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JOYFUL LIVING #2	6125 LOUISE STREET FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on June 15, 2023. 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 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105		

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

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V 105	Continued From page 2	V 105		

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

Review on 6/13/23 of the North Carolina Division of Health Service Regulation facility CLIA waiver history revealed no current CLIA waiver since 2014.

Finding #1:
Review on 6/14/23 client #3's record revealed:
-45 year old male.
-Admission date, 10/12/10.
-Diagnoses included Intellectual Functioning Disorder, Diabetes Mellitus; Impulse Control Disorder, Hypertension, and Allergic Rhinitis.
-Treatment plan dated 1/24/23 documented staff would monitor client #3's blood glucose daily.
-No physician order for fingerstick blood sugar (FSBS) testing documented.

Refer to V291 for the range of client #3's FSBS results from 3/1/23 - 6/13/23 revealed:

Finding #2:
Review on 6/14/23 client #6's record revealed:
-44 year old male.
-Admission date, 6/26/09.
-Diagnoses included Schizophrenia Disorder with Depression, Anxiety Disorder, Hypertension, Diabetes Mellitus, Acid Reflux.

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V 105	Continued From page 3 -No physician order for FSBS testing documented. Refer to V291 for the range of client #6's FSBS results from 3/1/23 - 6/13/23 revealed: Interview on 6/14/23 Staff #1 stated: -He performed the FSBS checks for client #3 and #6. Each client had their own glucometer. -He was taught how to perform the FSBS checks by the Licensee. Interview on 6/15/23 the Licensee stated: -She had received a CLIA waiver in the past but she did not have a current waiver for FSBS testing.	V 105		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and	V 112		

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V 112	Continued From page 4 (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 (1) develop and implement treatment plans based on client assessment for 3 of 3 clients audited (#1,#3,#6); (2) document unsupervised time for 3 of 3 audited clients (#1, #3, #6); and (3) failed to assure current treatment plans were signed by the client or legal guardian for 2 of 3 clients audited (#1, #3). The findings are: Finding #1: Review on 6/14/23 client #1's record revealed: -22 year old male. -Admission date, 6/1/22. -Diagnoses included Intellectual Disability; Schizoaffective Disorder,Bipolar Type; Generalized Anxiety Disorder; and Attention Deficit Hyperactivity Disorder, Combined Type. -Client #1 was his own guardian. Review on 6/14/23 of client #1's Admission Assessment dated 6/1/22 revealed: -Behavior problems: loses his temper easily; verbal threats; cries/screams; damages property; sexual behaviors.	V 112		

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V 112	Continued From page 5 -Presenting problems: Required 24 hour supervision; poor insight/judgement. -Was in special education classes, but "dropped out" of school in the 7th grade. Review on 6/14/23 of client #1's treatment plan dated 1/24/23 revealed: -Plan had not been signed by client #1. -Goals addressed the following: -Attend medical appointments and take medications as prescribed. -Complete daily hygiene. -Complete simple household chores. -No goals to address the following: -Behavior problems identified on his assessment. -History of actual or alleged inappropriate sexualized behaviors. -Client #1's interest in continuing his education. -No documentation client #1 was capable of remaining the home or community without supervision. Interview on 6/14/23 client #1 stated: -He had been allowed to walk to the nearby gas station along with other clients and no staff present. -Clients would get permission from the staff before they left the facility unsupervised. -He was not allowed to leave the facility unsupervised unless he was with other clients. -Client #6 was the only client that could leave the facility unsupervised and not be required to have other clients with him. -Clients were allowed to walk from the neighborhood and down a nearby multi-lane street to a store, but they could not cross the multi-lane street. -Clients knew "in general" when to come back.	V 112		

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V 112	Continued From page 6	V 112		

-When he had gone out with his peers they returned as a group.
-Clients go out walking without staff more than 2 times a week on average and it did not matter if they went during the week or weekend.
-The Licensee asked him what his goals were when he moved in.
-This was the only time he had discussed his goals with anyone.
-His long term goal was to go to college.
-He and the Licensee had discussed a program to prepare him to get his high school degree.

