STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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, complaint and follow up survey was completed on January 18, 2023. The complaint was unsubstantiated (intake # NC00195537). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross,	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 108	Continued From page 1 the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide training to meet the client's mh/dd/sa needs as specified in the treatment/habilitation plan affecting 5 of 5 paraprofessional staff (#1, #2, #3, #4, and #5). The findings are: Review on 12/15/22 of Staff #1's personnel record revealed: -Paraprofessional hired 12/23/08. -Position title, "Residential Tech (technician)." -No documentation of training to meet client #1's needs as specified in his treatment plan. Review on 12/15/22 of Staff #2's personnel record revealed: -Paraprofessional hired 12/30/09. -Position title, "Residential Tech." -No documentation of training to meet client #1's needs as specified in his treatment plan. Review on 12/15/22 of Staff #3's personnel record revealed: -Paraprofessional hired 12/23/20. -Position title, "Residential Tech." -No documentation of training to meet client #1's	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 108	Continued From page 2	V 108		

needs as specified in his treatment plan.

Review on 12/15/22 of Staff #4's personnel record revealed:
-Paraprofessional hired 1/10/22.
-Position title, "Residential Tech."
-No documentation of training to meet client #1's needs as specified in his treatment plan.

Review on 12/21/22 of Staff #5's personnel record revealed:
-Paraprofessional hired 12/23/21.
-Position title, "Residential Tech."
-No documentation of training to meet client #1's needs as specified in his treatment plan.

Review on 12/14/22 and 12/15/22 of client #1's records revealed:
-19 year old male admitted 10/29/22.
-Diagnoses documented were autism disorder and intellectual developmental disabilities, unspecified.
-Client #1 was admitted from another facility.
-Client #1's admission assessment dated 10/29/22 documented, "Present condition: [client #1] displays physical aggression, noncompliance, property misuse, self-injurious behaviors, tantrums, screaming, crying and attempting to leave the facility."
-Since his admission client #1 had 2 elopements (11/29/22 and 12/19/22), hospitalized for a seizure (12/3/22 - 12/7/22), and taken to the Emergency Department on 12/8/22 due to aggressive behaviors.
-Client #1 was at risk for choking.
-Client #1 had his first visit with his new Psychiatric Provider on 12/12/22.

Interview on 12/15/22 Staff #1 stated:
-There was no treatment plan for client #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 108 — Continued From page 3 — V 108

-There was a team meeting scheduled for the following Monday (12/19/22) to develop a plan.
-All of the information the staff had for client #1 was in his on site record given to the surveyor to review on 12/14/22.

Interview on 12/16/22 Staff #2 stated:
-Had not seen a treatment plan or behavior plan for client #1.
-Had been made aware of client #1's specific needs when he was "briefed" by the client's mother at the time of admission.

Interview on 12/15/22 and 12/21/22 Staff #4 stated:
-Worked the overnight shift as the awake staff.
-Had worked for the facility a year.
-When hired she had been trained by co-workers about specific clients.
-Had learned about client #1's specific needs by observing him and by "trial and error."
-The phone numbers of client #1's parents were posted and she could call them if she needed more information.
-Client #1 had a treatment plan, but she did not know where it was.
-Was not aware of any concerns that required monitoring client #1 during meals; he was independent.
-Was on duty and saw client #1 eloping through his window on 11/29/22 at 3:15 am.
-Client #1's elopement on 11/29/22 was the first time she had such a situation occur, and she was not sure of the "proper procedure."
-There had been no additional training following his elopement on 11/29/22.
-Client #1 eloped again on her shift 12/19/22 while she prepared breakfast.

Interview on 12/20/22 Staff #5 stated:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 108	Continued From page 4 -Was responsible to transport clients. -Learned client #1 had ADHD (attention deficit hyperactivity disorder) and autism on 12/12/22 during a doctor's appointment. -It was her job to monitor clients when she took them to appointments. Interview on 12/21/22 the Local Management Entity/Managed Care Organization Care Manager stated: -During the 12/19/22 virtual Behavior Support meeting, Staff #1 and #5 shared that client #1 "went out the window" the night before the meeting. -Staff #5 stated it was not an elopement because he did not go to a neighbor's home. -The staff needed more education about significant reportable incidents Interview on 12/16/22 the Qualified Professional/Clinical Director stated: -Had placed a copy of client #1's treatment plan in the group home and told the staff to read the plan. -Had not provided any training for the staff on client #1's specific needs or his treatment/behavior plans. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R **01/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	**2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312**

(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 109	Continued From page 5 ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by:	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 109	Continued From page 6 Based on record review, observation, and interview, 1 of 1 Qualified Professional/Clinical Director (QP/CD) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108). Based on record review and interview, the facility failed to provide training to meet the client's mh/dd/sa needs as specified in the treatment/habilitation plan affecting 5 of 5 paraprofessional staff (#1, #2, #3, #4, and #5). Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V111). Based on record review and interview the facility failed to develop strategies to address the client's presenting problems when services were provided prior to the implementation of the treatment/habilitation or service plan for 1 of 2 clients (client #1). Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112). Based on record review, observation, and interview, the facility failed to implement strategies based on assessment to meet the needs of 2 of 2 clients (clients #1 and #2). Review on 12/15/22 of the QP/CD's record revealed: -Hire date 4/10/19. -Met the educational qualifications for a QP. Interview on 12/20/22 client #1's mother/guardian stated:	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 109	Continued From page 7	V 109		

-Attended the initial visit with client #1's Psychiatric Provider on 12/12/22.
-Did not understand why the facility staff needed to be present during the visit, and said, "There were so many people."
-Was upset that the transporter (Staff #5) was present during the appointment "...voicing her opinions and portraying she had knowledge ... I shut her down."
-Had never met Staff #5, did not know her, and questioned why the transporter needed to be present.

