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
	MHL040-019	A. BUILDING: _____ B. WING _____	R 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTER SEALS UCP-GREENE COUNTY GROUP HOM	704 SE SECOND STREET SNOW HILL, NC 28580

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on April 13, 2023. The complaint was substantiated (intake #NC00199912). 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 6 and currently has a census of 5. The survey sample consisted of audits of 5 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	V112 Plans signed by 5/3/23. Two of the five plans had been signed, but the signatures was not filed in the EHR (Electronic Health Record). Coaching for Manager by Program Director to ensure all plans are signed and uploaded in the EHR. ESUCP's EHR is set up to prevent staff from documenting on goals if plans are not updated (this includes with guardian signature). DHSR - Mental Health MAY 11 2023 Lic. & Cert. Section	5/5/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leslie Flowers, Snr. QM Director — TITLE — (X6) DATE: 5/5/23

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure written consent or agreement by the client or responsible party or a written statement of why such consent could not be obtained was included on the treatment/habilitation or service plan for 4 of 5 audited clients (#2, #3, #4, and #5). The findings are:

Review on 4/11/23 of client #2's record revealed:
- 21 years old, admitted 2/24/21.
- Diagnoses included Intellectual/Developmental Disability (I/DD), severe; and Cerebral Palsy (CP) with spastic quadriplegia.
- Client #2's guardian was a local Department of Social Services.
- Habilitation plan with short term goals dated 12/01/22 with no guardian signature/consent or statement of why guardian signature/consent could not be obtained.

Telephone call on 4/13/23 to client #2's guardian was not answered or returned.

Review on 4/11/23 of client #3's record revealed:
- 73 years old, admitted 8/15/88.
- Diagnoses included I/DD, severe; CP; and Stroke with probable right hemiparesis.
- Client #3 was not adjudicated incompetent and

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V 112	Continued From page 2 was his own guardian. - Habilitation plan with short term goals dated 11/02/22 with no client signature/consent or statement of why client #3's signature/consent could not be obtained. During attempted interview on 4/11/23 client #3 spoke in a low tone and his speech was mumbled and difficult to understand. Review on 4/12/23 of client #4's record revealed: - 73 years old, admitted 8/11/88. - Diagnoses included I/DD, severe and CP. - Client #4 ' s sister was his guardian. - Habilitation plan with short term goals dated 7/01/22 with no guardian signature/consent or statement of why guardian signature/consent could not be obtained. Review on 4/11/23 of client #5's record revealed: - 39 years old, admitted 3/03/17. - Diagnoses included I/DD, profound; and CP. - Client #5 ' s mother was her guardian. - Habilitation plan with short term goals dated 9/01/22 with no guardian signature/consent or statement of why guardian signature/consent could not be obtained. Attempted interview on 4/13/23 with client #5's mother/guardian; telephone call was unanswered; surveyor was unable to leave a voicemail. During interview on 4/11/23 the Supervisor/House Manager/Qualified Professional stated: - She thought the guardian and client signatures were on the habilitation plans. - She did not have signed signature pages for the current habilitation plans. - Signatures would be obtained.	V 112		

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V 114	Continued From page 3	V 114		
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. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: Reviews on 4/11/23 and 4/13/23 of the facility's fire and disaster drill records April 2022 - March 2023 revealed: - No documentation of a weekday fire or disaster drill for the 3rd shift in the fourth quarter (October - December) 2022. - No documentation of fire or disaster drills held on the weekends for the third quarter (July - September) 2022 or the first quarter (January - March) 2023. - No documentation of any fire or disaster drills for the second quarter (April - June) 2022.	V 114	V114: Drills reviewed by the surveyor were practice drills the manager completed with the new staff – this contributed to the timeframe being extended. Moving forward, manager will indicate "Staff Training" on the drills completed with new staff. Program Director will reach out to Care Coordinator in obtaining an Orbit – which is an adaptive equipment staff may use to transfer resident out of bed in order to decrease time taken to egress. Program Director and Program VP working with Human Resources Talent Acquisition to obtain an additional staff to support egress at night. This would ensure residents have the needed support in order to be transferred from their bed and into their chairs for evacuation. Due to residents either being out of the facility or currently in their wheelchairs, additional staff are not needed for other shifts.	5/5/23

