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V 000	INITIAL COMMENTS	V 000		

An annual, follow up and complaint survey was completed on 6/20/23. The complaint was substantiated (Intake #NC 09200736). Deficiencies were cited.

This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness

The facility is licensed for six and currently has a census of five. The survey sample consisted of audits of five current clients.

In this report the person identified as the girlfriend was in a long term relationship with the person identified as the boyfriend.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
V 114	27G .0207 Emergency Plans and Supplies	V 114		

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:

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V 114	Continued From page 1 Based on record review and interview the facility failed to ensure Fire and Disaster Drills were conducted quarterly for each shift. The findings are: Review on 5/17/23 of facility records from May 2022 through May 2023 revealed there were no fire and disaster drills documented. Interview on 5/17/23 client #1 stated: -Had done a few fire drills, not sure when or how many. -No disaster drills completed. Interview on 5/17/23 client #2 stated: -They did a fire drill a few weeks ago with another staff who was filling in. -Staff #1 had not done fire drills with them. -No Disaster drills completed. Interview on 5/17/23 client #3 stated: -Did a fire drill a few weeks ago with staff #2. -Did some fire drills with staff #1, but could not remember when. -No disaster drills completed. Interview on 5/17/23 client #4 stated: -Did a few fire drills over the last few years. -Did one a few weeks ago with staff #2. -No disaster drills completed. Interview on 5/17/23 client #5 stated: -Had only done about three fire drills since living in the home (admission date 4/1/21). -Never did a fire drill during the night time, only during the day. -No disaster drills completed. Interview on 5/17/23 staff #1 stated: -Had been doing fire drills, but not writing them	V 114		

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V 114	Continued From page 2 down. -Not sure when the last time he did one. -Had not completed any disaster drills. -Was told to do the drills and write them down. -Just had forgot to write them down. Interview on 5/18/23 the Qualified Professional (QP) stated: -Staff #1 had done fire drills in the past. -Trained staff #1 to do the fire drills and write them down. -"I can't say if he wrote them down." -The Licensee/ Registered Nurse (RN) checked for those drills when she visited the home. Interview on 5/30/23 the Licensee/RN stated: -She and the QP would check for fire and disaster drills. -Not aware staff #1 was not writing the drills down. -In reviewing the fire drills, "I thought I did" This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be	V 118		

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V 118	Continued From page 3	V 118		

Continued From page 3

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.

This Rule is not met as evidenced by:
Based on record review, observation and interview the facility failed to ensure medications were administered on the written order of a physician for two of five clients (#2 and 4), Ensure MAR's were kept current for one of five clients (#2) and one of two staff (#1) demonstrated competency in administering medications. The findings are:

Review on 5/17/23 of client #1's record revealed:
-Admission date of 5/8/22
-Diagnoses of Schizoaffective Disorder

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Review on 5/17/23 of client #1's March, April and May 2023 MAR revealed the following medications:
-Olanzapine (Schizophrenia) 10 milligram (mg)- two at bedtime
-Depakote (Bipolar) 500 mg- 1 1/2 AM and 1/2 bedtime
-Trazodone (Depression) 100 mg- 1 1/2 at night
-Paliperidone (Schizoaffective Disorder) 234 mg- Once a month.

Review on 5/17/23 of client #1's record revealed no current physician's orders in the facility.

Further review on 6/2/23 of client #1's record revealed physician orders dated 5/24/23 for the above medications were obtained during his 5/17/23 appointment.

Review on 5/19/23 of client #2's record revealed:
-Admission date of 4/19/16
-Diagnoses of Schizophrenia, Type II Diabetes and Hypertension

Review on 5/19/23 of client #2's March, April and May 2023 MAR revealed the following medications:
-Aspirin (blood thinner) 81 mg- one AM
-B 12 (vitamin supplement) 1,000- one AM
-Amlodipine Besylate (Blood Pressure) 10 mg- one AM
-Fenofibrate (Diabetes) 145 mg- one AM
-Benazepril (Blood Pressure) 40 mg- one AM
-Hydrochlorothiazide (Blood Pressure) 25 mg- one AM
-Spironolactone (Blood Pressure) 25 mg- one AM
-Vitamin D2 (Vitamin supplement) 1,000- one AM
-Glipizide (Diabetes) 2.5 mg- one AM
-Toprol (Heart failure and Blood Pressure) - one AM

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-Lorazepam (Anxiety) 1 mg- one at night
-Metformin (Diabetes) 1000- twice a day
-Ferrous Sulfate (Iron Supplement) 325 mg- twice a day
-Potassium (supplement) 20 mg- BID
-Accu Check (Blood sugar check) once at AM

Review on 6/1/23 of client #2's record revealed physician orders dated 4/19/23 for the above medications.