Interview on 12/21/22 client #1's Psychiatric Provider stated:
-Had never met client #1 before his initial visit on 12/12/22.
-Felt there were too many people in the exam room.
-In addition to the Psychiatric Provider, client #1, and the client's mother/guardian, there were 3 staff in the exam room.
-There was the QP/CD, a direct care staff (Staff #1), and the transporter (Staff #5) in the room.
-The number of people were "too overwhelming" for the client.
-Asked the QP/CD why they needed 3 facility staff, and he said they had "concerns they wanted to bring to the table."
-Could not understand why the transporter needed to be in the room.
-The number of people limited the mother's time to converse with the provider.
-Did not want to "throw anyone under the bus... but there were too many people's opinions being expressed to get an actual understanding of the client that I was seeing for the first time."
-The facility brought a lot of paperwork and she did not have time to read it all.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ____ B. WING ____	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 109	Continued From page 8	V 109		

Interview on 12/21/22 the QP/CD stated:
-Knew client #1's mother had concerns with Staff #5 during the 12/12/22 appointment.
-Staff #5 asked the Psychiatric Provider if it were possible client #1 was hearing voices.
-Thought this question "upset the mother."
-Thought it was appropriate to have the staff present during the appointment, including Staff #5.
-Staff #5 had "years of experience."

Review on 12/16/22 of the Plan of Protection dated 12/16/22 and signed by the QP/CD revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care. The Loving Home, Inc. (Licensee) will ensure staff [client #1] safety by doing the following:
-Staying in sight of him at all times while he is in the group home, outside or in the community.
-Placing door chimes on the front/back doors to inform staff if anyone is entering or leaving the group home.
-Keeping the doors closed at all times when he is in the house.
-Make sure the ISP (Individual Support Plan) and Behavior Support Plan is placed in the group home.
-Describe your plans to make sure the above happens.
-The Loving Home, Inc. will install door chimes on the front/back doors.
-The Loving Home, Inc. will have all staff that provide services to [client #1] trained on his ISP and behavior Support Plan by an outside Qualified Professional to ensure their competency to effectively work with [client #1]."

Review on 12/21/22 of the "Addendum to Plan of Protection" dated 12/21/22 and signed by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 109	Continued From page 9	V 109		

QP/CD revealed:
-"Plans to put in place to ensure [client #1] does not elope again in the future.
-Having 3rd (shift) staff focus on monitoring [client #1] throughout his/her shift without any other responsibilities.
-1st shift staff will come to work 45 minutes earlier to assist 3rd shift staff with the morning preparation of getting breakfast ready, assisting the individuals with their hygiene and getting dressed for the day."

Client #1 was admitted to the facility on 10/29/22 with diagnoses of autism disorder and intellectual developmental disabilities, unspecified. Client #1 had a history of elopement behaviors and was at risk for choking. Client #1 had a Behavior Support Plan dated 7/1/22 and an Individual Support Plan dated 10/29/22; however, the QP/CD had not provided staff training on client #1's plan/strategies, and the staff did not have access to his plan. The staff were unaware client #1 was at risk for choking and did not implement the treatment plan strategies for prevention.

With the exception of an alarm on client #1's bedroom window, there were no other strategies implemented to prevent his elopement. Client #1 eloped through his bedroom window on 11/29/22 and found approximately 3 hours later, at 5:22 am, inside a neighbor's home. Client #1 had broken into the home and the homeowner told police he almost shot the client. On 12/19/22 at 5:30 am client #1 eloped a second time through his bedroom window, as Staff #5 was preparing breakfast. The QP/CD had not implemented any changes following the elopement on 11/29/22 that would have enabled the night staff to increase direct supervision of client #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 109	Continued From page 10 On 12/12/22 client #1 had his initial psychiatry appointment with his mother/guardian, the QP/CD, Staff #1, and Staff #5 (transporter) in attendance. After the Psychiatric Provider questioned the need for 3 facility staff to be present, the QP/CD allowed all to remain and verbally participate. Staff comments were upsetting to the mother/guardian and the Psychiatric Provider was unable to get a full understanding of client #1 because there were too many people voicing their opinions. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5,000.00 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 facility is out of compliance beyond the 23rd day.	V 109		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission;	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	**2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312**

(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 111	Continued From page 11	V 111		

(4) a pertinent social, family, and medical history; and
(5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs.
(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to develop strategies to address the client's presenting problems when services were provided prior to the implementation of the treatment/habilitation or service plan for 1 of 2 clients (client #1). The findings are:

Review on 12/14/22 and 12/15/22 of client #1's record revealed:
-19 year old male admitted 10/29/22.
-Diagnoses documented were autism disorder and intellectual developmental disabilities, unspecified.
-Client #1's admission assessment dated 10/29/22 documented, "Present condition: [client #1] displays physical aggression, noncompliance, property misuse, self-injurious behaviors,

(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 111	Continued From page 12 tantrums, screaming, crying and attempting to leave the facility." -No strategies to address client #1's presenting problems had been developed. Review on 12/14/22 of client #1's North Carolina Incident Response Improvement System report of incident dated 11/29/22 revealed: -"On 11/29/22 approximately 3:45am while consumer was in his bedroom he raised window and eloped out while the alarm was going off. Staff interred the room consumer going out the window. Staff when outside to locate the consumer but due to the darkness was unable to fine consumer. Staff looked around the boundary of the properly calling consumer's name. When staff was unsuccessful fine consumer staff contacted director. The [local] County Sheriff Dept. (department) was notified of consumer being missing. Two deputy sheriffs later returned consumer by to the group home facility and said the consumer had broken into a neighbor's back window entered in the house and grab bag of [chocolate] Cookies, turned on the television set down in a chair and started watching it. The neighbors in the home said he was about to shoot him for breaking and entering but notice consumer was not posing a threat to anyone. But the wife was terrified." Review on 12/16/22 and 12/20/22 of calls received on 11/29/22 by the local 911 Emergency Operations dispatch regarding client #1 revealed: -2:22 am: Caller reported a stranger was at the back door of their home, then walked around to the front of their home. Address of caller was redacted. -2:41 am: "ANO (another) CALL FROM (REDACTED HOUSE NUMBER) [street that is same as facility address]... A MALE IS HANGING	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 111	Continued From page 13	V 111		