Finding #2:
Review on 6/14/23 client #3's record revealed:
-45 year old male.
-Admission date, 10/12/10.
-Diagnoses included Intellectual Functioning Disorder, Diabetes Mellitus; Impulse Control Disorder, Hypertension, and Allergic Rhinitis.
-FL2 dated 9/12/22 documented client #1 was intermittently disoriented; had behaviors that were injurious to others and property; functional limitation, speech impediment.
-Client #3 had a Department of Social Services (DSS) guardian.

Review on 6/14/23 of client #3's treatment plan dated 1/24/23 revealed:
-Plan had not been signed by client #1's DSS guardian.
-Goals addressed the following:
    -Complete daily hygiene.
    -Staff would check his blood sugar daily.
-Crisis plan documented client #3 would hit people at random for no reason; does not have to be provoked to act out and hit others.
-No goals to address behavior problems identified on his FL2 or crisis plan.
-No documentation client #3 was capable of

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V 112	Continued From page 7 remaining the home or community without supervision. Interview on 6/14/23 client #3 stated: -He had lived in the facility for 13 years, it felt like home. -He was allowed to walk to the store by himself and without staff. -Sometimes other clients would walk with him, to include client #6 and sometimes client #1. -Clients were not allowed to cross the nearby street and they returned like they were supposed to. -Clients would ask staff for permission before they left the group home unsupervised. Finding #3: Review on 6/14/23 client #6's record revealed: -44 year old male. -Admission date, 6/26/09. -Diagnoses included Schizophrenia Disorder with Depression, Anxiety Disorder, Hypertension, Diabetes Mellitus, Acid Reflux. -FL2 dated 3/16/23 documented client #6 was intermittently disoriented, verbally abusive, and injurious to others. Review on 6/14/23 of client #6's treatment plan dated 1/24/23 revealed: -Goals addressed the following: -Attend medical appointments and take medications as prescribed. -Complete activities of daily living. -Complete simple household chores. -No goals to address behavior problems identified on his FL2. -No documentation client #6 was capable of remaining the home or community without supervision.	V 112		

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V 112	Continued From page 8 Interview on 6/14/23 client #6 stated: -He had lived in the facility for 14 years. -He was allowed to leave the facility without staff. -He was the only client allowed unsupervised time without having other peers with him. -When on unsupervised time the clients never crossed the nearby road. -When out of the facility unsupervised, the clients mostly walked to a nearby park. -Other clients that walked with him during unsupervised time included client #1 and #3. Staff "trust" client #6 to "watch out" for the other peers when they were in the community unsupervised. Interview on 6/14/23 Staff #1 stated: -All clients were allowed to go out into the community without staff. -The clients let staff know before they leave. -There were no time limits for unsupervised time. -Clients were allowed to leave the neighborhood and walk down a nearby multi-lane street as long as they did not cross this street. -There had not been any problems when clients were out in the community unsupervised. -He thought the Licensee was the Qualified Professional (QP) -When given the name of the QP, stated he had not seen this QP at the facility. Interview on 6/14/23 the Group Home Manager stated: -He had checked with the Licensee and the treatment plans had not been updated to include unsupervised time since the pandemic. Interview on 6/15/23 the Qualified Professional stated: -She was responsible for client treatment plans. -Prior to the pandemic she held treatment team meetings to develop plans.	V 112		

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V 112	Continued From page 9 -During the pandemic the facility stopped sending clients to day programs, but now were trying to get them back into programs. -All of the clients were allowed unsupervised time to walk to the park, the store, or a nearby restaurant. -She did not know if client #1 could have unsupervised time. -The facility learned client #1 had pending legal charges for sexualized behaviors involving children after he was admitted. -She had not done an assessment to determine if client #1 could have unsupervised time. -There had not been any adverse incidents during unsupervised time. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which	V 113		

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V 113	Continued From page 10 shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of progress towards outcomes/goals for 3 of 3 audited clients (#1, #3, #6) The findings are: Finding #1: Review on 6/14/23 client #1's record revealed: -22 year old male. -Admission date, 6/1/22. -Diagnoses included Intellectual Disability;	V 113		

