR - Mental Health

DEC 02 2022

Lic. & Cert. Section

NATURE TITLE (X6) DATE  
11/23/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-471</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/02/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>EASTER SEALS UCP NC RALEIGH GROUP HO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1529 BEN LLOYD DRIVE RALEIGH, NC 27604</b>
---	--

(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	<p>Continued From page 1</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting two of three audited clients (#2,#5). The findings are:</p> <p>Review on 11/01/22 of client #5's record revealed: - Admitted: 9/21/22 - Diagnoses :Moderate Intellectual Disability, Autistic Disorder, Cerebral Palsy, &amp; Encephalopathy - Physician's orders dated 8/29/22 for Ibuprofen 200mg- Take 1 tablet by mouth every six hours as needed for pain</p> <p>Observation on 11/01/22 at 11:00am revealed: -Ibuprofen 200mg expired 9/21/21</p> <p>Review on 11/01/22 of client #2's record revealed: - Admitted : 9/7/17 - Diagnoses: Intellectual disability moderate, Hypertension Diabetes, High Cholesterol - Physician's orders dated 5/9/22 - Terbinafine 250mg-take 1 tablet by mouth every day - Benzonatate 100 G Cap- take 1 capsule by mouth three times daily as needed for cough - Jobst Knee-hi small/regular- Put on in the</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-471</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/02/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER <b>EASTER SEALS UCP NC RALEIGH GROUP HO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1529 BEN LLOYD DRIVE RALEIGH, NC 27604</b>
---	--

(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 2 morning and remove at bedtime  Observation on 11/1/22 at 11:30am revealed: None of the above listed medication were present in the home  Interview on 11/2/22 the Qualified Professional : - She has addressed the medication refills, will address again with new staff - Checks the medication and the QuickMAR weekly - The QuickMAR doesn't inform when medications are low	V 118		
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.  This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. The findings are:  Observation on 11/02/22 at 2:30pm revealed: -Bedroom #3 globe from the overhead light was missing -Bedroom #4 a hole in the wall near the floor the size of a dollar bill black marks on the wall stretching from the	V 736	V736  QM and Program Director will train GH Manager on basic maintenance and documentation on the Facility Checklist.  Facility Manager will illustrate how to change out the globe, patch the hole, and cleanup the black marks.  The cracked window, hole patched, and Tile will be scheduled for maintenance to address.	12/1/22  12/5/22  11/28/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-471</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/02/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER <b>EASTER SEALS UCP NC RALEIGH GROUP HO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1529 BEN LLOYD DRIVE RALEIGH, NC 27604</b>
---	--

(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 736	Continued From page 3 closet door to the adjacent wall the window cracked the length of two dollar bills -Bathroom #2 floor tile cracked the size of a football  Interview on 11/02/22 the Qualified Professional stated: -She does not know why the globe was taken down -She was aware of the maintenance issues in bedroom #4 - She had not notice that the window was cracked in bedroom #4 - She will call maintenance about the issues	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 observation and interviews the facility's water temperature was not maintained between 100-116 degrees Fahrenheit. The findings are:  Observation on 11/2/22 of the facility at 1:00 am revealed: -Kitchen sink water temperature was 90 degrees Fahrenheit.	V 752	V752  Hot water temperature was addressed by the Facility Manager on 11/7. Facility Manger will trains GH Manager on how to adjust temperature levels on the hot water heater.	12/1/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-471</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/02/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>EASTER SEALS UCP NC RALEIGH GROUP HO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1529 BEN LLOYD DRIVE RALEIGH, NC 27604</b>
---	--

(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 752	<p>Continued From page 4</p> <p>-Bathroom #1, and Bathroom #2 sink water temperatures were 95 degrees Fahrenheit.</p> <p>Facility's Group Home Water Temperature Log            9-22-22 9:08am 89.2 degrees            9-27-22 1:29pm 88.8 degrees            10-12-22 12:40pm 92.3 degrees            10:26-22 1:00pm 80.4 degrees</p> <p>Interview on 11/3/22 with staff #2 stated:            - Staff had taken the water temperature            - The water heater has had some recent work            - The water does not get hot enough</p> <p>Interview on 11/3/22 with Qualified Professional (QP) stated:            -Had a water leak in September            -Will call the contractor to regulate the water temperature</p>	V 752		



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

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

11/16/22

[REDACTED] Licensing and Regulatory Coordinator  
Easter Seals UCP North Carolina & Virginia, Inc  
5171 Glenwood Avenue Suite 211  
Raleigh, NC 27612

Re: Annual Survey completed 11/02/22  
Easter Seals UCP NC Raleigh Group Home, 1529 Ben Lloyd Drive, Raleigh, NC 27604  
MHL # 092-471  
E-mail Address: [REDACTED]

Dear [REDACTED]

Thank you for the cooperation and courtesy extended during the annual survey completed 11/02/22.

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 1/1/23.

**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 & 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

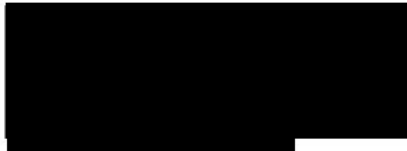
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

11/16/22  
Easter Seals Ucp of North Carolina & Virginia

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,



Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org  
Pam Pridgen, Administrative Supervisor