Division of Health Service Regulation

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 _____	02/24/2022

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 A complaint and follow up survey was completed on February 24, 2022. The complaint was unsubstantiated (intake #NC00186057 and NC00186067). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised living for Adults with Developmental Disabilities. This survey sample consisted of 2 current clients and 1 former client.	V 000		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing
V 111	27F .0205(A-B) 10A NCAC 27F .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 strength; (3) a provisional or admitting diagnosis with an established diagnosis determined with 30 days of admission, except that a client admitted to a detoxification of other 23-hour medical program shall have an established diagnosis upon admission; (4) 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.	V 111		

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V111	Continued From page 1 The Rule is not met as evidenced by: Based on record review and interview the facility failed to complete an assessment that included their needs and strengths prior to delivery of services for one of one former client (FC) (#3). The findings are: Review on 02/18/22 of FC #3's record revealed: -18 year old female. --Admission date of 10/15/21 -Diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Disability, Post Traumatic Stress Disorder Asthma and Schizoaffective Disorder. -Discharge of 2/4/22. -No admission assessment prior to delivery of services. Interview on 02/18/22 the Qualified Professional stated he understood an admission assessment had to be created prior to the delivery of services.	V 111	The Loving Home, Inc. (TLH) Qualified Professional (QP) and/or Medical Record Personnel will ensure admission forms and a plan is developed based on the assessment in partnership with the client, or legal responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days are in clients record. Also the QP and/or Medical Record Personnel will ensure that strategies, staff responsible. A schedule for review of the plan at least annually in consultation with the clients or legally responsible person or both. Basis for evaluation or assessment of outcome achievement, and written consent or agreement by the client or responsible party or a written statement by TLH stating why such consent could not be obtained. TLH QP or Medical Record Personnel will conduct a peer review quarterly to ensure all client's record are in compliance.	Implementation Date: 10/15/2022 Projected Completion Date: Ongoing
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan			

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V112	Continued From page 2 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 legal responsible person or both, within 30 day of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment for two of two current clients (#1 and #2) and one of one former clients (FC) #3). The finding are: Finding #1:	V 112		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

PRINTED: 02/28/2022
FORM APPROVED

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V112	Continued From page 3 Review on 02/18/22 of client #1's record revealed: -32 year old male. -Admission date of 11/28/07 -Diagnoses of Obsessive Compulsive Disorder, Schizoaffective Disorder, Borderline Personality Disorder, Mild Intellectual Developmental Disability, Asthma and Colostomy. Review on 02/18/22 on client #1's Individual Service Plan (ISP) revealed: -Date of Plan 06/01/21 -No strategies identified to address client #1's history of making false allegations. Finding #2: Review on 02/18/22 of client #2's record revealed: -42 year old female. -Admission date of 1017/10 -Diagnoses of Mild IDD, Attention Deficit Hyperactivity Disorder, Obesity and Schizophrenia. -No tracking information for client #2's ISP dated 11/1/21 revealed: -Goal #3: Client #2 to learn health and safety at home and in the community. -'[Client #2] can drink 5 cups of water per day." -Medical Supports: Client #2 can drink cups of water daily to regulate sodium levels. -Staff have a tracking system in place to track fluid intake. Finding #3: Review on 02/18/22 of FC #3 record revealed: -18 year old female. -Admission date of 10/15/21	V 112	TLH staff will ensure all clients will have documentation on every client that has a monitoring scheduling for a goal in their records to show outcome of the goal. QP or Medical Record Personnel will conduct a quarterly peer view to ensure the documentation of client(s) goal is in their plans.	Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

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V112	Continued From page 4 -Diagnoses of ADHD, Oppositional Defiant Disorder, IDD, Post Traumatic Stress Disorder, Asthma and Schizoaffective Disorder. -Discharge of 2/4/22 Review on 02/18/22 of FC #3's record revealed: -A discharge summary from an acute care hospital dated 10/15/21. -The reason for admission was suicide attempt at home. Review on 02/18/22of FC #3's Person Center Plan dated 01/13/22 revealed no strategies to address FC #3's self injurious behavior. Interview on 02/18/22 and 02/23/22 the Qualified Professional stated: -Client #1 had a history of making false allegations against staff. -Client #1 had attempted to get several staff fired of the past few years. -He did not know if staff documented client #2's fluid intake. -He would follow up on client #2's fluid intake documentation. -He understood the treatment plans had to have strategies for identified problems.	V 112		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing
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	V 114		

