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	MHL092-686	A. BUILDING: _____ B. WING _____	R 12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTHCARE SERVICES, INC	3716 SUMMER PLACE 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 and follow up survey was completed on 12/5/22. 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 4. 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 needs; and	V 105		

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V 105	Continued From page 1 (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	V 105		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the use of a Glucometer instrument including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are:

A. Record review on 12/2/22 of client #1's record revealed:
- admitted 11/5/18
- diagnoses of Schizoaffective Disorder
- no CLIA waiver

During interview on 10/31/22 client #1 reported:
- been a diabetic year or year in a half
- blood sugars (BS) taken at bedtime
- he checked his own BS & sometimes staff

B. Record review on 12/2/22 of client #4's record revealed:
- admitted 8/24/16
- diagnoses: Schizophrenia & Diabetes
- no CLIA waiver

During interview on 10/31/22 client #4 reported:
- staff checked his blood sugars (BS) daily

During interview on 10/31/22 staff #1 verified she checked the clients BS

During interview on 12/5/22 the Licensee reported:
- the CLIA waiver expired
- would contact the appropriate officials to

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V 105	Continued From page 3 obtain the CLIA waiver	V 105		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by:	V 112		

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V 112	Continued From page 4 Based on record review and interview the facility failed to develop and implement goals and strategies for 3 of 3 audited clients. The findings are: A. Record review on 12/2/22 of client #1's record revealed: - admitted 11/5/18 - diagnoses of Schizoaffective Disorder - treatment plan dated 1/7/19 During interview on 10/31/22 client #1 reported: - he attended a day program - worked on goals at program B. Record review on 12/2/22 of client #4's record revealed - admitted 8/24/16 - diagnoses: Schizophrenia & Diabetes - treatment plan dated 12/18/18 During interview on 12/2/22 the Licensee reported: - during the pandemic the clients were not able to attend a program - returned to the program this year - in the future, he would ensure the Qualified Professional updated the treatment plans	V 112		
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	V 290		

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V 290	Continued From page 5 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 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.	V 290		

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V 290	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure staff was present except when the client's treatment plan documented client was capable of remaining in the community for 1 of 3 audited clients (#1). The findings are: Record review on 12/2/22 of client #1's record revealed: - admitted 11/5/18 - diagnoses of Schizoaffective Disorder - treatment plan dated 1/7/19 - no documentation of unsupervised time During interview on 10/31/22 client #1 reported: - he could walk to the store - it was 5 - 6 blocks away - he walked on the side walk During interview on 12/2/22 Licensee reported: - client #1 walked to the store - he was his own guardian - will have the Qualified Professional update his treatment plan	V 290		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for	V 291		

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V 291	Continued From page 7	V 291		

treatment/habilitation or case management.
(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.
(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to coordinate with other Qualified Professionals (QP) who are responsible for 2 of 3 audited clients (#1 & #2). The findings are:

A. Record review on 12/2/22 of client #1's record revealed:
- admitted 11/5/18
- diagnoses of Schizoaffective Disorder
- a FL2 dated 2/16/22: Jardiance 10mg daily (Diabetes) & check blood sugars (BS) twice a day
- 11//1/22 - primary care visit

Review on 12/2/22 of client #1's September 2022, October 2022 & November 2022 revealed:
- September - refused BS checks approximately 19 times

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V 291	Continued From page 8 - October - refused morning BS checks & refused 22 times at QHS - November - refused morning BS checks & refused approximately 20 times at QHS During interview on 10/31/22 client #1 reported: - been a diabetic year or year in a half - BS taken at QHS - he will take it or staff, unless he refused - does not refuse often - "do not like the needle pricking finger" During interview on 12/2/22 staff #1 reported: - will ensure the physician document his awareness of client #1's BS refusals B. Record review on 12/2/22 of client #3's record revealed: - admitted 3/31/18 - diagnoses of Seizure D/O, Bipolar & Hypertension - a FL2 dated 2/16/22: Advair twice a day (asthma) Review on 12/2/22 of client #3's September 2022, October 2022 & November 2022 MAR revealed: - no documentation the entire months of September 2022 - November 2022 During interview on 12/2/22 staff #1 reported: - client #3 stopped using the inhaler a couple of months ago - had a 12/8/22 physician's appointment - will inform the physician During interview on 12/5/22 the Licensee reported: - would ensure the physician was made aware of clients' refusals	V 291		

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V 537	Continued From page 9	V 537		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (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 plans to employ must be approved by the Division of MH/DD/SAS pursuant to	V 537		

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V 537	Continued From page 10 Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (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 Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the	V 537		

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V 537	Continued From page 11 need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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. (5) 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 (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once	V 537		

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V 537	Continued From page 12 annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) 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 outcome (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. (l) 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. (m) 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 1 of 2 audited staff (Qualified Professional (QP)'s restrictive intervention was refreshed on an annual basis. The findings are: Record review on 12/2/22 of the QP's record revealed: - hired 11/2018 - EBPI training expired 5/31/20 During interview on 12/5/22 the Licensee	V 537		

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V 537	Continued From page 13 reported: - he was responsible for ensuring staff's training was updated - will ensure the QP restrictive intervention was updated	V 537		
V 748	27G .0304(b)(2) Fire Retardant Mattresses 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. (2) All mattresses purchased for existing or new facilities shall be fire retardant. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure 1 of 3 audited client (#1) mattress was equipped in a safe manner. The findings are: Record review on 12/2/22 of client #1's record revealed: - admitted 11/5/18 - diagnoses of Schizoaffective Disorder Observation on 10/31/22 at 4:10pm of client #1's bedroom revealed: - a mattress collapsed in the middle - black spots throughout the mattress During interview on 12/2/22 client #1 reported:	V 748		

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V 748	Continued From page 14 - there was a "big lump" in the middle of the mattress - slept "ok" During interview on 12/5/22 the Licensee reported: - was not aware of the condition of client #1's mattress - will have it replaced	V 748		