Review on 6/1/23 of client #2's order dated 2/15/22 to "check his own blood sugar."

Review on 5/19/23 of client #3's record revealed:
-Admission date of 5/1/19
-Diagnoses of Paranoid Schizophrenia, Mild Mental Retardation, Hypertension and Type II Diabetes

Review on 5/19/23 of client #3's March, April and May 2023 MAR revealed the following medications:
-Pepcid (Reflux) 20 mg- Two AM
-Accu Check Test Strip (Diabetes)- Check blood sugar in the AM before breakfast
-Olanzapine (Schizophrenia) 10 mg- one AM
-Olanzapine- 20 mg- one at bedtime
-Lisinopril (Blood Pressure) 30 mg- one AM
-Simvastatin (Cholesterol) 10 mg- one at bedtime
-Docusate Sodium (Constipation) 100 mg- one at bedtime
-Janumet Xr (extended release) (Diabetes) 100- one AM
-Hydroxyzine (Anxiety) 25 mg- once a day -PRN (as needed)
-Ventolin (Asthma)- 90 mg 2 puffs 4-6 hours- PRN for wheezing
-Ibuprofen (pain reliever) 400 mg- twice a day- PRN

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Review on 6/1/23 of client #3's record revealed physician orders dated 3/24/23 for the above medications.

Review on 5/17/23 of client #4's record revealed:
-Admission date of 8/19/19
-Diagnoses of Schizophrenia and Diabetes Type II

Review on 5/17/23 of client #4's March, April and May 2023 MAR revealed the following medications:
-Olanzapine 15 mg- two at bedtime
-Metoprolol (Blood Pressure) 100 mg- twice a day
-Advair (Asthma) 100- twice a day
-Trulicity (Diabetes) 1.5 mg- inject once a week
-Albuterol (Asthma) 90 mg- two puffs every 4-6 hours PRN
-Docusate Sodium (Constipation) 100 mg- once a day PRN
-Check blood sugar in the mornings
-Vitamin D3 (Supplement) 400 mg- one a day
-Diltiazem (Blood Pressure) 120 mg- one a day
-Aspirin (Blood Thinner) 81 mg- one a day
-Ezetimibe (Cholesterol) 10 mg- one a day
-Synjardy (Diabetes) XR 12.5-1000 mg- one AM
-Valsartan (Blood Pressure) 120 mg- one a day
-Vitamin B6 (Supplement) 100 mg- one a day
-Atorvastatin (Cholesterol) 80 mg- one at bedtime
-Montelukast Sodium (Asthma) 10 mg- one at bedtime

Review on 6/1/23 of client #4's record revealed physician orders dated 8/26/22 for the above medications.

Review on 5/17/23 of client #5's record revealed:
-Admission date of 4/1/21
-Diagnoses of Schizophrenia, Hepatitis C and

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Chronic back pain

Review on 5/17/23 of client #5's March, April and May 2023 MAR revealed the following medications:
-Olanzapine 20 mg- one at bedtime
-Haldol (Schizophrenia) 5 mg- twice a day
-Gabapentin (mood) 600 mg- Three times a day

Review on 6/1/23 of client #5's record revealed physician orders dated 3/24/23 for the above medications.

A. Cross Reference 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V120) Based on observation, record review and interview the facility failed to ensure 5 of 5 clients (#1, #2, #3, #4, #5) medications were stored in a locked cabinet.

B. Example of MAR's not kept current:

Review on 5/19/23 of client #2's MAR at approximately 10:00 AM revealed no blood sugar checks from 5/1/23-5/12/23.

Interview on 5/19/23 client #2 stated:
-Checked his blood sugar every morning.
-Would tell staff who was working what his blood sugar numbers were.
-Kept his blood sugar numbers in his own personal notebook.
-Had not missed a day checking his blood sugar.

Interview on 5/19/23 staff #1 stated:
-He was not working the dates of 5/1/23-5/12/23.
-Client #2 would check his blood sugar in the mornings and give him the numbers to document on the MAR.

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Interview, observation and & record review on 5/19/23 approximately 10:00 AM with client #2 revealed:
-Requested client #2 to obtain his personal notebook to check his blood sugar readings.
-Staff #1 took the May 2023 MAR with him to client #2's bedroom.
-Staff #1 returned with blood sugar readings gilled in for 5/1/23-5/12/23. Staff #1 did not have client #2's personal notebook.
-Requested again to see client #2's personal notebook, at which time client #2 then provided his notebook for review with the following blood sugar readings:
-"5/1/23-108
-5/2/23-102
-5/3/23- 99
-5/4/23-108
5/5/23-101"
-The QP was sitting at the table and witnessed the above interactions.