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V 114	Continued From page 4 During attempted interview on 4/11/23 client #3 spoke in a low tone and his speech was mumbled and difficult to understand. During interview on 4/13/23 client #4 stated he went outside for fire drills. During interview on 4/11/23 staff #1 stated drills were done once monthly. During interview on 4/11/23 staff #2 stated she was not sure how often drills were done, she remembered 2 or 3 drills. During interview on 4/11/23 the Supervisor/House Manager/Qualified Professional stated: - The facility operated with three shifts Monday through Friday: 1st shift 8:00 am - 4:00 pm; 2nd shift 4:00 pm - 12:00 am; 3rd shift 12:00 am - 8:00 am; and 12 hour shifts on the Saturday and Sunday, 8:00 am - 8:00 pm and 8:00 pm - 8:00 am. - Clients were usually in the community or at their day program during the first shift Monday - Friday. - She conducted the third shift drills for the fourth quarter of 2022 "I did them on second shift." - She could not locate documentation of the drills for the second quarter of 2022. - She trained staff how to conduct drills and often was present when drills were held. - Clients went to either the backyard or to the street during fire drills depending on the location of the mock fire. - Corporate management provided a schedule for fire and disaster drills for staff to follow. This deficiency is cross-referenced into 10A NCAC 27G .5602 Supervised Living - Staff (V290) for a Type A2 rule violation and must be	V 114		

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V 114	Continued From page 5 corrected within 23 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 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.	V 118	V118: According to staff – documentation had occurred, but the computer had not synced. Program Manager meet with staff regarding new guidance – print off MARs at the beginning of the month for staff to document administration when experiencing syncing issues virtually. This will then be uploaded and documented in Quickmar as a late entry by the GH Manager. QM and team (RN and Program Director) provided coaching to the manager regarding Physician's orders. If a Physician's order is received, manager is to pull the meds immediately rather than waiting on confirmation from the Pharmacy and the RN.	5/15/23

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V 118	Continued From page 6 This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to ensure medications were administered as ordered and to keep the MARs current for 2 of 5 audited clients (#3 and #5). The findings are: Finding #1: Review on 4/11/23 of client #3's record revealed: - 73 years old, admitted 8/15/88. - Diagnoses included I/DD, severe; CP; Stroke with probable right hemiparesis; and type 2 Diabetes. - Physician's order signed 3/23/23 for blood glucose checks three times daily; Novolog Flexpen (diabetes), inject subcutaneously at breakfast, lunch and dinner as directed per sliding scale. - Sliding scale for Novolog Flexpen included: 0-150 give 0 units 150 - 200 give 1 units 201 - 250 give 2 units 251 - 300 give 3 units 301 - 350 give 4 units 351 and greater give 5 units Review on 4/11/23 of client #3's MARs for February - April 2023 revealed: -No documented blood sugar checks or administration of Novolog 7:00 am 4/08/23; 7:00 am 3/25/23; 12:00 pm 2/06/23. Finding #2: Review on 4/11/23 of client #5's record revealed: - 39 years old, admitted 3/03/17. - Diagnoses included I/DD, profound; and CP. - Physician's order signed 12/05/22 for Miralax (laxative) mix 17 grams in 8 ounces of beverage and drink every night at bedtime; 4/05/23 to	V 118		

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V 118	Continued From page 7 discontinue Miralax and start Linzess (laxative) 72 micrograms 1 capsule daily. Review on 4/11/23 of client #5's MAR for April 2023 revealed: - Transcription for polyethylene glycol (generic for Miralax) with documentation of administration daily 4/01/23 - 4/10/23. - Transcription for Linzess with documentation of administration daily 4/07/23 - 4/10/23. During interview on 4/12/23 staff #3 stated client #5 received her medications daily as ordered. During interviews on 4/11/23 and 4/12/23 the Supervisor/House Manager/Qualified Professional stated: - She did not know why client #3's blood sugar checks and Novolog administration were not documented three times. - She did not realize client #5's Miralax was discontinued. - The Linzess was added to the MAR, but the Miralax was not removed. - Client #5 continued to receive Miralax after the physician discontinued it. - Client #5 had not experienced any diarrhea or changes in her bowel patterns. - She understood the requirement for MARs to be kept current. - She would remind staff to document medications on the MARs immediately after administration.	V 118		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d)	V 290	V290 Program Director will reach out to Care Coordinator in obtaining an Orbit – which is an adaptive equipment staff may use to transfer resident out of bed	5/5/23