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V 113	Continued From page 11 Schizoaffective Disorder,Bipolar Type; Generalized Anxiety Disorder; and Attention Deficit Hyperactivity Disorder, Combined Type. -Goals addressed the following: -Attend medical appointments and take medications as prescribed. -Complete daily hygiene. -Complete simple household chores. -No documentation of progress toward outcomes/goals. Interview on 6/14/23 client #1 stated: -He had not been participating in household chores. -He would like to do chores in the kitchen and cook. Finding #2: Review on 6/14/23 client #3's record revealed: -45 year old male. -Admission date, 10/12/10. -Diagnoses included Intellectual Functioning Disorder, Diabetes Mellitus; Impulse Control Disorder, Hypertension, and Allergic Rhinitis. -Goals addressed the following: -Complete daily hygiene. -Staff would check his blood sugar daily. -No documentation of progress toward outcomes/goals. Finding #3: Review on 6/14/23 client #6's record revealed: -44 year old male. -Admission date, 6/26/09. -Diagnoses included Schizophrenia Disorder with Depression, Anxiety Disorder, Hypertension, Diabetes Mellitus, Acid Reflux. -Goals addressed the following: -Attend medical appointments and take medications as prescribed.	V 113		

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V 113	Continued From page 12 -Complete activities of daily living. -Complete simple household chores. -No documentation of progress toward outcomes/goals. Interview on 6/15/23 the Qualified Professional stated: -Any progress toward goals would be documented on a client's treatment plan. -"Truth be told," the clients all had goals for ADLs and likely never make progress without staff intervention. -Therefore, no progress to document. -The clients continued to need staff to intervene and prompt them to meet their ADL goals. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 113		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below:	V 289		

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V 289	Continued From page 13 (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living	V 289		

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	MHL026-856	A. BUILDING: _____ B. WING _____	R 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL LIVING #2	6125 LOUISE STREET FAYETTEVILLE, NC 28314

(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 289	Continued From page 14 (AFL). This Rule is not met as evidenced by: Based on interview and record review, the facility failed to operate within the scope of licensure by (1) serving 1 of 3 audited clients (#6) without a primary diagnosis of Developmental Disability, and (2) served as the private residence of 1 of 2 direct care staff audited (Staff #1). The findings are: Review on 6/14/23 of Division of Health Service Regulation (DHSR) records revealed the facility is licensed under 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities. Finding #1: Review on 6/14/23 client #6's record revealed: -44 year old male. -Admission date, 6/26/09. -Diagnoses included Schizophrenia Disorder with Depression, Anxiety Disorder, Hypertension, Diabetes Mellitus, Acid Reflux. -Letter dated 5/4/10 approving the facility request for Waiver of Rule 10A NCAC 27G .5600 (c)(3) to serve client #6. The waiver expired 12/31/10. Interview on 6/14/23 client #6 stated he had lived in the facility for 14 years. Finding#2: Review on 6/14/23 of Staff #1's personnel record revealed: -Hire date: 1/7/19.	V 289		

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V 289	Continued From page 15 -Address on his application was the same as the facility address. Interview on 6/14/23 Staff #1 stated: -The facility was his private residence. -When he accepted the job he moved into the facility. -He had been employed at the facility for almost 4 ½ years. -His schedule was 8 am - 10 pm. After 10 pm he was "in house" overnight staff. -Since the pandemic he had been working every day with the Group Home Manager relieving him as needed. -He had not had another private residence since moving into the facility when he accepted the job. Interview on 6/15/23 the Licensee stated: -She did not have a current waiver to serve client #6 in the facility. -She made several requests in the past for additional waivers to serve client #6, but they had been denied or she had received no response. -She was not aware the facility could not be a staff's private residence.	V 289		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for	V 291		