AROUND AIMLESSLY AROUND THEIR YARD...ACTING LIKE HE IS IN A TRANCE...POSS (possibly) SLEEP WALKING... WM (white male) WHI (white) T-SHIRT PAJAMA PANTS." The street of the caller's location was the same as the street of the facility location, but the specific address had been redacted.
-3:14 am: Caller from a neighboring street, exact location redacted, reported "MALE IN THE AREA TRYING TO OPEN DOOR."
-5:22 am: "Caller Statement: SOMEONE IS IN HER HOUSE."
-5:53 am: Call received from the facility address. "Caller Statement: SUBJ (subject) RAN AWAY FROM LOC (location)...clothing: WHITE SHIRT\GRAY SWEAT PANTS...Subj last seen: 355AM."
-5:53 am: Police documented they had custody of client #1.
-6:25 am: responding officer documented, "... assisted with locating the subject. I transported the subject to his home address at (redacted house number) [facility street]... The subject broke into a home ... male living at an Adult Group Home."
-A canine unit had been used in an effort to locate the "subject."
-Client #1 had entered the home through a window.
-There was only 1 call received by dispatch on 11/29/22 that reported an elopement from the facility.

Review on 12/21/22 of the police report for the incident dated 11/29/22 revealed the address where client #1 was found on 11/29/22 was approximately 2 miles from the facility.

Review on 12/14/22 of client #1's 11/28/22 incident report revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 111	Continued From page 14	V 111		

-Between 1:30 am and 6:30 am client #1 became "combative" after Staff #1 redirected him from the refrigerator.
-Staff #4 wrote, client #1, "... slapped my phone out of my hand and became extremely confrontational. I told him to take a few minutes to himself hoping he could decompress after breakfast and medication."
-Client #1's behaviors escalated as he slapped the staff's hand again causing her to drop her phone, screamed, cried, and punched holes in the walls and doors.

Interview on 12/15/22 and 12/21/22 Staff #4 stated:
-Since his admission client #1 had difficulty sleeping through the night.
-The staff thought he was not sleeping because he was adjusting to the facility and they hoped once his medications "stabilized," he would "settle down."
-Client #1 would have behaviors similar to a temper tantrum at night.
-About 1 ½ weeks after he was admitted he would get "irate" when he could not go into the refrigerator.
-This behavior seemed to occur around 3 am.
-When this occurred, she would "supervise" the client and let him "wind down."
-There were no warning signs client #1 was going to elope on 11/29/22.
-On 11/29/22 she had checked on client #1 at 3 am and when she went back at 3:15 am she heard the alarm going off and saw him going out the window.
-Tried to get client #1 to stop, but he did not comply.
-Went outdoors and looked for him "about 10 minutes," but could not stay out too long because client #2 was inside the home.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 111	Continued From page 15 -Notified the Qualified Professional/Clinical Director (QP/CD). -Client #1 had no history of choking to her knowledge; he was independent as far as eating was concerned. Interview on 12/16/22 the QP/CD stated: -Had placed a copy of client #1's treatment plan in the group home and told the staff to read the plan. -Could not understand why the staff reported they had never seen client #1's treatment plan or behavior plan. This is a recited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 111		
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;	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 112	Continued From page 16 (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: Based on record review, observation, and interview, the facility failed to implement strategies based on assessment for 2 of 2 clients (clients #1 and #2). The findings are: Finding #1: Review on 12/14/22 of client #1's on site facility record revealed: -19 year old male admitted 10/29/22. -Diagnoses documented were autism disorder and intellectual developmental disabilities, unspecified. Review on 12/15/22 of client #1's records maintained at the Qualified Professional/Clinical Director's (QP/CD) office revealed: -Client #1's admission assessment dated 10/29/22 documented, "Present condition: [client #1] displays physical aggression, noncompliance,	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 112	Continued From page 17 property misuse, self-injurious behaviors, tantrums, screaming, crying and attempting to leave the facility." -Client #1's Individual Support Plan (ISP) documented the implementation date was 10/29/22. -Client #1's Behavior Support Plan was dated 7/1/22 Review on 12/15/22 of client #1's ISP dated 10/29/22 revealed: -"What is happening in my life right now?... Most recently the group home has reported choking concerns due to the client eating very rapidly and putting too much food in his mouth, so much so he had a choking incident reported in September 2022." -Client #1 could verbalize some words but exhibited verbal communication deficits. -"Things that may create stress. Situations where I'll need extra help..." included being told "no," when transitioned from his electronic devices, an interrupted schedule, not getting what he desired, not being able to communicate his wants and/or needs, and being misunderstood. -Six (6) "Long Range Goals" were listed and addressed participation in activities of daily living, socialization skills, safety skills, coping skills as evidenced by data, and he would have supports needed to maintain his health, and adjust to the new home and community. -There were no short term residential goals with strategies included in the ISP. -Elopement risk was documented as part of "Where am I now" for the long range safety and coping skills goals without any strategies documented. -"...challenges with his communication and assistance is needed with the usage of resources to aid him" was documented as part of "Where I	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 112	Continued From page 18	V 112		

am now" for his long term goal to increase socialization skills. No strategies were documented.
-Choking risks were documented as part of "Where I am now" for the goal to provide supports to maintain his health. It was listed that his food should be cut/chopped and staff should monitor his eating for portion control to prevent overfilling his mouth and eating too rapidly.

Review on 12/15/22 of client #1's Behavior Support Plan dated 7/1/22 revealed:
-"Target Behaviors:" (1) physical aggression, (2) wandering away/elopement; (3) non-compliance; (4) tantrums; (5) skin picking; (6) inappropriately obtaining food.
-The following safety measures were to be in place to prevent elopement:
-Standard door chimes on the front and back doors.
-All windows set to alarm if opened.
-An alarmed floor mat placed next to his bed and in the hallway leading to his room.