			in order to decrease time taken to egress. Program Director and Program VP working with Human Resources Talent Acquisition to obtain an additional staff to support egress at night. This would ensure residents have the needed support in order to be transferred from their bed and into their chairs for evacuation. Due to residents either being out of the facility or currently in their wheelchairs, additional staff are not needed for other shifts.	

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V 290	Continued From page 8 of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance	V 290		

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V 290	Continued From page 9 abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facilty failed to maintain staff-client ratios above the minimum numbers to enable staff to respond to client needs affecting 5 of 5 clients (#1, #2, #3, #4, and #5). The findings are: Cross-Reference: 10A NCAC 27G .0207 Emergency Plans and Supplies (Tag V114). Based on record reviews and interviews the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. Observations on 4/11/23 at approximately 9:15 am and 4/12/23 at approximately 10:30 am revealed: - The facility had 2 bedroom halls with 3 bedrooms on each hall. - Sprinklers present in the ceilings throughout the facility; a fire extinguisher in each bedroom hallway and in the kitchen. - A mechanical lift in the facility living room. - A mechanical lift and hospital bed in client #2's bedroom. - Client #2 was seated in a manual tilt-in-space wheelchair; due to his physical limitations, including contractures of his hands, he was unable to maneuver his wheelchair independently. - A mechanical lift and hospital bed in client #3's bedroom. - Client #3 was seated in a motorized wheelchair; he was not observed to maneuver the wheelchair	V 290		

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V 290	Continued From page 10 independently. - Client #4 was seated in a motorized wheelchair; he was observed to maneuver the wheelchair independently; he seemed to have difficulty going through doors without bumping into the door frame. - A mechanical lift and hospital bed in client #5's bedroom. - On 4/11/23 client #5 was observed in her bed with the bedrails raised. - On 4/12/23 client #5 was observed seated in a manual tilt-in-space wheelchair; due to her physical limitations she was unable to maneuver her wheelchair independently. Review on 4/11/23 of client #1's record revealed: - 53 years old, admitted 8/01/08. - Diagnoses included Intellectual/Developmental Disability (I/DD), profound; Cerebral Palsy (CP); Autism Spectrum Disorder; blind. - Psychological Evaluation dated 2/10/21 included ". . . self-direction - requires total support/assistance . . ." - FL-2 dated 1/07/21 included documented risk of wandering, constant disorientation, functional limitations in sight and speech. - Individual Support Plan dated 9/01/22 included documentation that client #1 would place his hand on staff's shoulder for guidance during ambulation; he required complete assistance for some basic skills and "all complex skills." Review on 4/11/23 of client #2's record revealed: - 21 years old, admitted 2/24/21. - Diagnoses included I/DD, severe; and CP with spastic quadriplegia. - Psychological Assessment dated 11/25/20 included documentation that client #2 was "vulnerable to . . . environmental dangers" and required assistance to maneuver his wheelchair.	V 290		

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V 290	Continued From page 11 - Individual Support Plan dated 12/02/22 included ". . . requires support to evacuate home . . . " Review on 4/11/23 of client #3's record revealed: - 73 years old, admitted 8/15/88. - Diagnoses included I/DD, severe; CP; and Stroke with probable right hemiparesis. - Psychological Evaluation dated 2/10/21 included ". . . Functional Limitations . . . Mobility: non-ambulatory - motor wheelchair . . . Capacity for Independent Living: Impaired - requires total support/assistance to live in the community home setting . . . " Review on 4/12/23 of client #4's record revealed: - 73 years old, admitted 8/11/88. - Diagnoses included I/DD, severe and CP. - Individual Support Plan dated 7/01/22 included ". . . has use of one side of his body . . . requires physical assistance with transfers . . ." Review on 4/11/23 of client #5's record revealed: - 39 years old, admitted 3/03/17. - Diagnoses included I/DD, profound; CP; and morbid obesity. - Psychological Evaluation dated 2/10/21 included ". . . Functional limitations: . . . vulnerable to . . . environmental dangers . . . " Reviews on 4/11/23 and 4/13/23 of the facility's fire and disaster drill records April 2022 - March 2023 revealed: - Staff documented "difficulty" with evacuation of the clients during a fire drill 2/27/23 and "difficulty" with the clients during tornado drills 12/15/22 and 2/27/23. - Durations of fire drills ranged from 7 minutes (2 clients and 3 staff) to 25 minutes (6 clients and 2 staff). - Durations of disaster drills ranged from 7	V 290		