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V114	Continued From page 5 and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility as all 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. The rule is not met as evidenced by: Based on record review and interview the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 02/17/22 of facility records from April 2021 thru December 2021 revealed: -No fire drills documented on first shift for the 2nd quarter of 2021. -No 2nd or 3rd shift fire drills documented for the 3rd and 4th quarter of 2021. -No 2nd or 3rd shift disaster drills documented for the 3rd quarter of 2021. Interview on 02/17/22 the House Manager stated: -She had been House Manager for approximately 2 months. -The facility had shifts per day. -1st shift was 8am to 4pm. -2nd shift was 4pm to 11pm. -3rd shift was 11pm to 11am. -The times staff enter the facility fluctuate at times. -She understood fire and disaster dills needed to be conducted on each shift quarterly. Interview on 02/2/22 the Qualified Professional	V 114	TLH Group Home Manager will ensure going forward that a fire and disaster drills are conducted and documenting at least quarterly on each shift to ensure the safety of the clients living in the group home. The QP will monitor fire and disaster drills quarterly to ensure a drill is conducted on each shift.	Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

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V114	Continued From page 6 Stated he understood fire and disaster drills need to be conducted quarterly and repeated on each shift.	V 114		Implementation Date: 10/15/2022
V118	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 b law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) Client's name; (B) name, strength, and quantity of the drug' (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V118		Projected Completion Date: Ongoing

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V118	Continued From page 7 The Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to the MARs current affecting two of two current clients (#1 and #2). The findings are: Finding#1: Review on 02/18/2/22 of client #1's record revealed: -32 year old male. -Admission date of 11/28/07 -Diagnoses of Obsessive Compulsive Disorder, Schizoaffective Disorder, Borderline Personality Disorder, Mild Intellectual Developmental Disability, Asthma and Colostomy. Review on 02/17/22 and 02/2/22 of client #1's medication orders revealed: 11/04/22 -Mupirocin 2% (used to treat skin infection) –apply 3 times daily. -Triamicnolone 0.5% (treats skin conditions) –apply twice daily. 02/01/22 Seroquel (antipsychotic) 200milligrams (mg) –take one at bedtime Review on 02/17/22 of client #1's December 2021 MARs revealed the following blanks: -Triamcinlone – 12/01/21 thru 12/31/21 at 7am and 7pm. -Mupirocin – 12/4/21, 12/05/21, 12/07/21 thru 12/12/21 and 12/18/2` thru 12/19/21 at 7am. -Mupirocin – 12.06 thru 12/07/21, 12/13/21 thru 12/14/21 and 12/20/21 at 7pm.	V 118	TLH will have staff attend a Medication Administration Record (MAR) re-cert class to review how to document on a MAR form on 03/11/2022 at the TLH Office. The Group Home Manager will review the MAR's weekly to ensure staff is documenting them properly. The QP or Medical Record Personnel will conduct a peer view quarterly to ensure clients MAR's are documented properly.	Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

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V118	Continued From page 8 Seroquel – 12/21/21 at 7pm. Interview on 02/1722 client #1 stated he received his medications daily. Finding#2: Review on 02/18/22 of client 2's record revealed: -42 year old female. -Admission date of 10/17/10. -Diagnoses of Mild IDD, Attention Deficit Hyperactivity Disorder, Obesity and Schizophrenia. Review on 02/17/22 and 02/23/22 of client #2's medication orders revealed: 1/14/21 -Latanoprost (treats high pressure in the eye) 0.005% -instill one drop in both eyes daily. 02/11/21 -Prilosec (treats conditions caused by excess stomach acid) 20mg – take once daily. -Colace (stool softener) 100mg – take one capsule twice daily. 08/11/21 -Metformin (treats diabetes) 500mg –take once daily. 10/20/21 -Celexa (antidepressant) 20mg – take once daily. -Seroquel 400mg – take once daily. -Atarax (antiaxiety) 50mg – take twice daily. 12/07/21 -Aspirin (treats pain and heart attacks) 81mh –take once daily. Review on 02/1722 of client #2's December	V 118		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

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V118	Continued From page 9 2021 and January 2011 MARs revealed the following blanks: December 2021 -Metformin – 12/04/21 and 1205/21 at 7am. -prilosec – 12/0421 and 12/05/21 at 7am. -Aspirin – 12/0421 and 12/05/21 at 7am. -Colace- 12/0421 and 12/05/21 at 7am. -Celexa - 12/0421 and 12/05/21 at 7am. -Atarax – 12/0421 and 12/05/21 at 7am and 12/14/21 at 7am. January 2022 -Colace - 01/1/22 at 7am. -Seroquel - 01/1/22 at 7am. -Latanoprost - 01/1/22 at 7am. Interview on 02/17/22 client #2 stated she received her medication daily. Interview on 20/17/22 the House Manager stated: -She had been the House Manager for approximately 2 months. -She understood the MARs need to be current and signed off when medications were administered. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 118		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing
V120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATTIION REQUIREMENTS (e) medication Storage: (1) All medication shall be stored: (A) in securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36	V120		