Review on 12/21/22 of client #1's incident report for his elopement on 12/19/22 revealed:
-Incident occurred at 5:30 am.
-Staff #4 was the staff on duty at the time of the incident.
-"[Client #1] was woke for breakfast. As I went back to kitchen to finish breakfast, I heard the window alarm going off, so I went to [client #1's] room and he was exiting window. I tried to stop him from going out but I couldn't. So, I grabbed my coat and went outside to look but it was dark and I couldn't find him. I circled the house twice looking for him, then I came inside to call my supervisor. Then I see a police car coming down driveway to bring [client #1] back."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 112	Continued From page 19	V 112		

Observations on 12/14/22 between 1:40 pm and 2:15 pm and 12/16/22 at 10:15 am revealed:
-There was an alarm present on the window in client #1's bedroom.
-There were no alarms present on the front or back doors.
-Client #1's bed was positioned in the room next to the wall opposite his window with approximately 8 feet between the bed and window.
-There were no floor alarm mats in place.
-The distance between the home and the road was approximately 500 feet.
-The facility was located on a rural road with no street lights or sidewalks.

Observations on 12/20/22 at 4 pm revealed alarms had been added to the exterior doors.

Interview on 12/15/22 and 12/21/22 Staff #4 stated:
-It was her responsibility to monitor clients every 15 minutes, prepare breakfast, and administer morning medications.
-Client #1 had a treatment plan, but she did not know where it was.
-The client's plan was "more of a day shift thing."
-Client #1 had temper tantrums at night.
-To calm client #1 she would talk to him and give him his computer tablet.
-On 12/19/22 she was making breakfast and went to wake client #1 when she heard his window alarm sound.
-Client #1 had gone out the window and out to the road.
-A "cop" who was passing by brought client #1 back to the facility.
-Client #1 had reached the end of the drive, made a right turn and walked out of her sight.
-There was no 911 call made. Client #1 was back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 112	Continued From page 20	V 112		

in 15 minutes.
-Reported the incident to the Qualified Professional/Clinical Director (QP/CD) and he requested an incident report.
-Client #1 had no issues with food, ate independently, and she was not aware of any history of choking.
-There had been no additional training about client #1's needs following his elopement on 11/29/22.

Interview on 12/15/22 Staff #1 stated:
-There was no treatment plan for client #1.
-There was a team meeting scheduled for the following Monday (12/19/22) to develop a plan.

Interview on 12/16/22 Staff #2 stated:
-Had not seen a treatment plan or behavior plan for client #1.
-A window alarm was placed on client #1's bedroom window the day he was admitted. No additional alarms were in place.

Interview on 12/20/22 client #1's mother/guardian stated:
-It seemed to her the facility needed to be a "bit more" prepared for client #1.
-In his plan it was documented that client #1 needed to be supervised when eating to prevent him from choking.
-Had observed the staff serve client #1 a large portion of meat and not monitor him.
-Made the staff aware his food needed to be served in small pieces and he needed to be monitored while eating.
-The QP/CD was given client #1's treatment plan and the Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator made sure they had client #1's file. "It is obvious [client #1] needs a lot of help."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 112	Continued From page 21	V 112		

-Understood the facility had requested additional funding for additional staff.

Interview on 12/21/22 client #1's LME/MCO Care Coordinator stated:
-Following client #1's first elopement she had discussed client #1's behaviors with the QP/CD.
-They had discussed other assistive technology such as motion sensors and a 2nd staff overnight to prevent future elopements.
-There was a meeting scheduled in January 2023 to further discuss additional staffing.

Interview on 12/16/22 and 12/21/22 the QP/CD stated:
-Had placed a copy of client #1's treatment plan in the group home and told the staff to read the plan.
-Had not provided any training for the staff on client #1's specific needs or his treatment/behavior plans.
-Had no explanation why the staff said they did not have the plan at the facility.
-Had tried unsuccessfully on 12/16/22 to locate floor alarm mats to be placed at client #1's bed and door as listed in client #1's Behavior Plan. He would add alarms to the doors.
-Did not have the resources to add a second staff on the night shift but he would have the day staff report earlier to provide 2 staff on site when breakfast was being prepared.

Finding #2:
Review on 12/15/22 and 12/20/22 of client #2's record revealed:
-43 year old female admitted 6/17/21.
-Diagnoses included schizophrenia, multiple episodes, currently in remission; depressive disorder, not otherwise specified; moderate intellectual developmental disability, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 112	Continued From page 22	V 112		

diabetes.
-Treatment plan dated 11/1/22 documented, "Medical Support Needs... Water/Fluid Intake - [client #2] has a water/fluid intake restriction to regulate sodium levels in her body. [client #2] can drink 6 cups of water per day. Her Primary Care Physician suspects psychogenic polydipsia (excessive thirst). This must be monitored by staff. The group home staff has a tracking system in place to monitor her fluid intake that is reported to work well. Each time [client #2] drinks a cup of water it is documented on a tracking form developed by the group home. Staff are aware to check the tracking sheet before [client #2] is given water/fluids and to document if they give her water/fluids. The current arrangement is 2 cups of water or other fluids per shift."
-There were no tracking forms documenting fluid intake.

Observation on 12/20/22 at approximately 5:30 pm revealed:
-Staff #1 retrieved a red glass from the kitchen used by the staff to measure client #2's liquids.
-Staff #1 pointed to a level, approximately the middle of the glass, as being 1 cup.
-There were no measurement markings on the glass.

Interview on 12/20/22 client #2 stated:
-The staff measured her liquids, but she did not know where they would record the amount she drank.
-Was allowed 8 ounces or 1 cup of liquids each shift.

Interview on 12/20/22 Staff #1 stated:
-Client #2 was allowed 6 cups of liquid per day.
-They used the red glass to measure her water intake.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 112	Continued From page 23 -They "eye ball" the glass to estimate 1 cup. -Was allowed 2 cups of liquid each shift. Interview on 12/21/22 Staff #4 stated: -She worked the night shift from 10 pm to 8 am. -Client #2 was only allowed to have liquid with her meals. -There was no form to record client #2's liquid intake. This is a recited deficiency. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 114	Continued From page 24	V 114		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are:

Review on 12/15/22 of fire and disaster drills documented between 10/1/21 and 9/30/22 revealed:
-Quarter 10/1/21 - 12/31/21:
    -No fire drills documented for any shift.
    -No disaster drill documented for the first shift.
-Quarter 1/1/22 - 3/31/22: No fire drills documented for any shift.
-Quarter 4/1/22 - 6/30/22: No fire drills documented for any shift.
-Quarter 7/1/22 - 9/30/22:
    -No fire drills documented on the second or third shifts.
    -No disaster drills documented on the third shift.