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V 290	Continued From page 12 minutes (2 clients and 3 staff) to 20 minutes (6 clients and 2 staff). - Licensee's expected durations for drills included 3 minutes for tornado drills, fire drills and shelter-in-place drills and 20 minutes for evacuation drills. During interview on 4/13/23 a representative of the Division of Health Service Regulation Construction Section stated: - Facilities with sprinkler systems were permitted to be licensed for up to 6 non-ambulatory clients. - A "staff to client ratio of 2:6 may not be sufficient" to evacuate if the clients were non-ambulatory. During interview on 4/11/23 staff #1 stated: - She worked second shift. - "If we have time on our side we could evacuate quickly." - It would take both staff to get everyone out safely. - Evacuations were "time consuming." During interview on 4/11/23 staff #2 stated: - She worked second shift. - 2 staff worked each shift. - She did not think 2 staff could safely and quickly evacuate the clients in the event of a fire. During interviews on 4/11/23, 4/12/23, and 4/13/23 the Supervisor/House Manager/Qualified Professional stated: - Client #1 could transfer independently, but required some guidance; the other clients required assistance to transfer; client #5 required use of the mechanical lift for all transfers. - Mechanical lifts were available for use by staff ; female staff were not physically able to manually lift client #3 or #5 because the clients were too	V 290		

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	MHL040-019	A. BUILDING: _____ B. WING _____	R 04/13/2023

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V 290	Continued From page 13 heavy. - Client #1 was blind and required someone to guide him out of the facility. - Client #3 required staff guidance when he was using his motorized wheelchair. - Clients #2, #3, and #5 had hospital beds and their bedrails were up when they were in bed; neither could lower the rails independently. - One staff could use the mecahanical lift to get client #5 out of her bed "but 2 (staff) are safer" when using the mecahanical lift. - Clients #2 and #5 required staff to move their manual wheelchairs. - Client #4 drove his wheelchair independently but often bumped into walls and door frames. - Two staff worked 2nd and 3rd shifts during the week and each weekend shift. - She did not think 2 staff could evacuate all 5 clients safely and quickly in the event of an emergency. - 2nd and 3rd shifts were "not safe." - Evacuation drills "are a struggle." - During drills staff would "rotate" going in and out of the facility to evacuate the clients. - In the event of a fire staff would have to call 911; the facility's smoke detection system did not automatically alarm to the local fire department. - She "mentioned" her concerns to the Regional Director during reviews of drill documentation. During interview on 4/13/23 the Regional Director stated she understood the concern for the clients' safety. Review on 4/13/23 of a Plan of Protection dated 4/13/23 and signed by the Qualified Professional/House Manager revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? Easter Seal (Licensee) will have 3 staff on each	V 290		