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V120	Continued From page 10 Degrees and 46 Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; © separately for each client; (D) separately for external and internal use' (E) in a secure manner if approved by a physician or a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled substances Act, G.S. 90, Article 5, including any subsequent amendments. The Rule is not met as evidenced by; Based on observation and interviews, the facility failed to ensure a refrigerated medication was kept in a locked compartment or container for one of one former client (FC) (#4). Observation on 02/17/22 at approximately 12:45pm revealed: -The facility refrigerator used for the client's food had to black metal boxes. -One of the metal boxes was unlocked -The unlocked metal box contained a Novolog (insulin pen to treat diabetes).\-The FC $4 no longer lived at the facility. Interview on 02/17/22 the House Manager stated FC # no longer resided at the facility. Interview on 0/23/22 the Qualified Professional Stated: -He did not know why FC 4's medications were in the facility refrigerator.	V 120	TLH will have staff attend a Medication Administration Record (MAR) re-cert class to review the important of medication required to be in refrigerator is in a locked container at all times. The Group Home manager will monitor daily to ensure medication(s) is/are in a locked container when refrigerated. QP will monitor the bi-monthly to ensure client(s) refrigerated medication(s) is/are locked in the refrigerator.	Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

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V120	Continued From page 11 -He understood client medications in the client refrigerator were required to be locked and secure. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 120		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing
V132	G.S 131E-256 HEALTH CARE PERSONNEL REGISTRY (9) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. Which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 13E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E -201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all	V132		

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V132	Continued From page 12 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) is notified of all allegations against health care personnel. The findings are: Review on 02/1822 of client #1's record revealed: -32 ear old male. -Admission date of 11/20/07. -Diagnoses of Obsessive Compulsive Disorder, Schizoaffective Disorder, Borderline Personality Disorder, Mild Intellectual Developmental Disability, Asthma and colostomy. Review on 02/18/22 of client #1's individual Service Plan (ISP) revealed: -Date of plan 06/01/21. -No strategies identified to address client #1's history of making false allegations. Review on 02/23/22 of an internal investigation	V 132	TLH QP will ensure the Health Care Personnel Registry (HCPR) Level II or Level III Incident Report is submitted to within 72 hours of the incident by completing the IRIS Report and submitting it to HCPR within the 72 hours window. The QP will receive the conformation inform from HCPR to ensure the IRIS Report was transmitted.	Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

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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 _____	02/24/2022

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
V132	Continued From page 13 For client #1's 02/10/22 allegation against staff #3 revealed: -The Qualified Professional (QP) had completed an internal investigation. -The QP unsubstantiated client #1's allegation of abuse against staff #3. -No documentation on the internal investigation the HCPR was notified of the allegation against staff #3. Interview on 02/17/22 client #1 stated: -He told his guardian about abuse from staff #3 -No one had witnessed staff #3 abusing him. -He spoke with the QP about the abuse allegation. Interview on 02/17/22 and 02/23/22 the QP stated: -He was made aware of client #1's allegation of abuse against client #1 on 02/10/22. -Client #1's guardian had notified him about client #1's allegation. -Client #1 had a history of making false allegations against staff. -He had not notified The HCPR of client #1's allegation against staff #3 nor the subsequent investigation results. -He understood any and all allegations against personnel should be sent to the HCPR.	V 132		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY AND B PROVIDERS (a)Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III	V367		

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V367	Continued From page 14 Incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report many be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities, and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy	V 367		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

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V367	Continued From page 15 of all level III incident reports to the division of Mental Health, Developmental disabilities and Substance Abuse Services with 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows; (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client of his living area; (4) seizures of client property or property in the possession of a client; and (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of the Rule and subparagraphs (1) through (4) of this Paragraph.	V 367		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

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V367	Continued From page 16 This rule is not met as evidenced by: Based on record review and interview the facility fail to ensure critical incident reports were submitted to the Local Management Entity (LME within 72 hours as required. The finding are. Review on 02/17/22 of the Incident Response improvement System (IRIS) website from December 2021 thru 02/17/22 revealed no level II incident reports for client#1 or former client (FC) #3. Finding #1: Review on 02/18/22 of client #1's record revealed: -2 year old male. -Admission date of 11/28/07 -Diagnoses of Obsessive Compulsive Disorder, Schizoaffective Disorder, Borderline Personality Disorder, Mild Intellectual Developmental Disability, Asthma and colostomy. Review on 02/18/22 of client #1's individual Service Plan (ISP) revealed: -Date of plan 06/01/21 -No strategies indentified to address client #'s history of making false allegations. Review on 02/2/22 of an internal investigation for client #1's allegation against staff #3 revealed: -The Qualified Professional (QP) had completed an internal investigation. -The QP unsubstantiated client #1's allegation of abuse against staff 3. -No documentation on the internal investigation the HCPR was notified of the allegation against staff 3.	V 367	TLH QP will ensure the Local Management Entity (LME) Level II or Level III Incident Report is submitted to within 72 hours of the incident by completing the IRIS Report and submitting it to HCPR within the 72 hours window. The QP will receive the conformation inform from HCPR to ensure the IRIS Report was transmitted.	Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