Interview on 12/15/22 Staff #1 stated:
-The facility shifts were as follows:
    -First shift: 8am - 5 pm
    -Second shift: 4 pm - 10 pm
    -Third shift: 10 pm - 8 am
-Documentation of fire and disaster drills was filed in the facility notebook.
-Documentation of fire and disaster drills was not sent to the Qualified Professional/Clinical Director's office.

Interview on 12/15/22 Staff #4 stated:
-Fire and disaster drills were done every month.
-For fire drills she told the clients it was a drill and then would take the clients outside in front of the home.
-For disaster drills she had the clients to follow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 114	Continued From page 25 her to a designated area, such as the bathroom if practicing a tornado drill. -Most of the disaster drills on the third shift were "questions and answers" because it was at night. Interview on 12/20/22 client#2 stated: -Fire drills were done "often." -The most recent fire drill had been done the prior month. -When a fire drill was done, staff would sound the alarm and the clients and staff would go outside to the gate. -Disaster drills were done at the same time the fire drills were done. -If the disaster drill was a bomb they would go to the street. If the disaster was a tornado she would go into her closet or the hall. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 114		
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	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	**2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312**

(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 26 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. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR for 1 of 2 clients (client #1). The findings are: Review on 12/14/22 and 12/15/22 of client #1's record revealed: -19 year old male admitted 10/29/22. -Diagnoses included autism disorder and intellectual developmental disabilities, unspecified. -He was admitted from another facility. -11/28/22: Incident report for extreme aggressive behaviors. -11/29/22: Eloped from the facility. -12/3/22 - 12/7/22: Hospital admission due to a seizure.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 27 -12/8/22: Emergency Department (ED) visit for aggressive behaviors. -12/12/22: Initial visit with his Psychiatric Provider. -No history or diagnosis of a seizure disorder prior to admission. -Order dated 12/7/22 for oxcarbazepine 300 mg (milligrams) twice daily for 14 doses. (seizure disorders) -Order dated 12/7/22 for oxcarbazepine 150 mg take 3 tablets twice daily for 60 doses. -No medication orders received by the facility on admission. Review on 12/15/22 of client #1's prior facility MAR dated 11/1/22 - 11/30/22 revealed: -The medications listed included: -Topiramate 50 mg, 7 pm daily. (seizures, mood stabilizer) -Guanfacine 1 mg, 7 am (attention deficit hyperactivity disorder) -Flintstone's Vitamins, 7 am daily. (supplement) -Triamcinolone 0.1% cream, 7 am 7 pm daily. (relieve discomfort caused by skin conditions) -Nystatin Cream, 7 am 7 pm daily. (topical antifungal) -Vitamin C 500 mg Chew tablet 7 am daily. (supplement) -QC Advanced Probiotic Capsule, 1 daily. (improve digestion) -Miralax, mix 1 packet in 8 ounces of fluid and drink daily as needed for constipation. -Beside the order for hydroxyzine 25 mg, 3 tablets (75 mg) at bedtime was hand written "D/'d" (discontinued.) -A note had been written at the end of the form, dated 10/29/22, that read, "Received remaining October 2022 meds (medications) and 30 day supply of prescription medications for month of November 2022."	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 28	V 118		

Review on 12/15/22 of the Psychiatric Provider office visit summary dated 12/12/22 revealed:
-The order for lorazepam had changed to 1 mg twice daily as needed for anxiety.
-Guanfacine 1 mg was listed as a current medication.

Review on 12/20/22 of client #1's medication orders revealed:
-Orders/dates for the following:
-10/4/22: Aripiprazole 5 mg at bedtime. (mental/mood disorders; irritability associated with autism disorder)
-10/4/22: Guanfacine 1 mg every morning.
-5/3/22: Guanfacine 2 mg twice daily at 4 pm and bedtime.
-12/12/22: Trazadone 100 mg at bedtime. (depression, anxiety, insomnia)
-5/12/22: Vitamin C 500 mg Chew tablet daily.
-9/6/22: QC Advanced Probiotic Capsule, 1 daily.
-12/7/22: Melatonin 5 mg, 2 tablets at bedtime. (sleep aid)
-No documentation the prescribing physician or pharmacist had been contacted to clarify orders for medications discontinued on 11/16/22.
-No order to discontinue guanfacine 1 mg every morning.
-No documentation the facility had contacted the pharmacy or a physician to clarify the discrepancy between the facility order dated 12/7/22 for oxcarbazepine 300 mg (administer twice daily for 14 doses), and the label on the medication dispensed 12/7/22 (administer tablet by mouth every day for 14 doses).
-No documentation the pharmacy had been contacted to clarify if the Psychiatric Provider had sent a change order for lorazepam as it was listed on the visit summary dated 12/12/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 29	V 118		

Review on 12/15/22 of client #1's hospital "After Visit Summary" for admission 12/3/22 - 12/8/22 revealed:
-Discharge instructions: "We have started a medication for seizures called oxcarbazepine (also know as Trileptal). The dosing for this medication is somewhat unusual when first starting it. WE are sending the patient with a few days of medications as well a prescriptions for the next phases of dosing. PLEASE MAKE SURE ALL MEDICATIONS ARE TAKEN AS PRESCRIBED. The MRI (magnetic resonance imaging) of the brain was normal and did not show any evidence of mass (tumor), bleeding, or other concerning features. WE were unable to get an EEG (electroencephalogram) done because attaching the wires to his (client #1's) head caused him too much distress. He should follow-up with neurology to manage seizure medications."
-Appointment made with a neurologist for 12/27/22.
-Guanfacine 1 mg each morning was listed as a medication to continue.
-The form was not signed by a provider.