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V 290	Continued From page 14 shift for safety. Calling in a 3rd staff starting today." - "Describe your plans to make sure the above happens. We will schedule a 3 staff on second & (and) third shift." Review on 4/13/23 of an amended Plan of Protection dated 4/13/23 and signed by the Qualified Professional/House Manager revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? Easter Seal will have 3 staff on each shift for safety. Easter Seal will conduct Fire Drills on weekend's will do more fire & disaster drill trainings. Calling in a 3rd staff starting today." - "Describe your plans to make sure the above happens. We will schedule a 3 staff on second & third shift. 4/17/23 will have a meeting and traing on Drills." Facility clients had diagnoses that included severe to profound Intellectual/Developmental Disability, Cerebral Palsy, and Autism Spectrum Disorder. Each client had significant physical limitations; 4 used wheelchairs for mobility, 3 relied on staff to maneuver their wheelchairs. One client was blind and required sighted guidance. Four clients required physical assistance with transfers with staff using a mechanical lift with 3 of the clients. Two staff worked on 2nd and 3rd shifts and were to evacuate all 5 clients in the event of an actual emergency. Staff reported concerns for client safety which included that 2 staff could not ensure the safe evacuation of all 5 clients in the event of a fire. Durations of fire and disaster drills in controlled, planned exercises ranged from 7 - 25 minutes. The facility's failure to ensure staffing to meet the clients' needs constitutes a Type A2 violation for substantial risk of serious harm and must be corrected within 23	V 290		

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V 290	Continued From page 15 days. An administrative penalty of $500.00 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 290		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for 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.	V 291	V291 Program Manager contact DSS, The Care Coordinator, and the family regarding the Psychologist recommendation that individual was assessed as being incompetent. This will be documented in the Coordination of care log.	6/1/23

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V 291	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure coordination of care between the facility operator and the professionals who are responsible for the clients' treatment affecting 1 of 5 audited clients (#3). The findings are: Review on 4/11/23 of client #3's record revealed: - 73 years old, admitted 8/15/88. - Diagnoses included Intellectual/Developmental Disability, severe; Cerebral Palsy; and Stroke with probable right hemiparesis. - Client #3 was not adjudicated incompetent and was his own guardian. - Psychological Evaluation dated 2/10/21 included ". . . Functional Limitations . . . Self-Direction: Impaired - requires total support/assistance due to incompetence . . . " - No documentation of follow up of client #3's assessed incompetence or need for appointment of a legal guardian. During attempted interview on 4/11/23 client #3 spoke in a low tone and his speech was mumbled and difficult to understand. During interviews on 4/11/23, 4/12/23 and 4/13/23 the Supervisor/House Manager/Qualified Professional stated: - Client #3's Psychological Evaluation was completed prior to her hire date. - She was not aware the Psychologist assessed client #3 to be incompetent. - She was not confident in client #3's capacity to make informed decisions about his care and treatment. - She would follow up with her supervisor for	V 291		

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V 291	Continued From page 17 guidance.	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 observations and interviews the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 4/11/23 at approximately 9:15 am revealed: - A chair with a broken support on the lower leg at the dining table. - A basketball sized light brown stain on the ceiling above the front door. - An upright freezer with rust stains and scuff marks on the lower half across the front and sides. - No cabinet face/door under the kitchen sink; the underside of the sink basins, the garbage disposal and the plumbing were exposed. - Client #4's room was cluttered with his belongings; the closet had no door or curtain covering and had various items including clean bedding stored on the floor; the window was very difficult for the Qualified Professional (QP) to open.	V 736	V736 Program Director engaged ESUCPs established Facilities Department to address identified issues. Utilizew the facilities checklist submitted ti the Facilities department Monthly to have requested repairs placed in Que.	5/5/23

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V 736	Continued From page 18 - Client #3's room was cluttered with his belongings; the closet had no door or curtain covering; his window stuck and was difficult for the QP to open. - The air filter in the hallway was missing its cover grate. - Bathroom #2 had black matter, consistent with mildew, in the grout in the shower - Client #5's room was very cluttered with her belongings including a recliner chair, her tilt-in-space wheelchair and a mechanical lift; the blades of the ceiling fan were covered in a layer of dust. - The walls and door frames throughout the facility were scuffed and damaged. - The screen for the sliding patio door was out of its track and leaning against the glass patio door. - A wooden storage building in the backyard had the door leaning against the structure. During interviews on 4/11/23 and 4/13/23 the Supervisor/Home Manager/Qualified Professional stated: - Client #4 damaged the air filter cover grate by running into it with his wheelchair; the grate was removed for replacement. - Damage and scuff marks on the walls were from wheelchairs. During interview on 4/13/23 the Regional Director stated the kitchen sink was lowered and the cabinet face/door was removed for wheelchair accessibility. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		