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V367	Continued From page 17 Interview on 02/17/22 client#1 stated: -He told his guardian about abuse from staff #3. -No one had witnessed staff #3 abusing him. -He spoke with the QP about the abuse allegation. Finding #2 Review o 02/18/22 of FC #3 record revealed -18 year old female. -Admission date of 10/15/21 -Disorder, Oppositional Defiant Disorder, Intellectual developmental Disability, Post Traumatic Stress Disorder Asthma and Schizoaffective disorder. -Discharge of 2/4/22 A. Review on 02/18/22 of the County Sheriff Department website revealed: -Law enforcement had been summoned to the facility on 02/02/22 and 02/04/22 due to FC #3's behavior. B. Review on 01/23/22 of an IRIS report not submitted to the LME dated 02/03/22 at 4:15pm revealed: -"On 02/03/22 approximately 4:15pm Director [QP], received a call from the lead school counselor at [local] High School stating [FC #3] refused to get on school bus to go home. Director pickup [FC #] and transported her to the group home. When we entered the group home [FC #3] stated accusing staff of talking about and she ran out the door running toward the street. Staff when behind her instructing her to come back. Staff had to restrain her securing her right arm above the elbow to prevent her from going into the street. Staff release her and they walked back to the group home. About 5 minutes later [FC #3]s boyfriend and his father arrived in the	V 367		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

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V367	Continued From page 18 Yard. The father said he came t apologize for letting [FC #3] lied and told his wife that she had permission from her home. When director enter back in the group home [FC#3] hand knock over the 55" television and broke cracked the screen. Also flipped over two chairs and attempted bang on the window. Staff had to removed [FC#3] from the window. She eventually clam down and started to her room. She then tells staff she was going to kill herself. Staff monitor [FC##3] the remaining of the evening by conducting sleep checks every 15 minutes." Interview on 02/17/22 and -2/23/22 the QP stated: -He was made aware of #1's allegation of abuse against client#1 on 0210/22. -Client #1's guardian had notified him about Client #1's allegation. -Client #1 had a history of making false allegations against staff. -He had not completed and IRIS report for client #1's allegation. -He had completed an IRIS report for FC #'s behavior on 02/03/22 -He thought the IRIS report on 02/03/22 had been submitted properly. -He understood the law enforcement involvement with FC 's behaviors on 01/01/22 and 02/04/22 needed to be documented in IRIS.	V 367		Implementation Date: 10/15/2022 Projected Completion Date: Ongoing
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	V 736		

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V763	Continued From page 19 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: Observation on 02/17/22 at approximately 12:45pm revealed: -The front porch ceiling was discolored. -The front door had three cracks in the surface. -The carpet throughout the facility appeared soiled with dark spots. -The linoleum in the kitchen had splits in the surface. The kitchen floor had sports and uneven. - The laundry area receptacle was pulled from the wall. -The kitchen ceiling fan had a bulb missing. -Client 1's bathroom had a rusty floor vent and one of the vanity light bulbs was broken in the socket. -Client 2's bedroom had 2 broken slats in the window blinds and thick layer of dust was on the ceiling fan blades. - Former client #3's bedroom door surface had a crack. The closet had a softball sized hole in the wall. A base sized hole in the wall. Interview on 02/2/22 the Qualified Professional stated the facility is scheduled for repairs. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 763	TLH QP will contact the contracted maintenance person paint front porch ceiling, replace or repair front door, repair kitchen floor, repair receptacle in laundry area. In client 1's bathroom replace floor vent, remove broken light bulbs in socket and install new light bulbs. In client 2's bedroom will put-up new window blinds. Contracted maintenance person will replace bedroom door in form client 3's bedroom and repair softball size like hole in the closet wall. QP will contact the contracted carpet cleaning company to come out and clean the carpet floors. Group home staff will install a light bulb in kitchen ceiling and clean the dust off client 2's ceiling fan blades. Group Home Manager will complete an Environmental Inspection Form monthly to ensure everything in the group home safe and working properly. If something needing fixing Group Home Manager will fill out a work order and submit it to the QP. QP will contact the responsible person to do the work needed.	Implementation Date: 10/15/2022 Projected Completion Date: Ongoing

Signature: Vincent M. Williams, Clinical Director
Vincent M. Williams, Clinical Program Director

Date: 05/29/2022