Review on 12/16/22 of the on site facility copy of client #1's hospital "After Visit Summary" dated 12/3/22 - 12/8/22 revealed:
-Slash marks had been made across the order to continue guanfacine 1 mg each morning.
-The form was not signed by a provider.
-There was no documentation of who would have marked through the guanfacine order.

Review on 12/15/22 of client #1's hospital "After Visit Summary" for the Emergency Department visit on 12/8/22 revealed:
-Reason for visit: Aggressive Behavior.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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		V 118		

Continued From page 30

-Diagnoses: Autism; Outbursts of explosive behavior.
-Guanfacine 1 mg was listed as a medication currently prescribed for client #1.

Review on 12/15/22 of www.webmd.com topiramate review revealed:
-Topiramate is an anticonvulsant medication but could be prescribed for other reasons.
-"Do not stop taking this medication without consulting your doctor. Some conditions may become worse when this drug is suddenly stopped. Your dose may need to be gradually decreased."
-"The top trigger for a seizure is not taking medication as prescribed. One missed dose probably won't cause a seizure, but your chances rise the longer you go without your meds. You could go into withdrawal or have an even worse seizure. Take your medication every day to build up a steady amount of it in your blood."

Review on 12/15/22 of client #1's MARs from 10/29/22 - 11/30/22 revealed:
-The facility staff documented medications from 10/29/22 - 11/16/22 on hand written MARs.
-Medications were documented from 11/16/22 - 11/30/22 on MARs printed/provided by the local pharmacy.
-The following medications were documented as given (hand written MARs) from 10/29/22 - 11/16/22, but were not transcribed/documented as given from 11/16/22 - 11/30/22 (pharmacy provided MARs).
    -Topiramate 50 mg administer at 7 pm daily
    -Flintstone's Vitamin administer at 7 am daily
    -Triamcinolone 0.1% cream administer at 7am 7pm daily
    -Nystatin Cream administer at 7am 7pm daily
    -Miralax daily as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 31 -Vitamin C 500 mg Chew tablet 7 am daily. -QC Advanced Probiotic Capsule, 1 daily. -Hydroxyzine 75 mg was administered beginning 11/16/22. Review on 12/16/22 and 12/20/22 of client #1's December 2022 MARs revealed: -Guanfacine 1 mg every morning had been discontinued on the MAR; the last dose documented was on 12/8/22. -A handwritten transcription read to administer oxcarbazepine 300 mg, 1 tablet daily for 14 doses. There were 2 dosing times listed, 7 am and 7 pm, and the first dose was documented at 7 am on 12/8/22. -Client #1 went to the ED on 12/8/22. -Staff documented oxcarbazepine 300 mg was administered twice daily for 4 days, 12/12/22 - 12/15/22, with the last dose at 7 am on 12/16/22. "D/Ced (discontinued) 16 Dec 22" was written on the MAR. -Oxcarbazepine 150 mg, 3 tablets twice daily at 7 am and 7 pm was started on 12/16/22 at 7 pm. -The order transcribed for lorazepam was the order written prior to admission. -Vitamin C 500 mg Chew tablet daily was handwritten on the MAR and the staff documented the first dose at 7 am on 12/20/22. (The last dose administered had been 11/16/22) -QC Advanced Probiotic Capsule, 1 daily was handwritten on the MAR and the staff documented the first dose at 7 pm on 12/19/22. (The last dose administered had been 11/16/22) -On 12/16/22 the following medications scheduled to be administered at 7 pm were not documented as given on 12/15/22; however, on 12/20/22 each had been documented as given at 7 pm on 12/15/22: -Aripiprazole 5 mg -Guanfacine 2 mg	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 32 -Hydroxyzine 25 mg, 3 tablets -Trazadone 100 mg -Melatonin 5 mg, 2 tablets Observations on 12/14/22 at 4 pm of client #1's medication box revealed: -3 tablets remaining on a bubble pack labeled oxcarbazepine 300 mg, "Take 1 tablet by mouth every day for 14 doses." Fourteen (14) tablets had been dispensed 12/7/22. "AM PM" had been hand written at the top of the card. -1 bubble pack card labeled oxcarbazepine 150 mg tablets, "Take 3 tablet by mouth 2 times a day for 60 doses." All 30 doses that had been dispensed 12/13/22 remained on the card. Observation on 12/16/22 at 1:20 pm of the red medication box revealed the following medications on hand that had been dispensed by client #1's former pharmacy: -Vitamin C 500 mg tablet Chew, chew 1 tablet every day; dispensed 9/20/22 with 2 refills remaining. -QC Advanced Probiotic, take 1 capsule daily; dispensed 9/20/22 with 10 refills remaining. -Miralax, mix 1 packet in 8 ounces of fluid and take daily as needed for constipation, dispensed 10/14/22. -Topiramate 50 mg, take 1 tablet at bedtime; dispensed 10/10/22 with 1 refill remaining. There were 11 tablets remaining on the bubble pack. -The ordering physician for Topiramate was client #1's prior Psychiatrist. Interview on 12/20/22 client #1's mother/guardian stated: -On client #1's day of admission she brought all of his medications, to include a few creams, and gave them to the staff. -Received a couple of text messages on her way	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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		V 118		

Continued From page 33

back home asking why client #1 was getting some of the creams.
-Had not been called about any other medications.
-Had received a group email on 12/15/22 from the Qualified Professional/Clinical Director (QP/CD) inquiring about client #1's FL2 and MARs. The email had also been sent to the Local Management Entity/Managed Care Organization Care Coordinator and QP from his previous group home.
-Had not been made aware of any medications discontinued in November, 2022.
-Had not been made aware any medications prescribed for behaviors had been discontinued and knew seizures, anger, and anxiety could occur if not weaned off of these medications.
-Had been called from the facility early one morning (did not give date) and informed client #1 had a seizure and was going to hospital.
-Was told the staff found client #1 "shaking in his bed."
-Client #1 was hospitalized and had a MRI under a general anesthesia and CT (computed tomography) scan.
-The hospital could find no reason for the seizure.
-Client #1 had no history of seizures and there was no family history of seizures.
-Was called the next day and told by Staff #1 that client #1 was "out of it," angry, acting out, and not "being present."
-The physician increased his oxcarbazepine, also a mood stabilizer.
-Was not aware of any order to discontinue client #1's guanfacine 1 mg.

