STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-267	A. BUILDING: _____ B. WING _____	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME SWEET HOME #1	1622 FLORA AVENUE BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on January 27, 2023. Deficiency was 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 four beds and currently has a census of three. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105		

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V 105	Continued From page 1 (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		

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

Review on 1/19/23 of client #2's record revealed:
-Admission date of 8/25/21.
-Diagnoses of Post-traumatic Stress Disorder-Unspecified, Unspecified Bipolar Disorder by history, Mild Intellectual Disabilities, Borderline Personality Disorder by history, Other Problem Related to Employment (unemployed) and Low Income
-Physician's order dated 8/12/22, check blood sugar once a week.

Review on 1/19/23 and 1/27/23 of Medication Administration Records (MARs) revealed:
-January 2023 MAR- staff checked client #2's blood sugar once a week from 1/1 through 1/27.
-November and December 2022 MARs- staff checked client #2's blood sugar once a week.

Review on 1/17/23 of the facility records revealed:
-No evidence the facility had a CLIA waiver to check client #2's blood sugar.

Interview on 1/27/23 with staff #1 revealed:
-Client #2 was not diagnosed as diabetic but doctors requested her blood sugar be checked weekly.
-She and other staff checked client #2 blood

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V 105	Continued From page 3 sugar once a week. Interview on 1/27/23 with the Director revealed: -She had never heard of the CLIA waiver. -Client #2 was their first client that required blood sugar checks. -She confirmed the facility failed to have a CLIA waiver.	V 105		