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V 291	Continued From page 16 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 interview and record review, the facility failed to maintain coordination between the facility operator and the qualified professionals who are responsible for treatment affecting 2 of 3 clients audited (#3, #6). The findings are: Finding #1: Review on 6/14/23 client #3's record revealed: -45 year old male. -Admission date, 10/12/10. -Diagnoses included Intellectual Functioning Disorder, Diabetes Mellitus; Impulse Control Disorder, Hypertension, and Allergic Rhinitis. -Treatment plan dated 1/24/23 documented staff would monitor client #3's blood glucose daily. -No physician order for fingerstick blood sugar	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 291	Continued From page 17 (FSBS) testing documented. -No physician orders or physician approved facility guidelines for staff to follow if FSBS results were below or above acceptable levels. Review on 6/14/23 of client #3's FSBS results from 3/1/23 - 6/13/23 revealed: -No times documented when FSBS testing was done 5/21/23 - 5/31/23. Other results were documented to have been done at either 8am or 8pm. -Results documented daily with a range as follows: -March (3/1/23 - 3/31/23): 102 - 136 -April (4/1/23 - 4/30/23): 97 - 134 -May (5/1/23 - 5/31/23): 99 - 138 -June (6/1/23 - 6/13/23): 90 - 145 Finding #2: Review on 6/14/23 client #6's record revealed: -44 year old male. -Admission date, 6/26/09. -Diagnoses included Schizophrenia Disorder with Depression, Anxiety Disorder, Hypertension, Diabetes Mellitus, Acid Reflux. -No physician order for FSBS testing documented. -No physician orders or physician approved facility guidelines for staff to follow if FSBS results were below or above acceptable levels. Review on 6/14/23 of client #6's FSBS results from 3/1/23 - 6/13/23 revealed: -Results were documented to have been done at either 8am or 8pm. -Results documented daily with a range as follows: -March (3/1/23 - 3/31/23): 99 - 134 -April (4/1/23 - 4/30/23): 97 - 131 -May (5/1/23 - 5/31/23): 96 - 129	V 291		

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V 291	Continued From page 18 -June (6/1/23 - 6/13/23): 91 - 131 Interview on 6/14/23 Staff #1 stated: -He performed the FSBS checks for client #3 and #6. -He knew when to do the FSBS because they "just do them in the morning or in the afternoon." -The lowest blood sugar result he would be concerned about was "90." -If a client had a blood sugar of 90 or below or higher than 145 he would call the Licensee and get further instructions. -He had not called the Licensee to report a blood sugar of 90 or lower or higher than 145. Interview on 6/14/23 the Group Home Manager stated: -There were 2 diabetic clients, client #3 and #6, who had FSBS checks done daily. -Most of the time Staff #1 did the FSBS checks. -They did a "mix" of testing in the am and pm. -If client #6 "gets anxious" they may repeat his FSBS check. -He remembered from his training the clients had not been "severe enough" to require a written plan for low or high blood sugar results.	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.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 736	Continued From page 19	V 736		

This Rule is not met as evidenced by:
Based on observations and interview, the facility failed to maintain the facility in a safe, clean, attractive and orderly manner . The findings are:

Observations during the facility tour on 6/14/23 between 10:30 am and 11:30 am revealed:
-Client #6's room had a ceiling crack greater than 12 inches long above the middle of a double window facing the street.
-Dark gray discolored areas dispersed along the ceiling at the top of the wall above Client #6's window. A faint discolored area could be seen about 12 x 24 inches on the ceiling above the the window on the right side.
-On the exterior of the home, the vinyl soffit was separated for approximately 2 feet above client #6's window.
-The soffit was separated along the right side of the front porch.
-Exterior carpet was torn on the front porch at the steps.
-The screen door on the front entrance would not close securely and the screen was loose.

Interview on 6/14/23 client #4 stated the crack had been present for a couple of years.

Interview on 6/14/23 the Group Home Manager stated:
-The ceiling crack in client #6's room had been there for at least 1 and 1/2 years.
-The facility had requested the home owner make repairs but what was done did not permanently fix the problem.
-The ceiling had painted over prior water damage.

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V 752	Continued From page 20	V 752		
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 observation and interview the facility failed to maintain the water temperature between 100 and 116 degrees Fahrenheit. The findings are: Observation on 6/14/23 between 10:30 am and 11:30 am revealed: -The water temperature at the kitchen sink was 124 degrees Fahrenheit. -The water temperature at the hall bathroom sink and tub was 126 degrees Fahrenheit. Interview on 6/14/23 the Group Home Manager stated: -He had checked and found the hot water heater had 2 thermostats both set above 120 degrees Fahrenheit. -He adjusted the thermostats on the water heater 115 degrees Fahrenheit.	V 752		