Interview on 12/15/22 the pharmacist stated:
-The pharmacy had received conflicting orders for client #1's oxcarbazepine on 12/7/22.
-The pharmacist had contacted the physician and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 34 received an order clarification to start oxcarbazepine 300 mg daily for 14 days then to increase to 450 mg twice daily. -Was not aware there were medications abruptly stopped on 11/16/22. -Transfer orders from client #1's pharmacy had not included orders for topiramate, Vitamin C, Flintstone Vitamin, or QC Advanced Probiotic. -Transfer orders did include hydroxyzine 75 mg at bedtime. -After becoming aware on 12/15/22 there were medications stopped suddenly on 11/16/22, he contacted the prior pharmacy and was told they did not transfer any prescriptions that did not have refills remaining. -Topiramate was among those orders that had not been transferred. -The sudden stop of topiramate could cause seizures. Interview on 12/15/22 client #1's prior pharmacy staff stated: -Topiramate orders were not transferred because it had no refills. -There had been a titration schedule for his topiramate and he had increased from 25 mg to 50 mg at bedtime. -The pharmacy had dispensed a medication supply to client #1's prior facility that would have been enough for October and November 2022. -Orders for QC Probiotic and Vitamin C had been transferred. -Flintstone vitamin and Miralax had no refills and were not transferred. Interviews on 12/15/22 and 12/21/22 the Psychiatric Provider stated: -Had seen client #1 for the first time on 12/12/22. -The staff stated they had orders for all of his current medications.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 35	V 118		

-Wrote a new order for lorazepam to be used as needed.
-The facility brought a copy of client #1's MAR; it was not up to date with the orders she could view electronically from his most recent hospital stay.
-There were no orders to discontinue his guanfacine 1mg morning dose.

Interview on 12/16/22 Staff #1 stated:
-Client #1's guanfacine 1 mg order had been discontinued because her copy of the hospital discharge summary dated 12/7/22 had slash marks through the medication.
-This was interpreted as a discontinue order.
-Realized when looking at the form (during interview) there were no signatures on the form by a provider and guanfacine had not been listed on the first page of the summary that listed any medication changes.

Interview on 12/16/22 Staff #2 stated:
-Transcribed client #1's medications to his October and November 2022 MARs from a medication list and the medication labels received on admission.
-Was the first staff to document medication administration on the MARs provided by the local pharmacy on 11/16/22.
-Identified there were some medications that had been administered since admission that were not on the printed MAR from the local pharmacy.
-Informed the QP/CD, and the QP/CD said he would "check" with the pharmacy.
-Then "pulled" those medications not listed on the pharmacy MAR from the clients medication box.
-The medications he "pulled" should be in one of the desk drawers or the "red med box."

Interview on 12/15/22 and 12/16/22 the QP/CD stated:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 36	V 118		

-Client #1's prior facility sent him copies of his MAR dated September 2022 and the name of the pharmacy.
-The QP/CD provided copies of client #1's September 2022 MAR to the local pharmacist, who then called the pharmacy to request transfer orders.
-The September 2022 MAR did not list an order for topiramate.
-The QP/CD did not get medication orders from the sending facility.
-Staff administered client #1's medications received on admission.
-The MAR (dated November 2022) received on admission was not compared to the September 2022 MAR received prior to admission.
-Client #1 was sent to the hospital on 12/3/22 because he had a seizure.
-Client #1's mother/guardian said the client did not have a history of seizures.
-Was not aware that medications had been stopped when the pharmacy MAR replaced the handwritten MAR in November.
-Did not recall Staff #2 informing him that some of the medications client #1 had been receiving since admission were not listed on the MAR received from the pharmacy on 11/16/22.
-Had not realized client #1 had been taking topiramate and that it had been stopped when it was not listed on the pharmacy provided MAR in November 2022.

Due to the failure to accurately document medication administration it could not be determined if client #1 received his medications as ordered by the physician.

Review on 12/16/22 of the Plan of Protection dated 12/16/22 and signed by the QP/CD revealed:

(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 37 -"What immediate action will the facility take to ensure the safety of the consumers in your care. The Loving Home, Inc. will ensure clients medications are transferred into the facility by doing the following: -When new medications come into the facility The Loving Home (TLH) staff will ensure all medications have a signed doctor's orders with it. -Before a new client is admitted in the facility, TLH staff will ensure all medications comes with a doctor's orders. -Describe your plans to make sure the above happens. A audit will be completed be the QP and reviewed by pharmacist to ensure all medications are in compliance with the doctor's orders." This is a recited deficiency. Client #1 was admitted from another facility on 10/29/22 with diagnoses of autism disorder and intellectual developmental disabilities, unspecified. Staff transcribed client #1's MARs from the prior facility MAR and medication labels on admission, as there were no orders in hand. On 11/16/22 the facility switched to the MAR printed/supplied by the local pharmacy that omitted some of the medications client #1 had been receiving since admission. There was no follow up to reconcile these discrepancies and those medications were discontinued without an order. This included topiramate 50 mg at bedtime, ordered by client #1's Psychiatrist prior to his admission. Twelve (12) days after topiramate had been discontinued, on 11/28/22 client #1's behaviors escalated to an extreme aggressive level. The next day, 11/29/22, client #2 eloped from the facility. On 12/3/22 client #1 was found having a seizure, admitted to the hospital on 12/3/22, and	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	**2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312**

(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 38	V 118		

discharged on 12/7/22. Client #1 had no history of seizures and no cause for seizures was diagnosed during his hospital stay. He was prescribed an anti-seizure medication, oxcarbazepine, at discharge. There were discrepancies between the oxcarbazepine orders in the facility, and the label instructions. The guanfacine 1mg order was discontinued on 12/8/22, but continued to be printed as a current order on the ED (12/8/22) and Psychiatric Provider's (12/12/22) After Visit Summaries. There was no follow up documented by the facility to reconcile either of these discrepancies.

This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 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 facility is out of compliance beyond the 23rd day.

V 121 | 27G .0209 (F) Medication Requirements | V 121

10A NCAC 27G .0209 MEDICATION REQUIREMENTS
(f) Medication review:
(1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated.
(2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 121	Continued From page 39	V 121		

This Rule is not met as evidenced by:
Based on interview and record review the facility failed to obtain a drug regimen review at least every six months for 1 of 1 client (client #2) who received psychotropic drugs and who had been admitted for more than 6 months. The findings are:

Review on 12/15/22 and 12/20/22 of client #2's record revealed:
-43 year old female admitted 6/17/21.
-Diagnoses included schizophrenia, multiple episodes, currently in remission; depressive disorder, not otherwise specified; moderate intellectual developmental disability, and diabetes.
-Orders dated 10/20/21 for the following psychotropic medications:
-Haloperidol 100 mg/ml (milligrams/milliliter), inject 2.5 ml every 28 days. (schizophrenia)
-Haloperidol 5 mg every night.
-Lamotrigine 50 mg daily. (mood stabilizer)
-Quetiapine fumarate 400 mg each night. (schizophrenia)
-Citalopram 40 mg daily. (depression)
-No documentation of a drug regimen review for client #2 within the past 6 months.

Interview on 12/15/22 the Qualified Professional/Clinical Director stated it had been more than 6 months ago that he obtained a drug regimen review for client #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ____ B. WING ____	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 291	Continued From page 40	V 291		
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 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, observation, and interview, the facility failed to ensure service coordination with the qualified professionals who were responsible for treatment/habilitation or	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 291	Continued From page 41 case management for 1 of 2 clients (client #1). The findings are: Review on 12/14/22, 12/15/22, and 12/21/22 of client #1's record revealed: -19 year old male admitted 10/29/22 -Diagnoses included autism disorder and intellectual developmental disabilities, unspecified. -Client #1 had a Behavior Support Plan dated 7/1/22 with "Target Behaviors" to include physical aggression, elopement, and tantrums. -Behavior Plan "Documentation" read, "Staff at home ... should document each time [client #1] engages in a target behavior using an ABC data sheet." -Level 1 incident report for incident on 11/28/22 when client #1 became combative, slapping Staff #4's phone from her hand twice, was screaming, punching holes in the walls, crying, and trying to throw the medicine cabinet. -Level 2 incident report of an elopement on 11/29/22. -Incident report of an elopement on 12/19/22. -Emergency Department visit on 12/8/22 for extreme aggressive behaviors. -The following medications administered from admission were discontinued on 11/16/22 because they were not printed on the Medication Administration Record from the pharmacy: -Topiramate 50 mg (milligrams) administer at 7 pm daily. (seizures, mood stabilizer) -Flintstone's Vitamin administer at 7 am daily. (supplement) -Triamcinolone 0.1% cream administer at 7am 7pm daily. (skin condition discomfort) -Nystatin Cream administer at 7am 7pm daily. (antifungal) -Vitamin C 500 mg Chew tablet 7 am daily. (supplement)	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 291	Continued From page 42 -QC Advanced Probiotic Capsule, 1 daily. (improve digestion) Interview on 12/21/22 the Local Management Entity/Managed Care Organization Care Manager stated she had requested behavior logs but had not received anything from the facility. Interview on 12/20/22 client #1's mother/guardian stated: -Had not been notified when client #1 eloped on 12/19/22. -Had not been informed of any medication changes. Interview on 12/16/22 the Pharmacist stated he was not aware medications had been discontinued on 11/16/22 because they were not printed on the Medication Administration Record provided by the pharmacy.	V 291		
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 interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are:	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ____ B. WING ____	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 43 Observations on 12/14/22 during facility tour between 1:40 pm and 2:30 pm revealed: -Kitchen wall cracked and punched in and around the light switches beside the rear exit door. Vertical cracks approximately 10 inches in length. -Vinyl flooring peeling away from the back door threshold exposing sub-floor. Sections of vinyl floor covering missing by the washer and dryer; one area approximately 12 inches and another approximately 5 inches in diameter. -Two mattresses and box springs with metal frames leaning against the house on the back porch. -Surfaces of the eaves along the back of the home were discolored with a gray staining. -Outside light fixture on the porch had no globe over an exposed light bulb. -Kitchen ceiling fan blades were bent downward. -Dining room overhead light fixture with 5 bulbs had one without a shade, and 2 bulbs were not working. -Unpainted wall repair by bathroom door approximately 12 by 24 inches in size. -Hall bathroom: Finish worn from surface of bathroom vanity; no stopper in sink; unfinished section of wall above the tub approximately 24 by 24 inches in size. Observations on 12/16/22 between 10 am and 10:15 am revealed: -Window screen bent away from window frame client #1's bedroom. -Three unpainted wall repairs, one at the head of client #1's bed approximately the size of a football, and 2 other areas between the wall and the bed of comparable size. -Approximately 4 broken or missing window blind slats in client #2's bedroom. -A section of wall from floor to ceiling about 3 feet in width had not been finished in client #2's	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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 44 bedroom. Interview on 12/16/22 Staff #1 stated: -Repairs were ongoing. -The unpainted wall repairs in the bathroom and client #2's room were the result of a leak in the bathroom shower. This deficiency has been cited 6 times since the original cite on 1/26/18 and must be corrected within 30 days.	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 observations and interview, the facility failed to maintain water temperatures between 100-116 degrees Fahrenheit where clients had access to hot water. The findings are Observations on 12/14/22 during facility tour between 1:40 pm and 2:30 pm revealed: -The hot water temperature at the hall bathroom sink measured 120 degrees Fahrenheit. -The hot water temperature at the master bathroom sink measured 120 degrees Fahrenheit.	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-826	A. BUILDING: ______ B. WING ______	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LOVING HOME, INC #2	2162 DOBBIN HOLMES ROAD FAYETTEVILLE, NC 28312

(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	Continued From page 45 Interview on 12/21/22 the Qualified Professional/Clinical Director stated he was not aware the hot water was out of acceptable range and would follow up.	V 752		