Review on 5/19/23 of client #2's MAR that was completed by staff #1 revelaed the following:
-"5/1/23- 108
-5/2/23-99
-5/3/23-98
-5/4/23-102
-5/5/23-95
-5/6/23-104
-5/7/23-97
-5/8/23-94
-5/9/23-103
-5/10/23-102
-5/11/23-100
-5/12/23-97"

Further interview on 5/19/23 client #2 stated:
-He had only recorded his blood sugar until 5/5/23 because he needed a new notebook.

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Interview on 5/19/23 staff #1 stated:
-Wrote client #2's blood sugar numbers on the MAR from client #2's notebook.
-Wrote different numbers on the MAR because client #2's numbers may not be correct.
-"Concerned [client #2] may not have wrote the right numbers down."
-Changed the numbers from client #2's notebook to the MAR.

C. Example of staff not administering medications to client #4 as ordered:

Interview on 5/17/23 client #4 stated:
-Not sure what time staff #1 had awakened in the mornings.
-Had missed his medications a few days back in April 2023.
-Got up at 6:30 AM to shower and catch the bus at 8:00 AM to his day program.
-Staff #1 had not gotten up to give him his medication before he left for his day program.
-Did not want to wake staff #1 to get his medications.
-Told staff at his day program after missing his medications for a few days.
-The day program called his Qualified Professional (QP) and she went to the home to talk to staff #1.
-Staff #1 was "suspended" and they sent him to another home.
-Since staff #1 had been back, he came to his room to give him his medications.
-When he missed his medications he was "thinking a lot, stayed up late and did not rest well."

Interview on 5/17/23 the Program Director of client #4's day program stated:

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-Client #4 came to her a few weeks ago stating he had not taken his medications in four to five days.
-Client #4 stated staff #1 did not give him his medications because he stayed in his room most of the time.
-Informed the Clinical Director of the day program of client #4's situation.
-Only behaviors she noticed was client #4 wore his shades at all times inside, but during those days he was not wearing them.
-He stated he was scared if he missed his medications he would start having behavior problems.

Interview on 5/17/23 the Clinical Director at client #4's day program stated:
-Was informed two to three weeks ago from the Program Director that client #4 had missed his medications at the facility.
-Contacted the facility's QP as they had a good working relationship.
-Was told by the QP they got everything straight and client #4 was receiving his medications.
-The QP stated to her she went to the home the next day to ensure client #4 was given his medications.
-Had checked in with him since he came to them and he stated he had received his medications.

Interview on 5/17/23 and 5/19/23 staff #1 stated:
-Had been working in the facility for one year.
-Gave clients their medications daily.
-Got up at 6:30AM to get the clients medications to hand out at 7:30 AM.
-Took the medications to each client.
-Would use a styrofoam cup to place their medications in and hand it to them.
-Had not put the clients medications on the table for them to take.

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-Never missed giving client #4 his medications.
-Not sure why client #4 would tell people he had missed his medications.
-Had not noticed any change in client #4's behavior recently.

Interviews between 5/17/23-6/3/23 the QP stated:
-Had concerns about staff #1 in the past few months regarding him staying in his room all the time.
-Addressed this with the Licensee/Registered Nurse (RN) and he was taken off the schedule for two weeks.
-The Licensee/RN brought staff #1 back on shift without letting her know.
-No clients had mentioned to her about their medications being left out on the table for them to take on their own.
-"Popped" up at the facility at different times and was there several times a month.
-She and the Licensee/RN checked the MARs and had not noticed any missed initials for medications.
-Never noticed any medications sitting out on the table.
-Staff #1 had been trained in medication administration.
-Always told staff to never leave medications out for clients and had used this same example over the years.
-Had received a telephone call from client #4's day program regarding the missed medications.
-The day program stated he was wiping down walls, which was out of character for him.
-Went to the facilty immediately to check the MAR's and the medications.
-Client #4 denied to her he missed medications and denied telling anyone at the day program he missed them.
-Contacted client #4's guardian and she stated if

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V 118	Continued From page 12 client #4 missed several days of medications he would have significant side effects. -Spoke with the Licensee/RN who was to follow up and monitor client #4's medications. -Very "surprised" that staff #1 falsified client #2's MAR in front of her and surveyor. -Looking to bring in a staff today (5/19/23) to remove staff #1 from the home. -Very "upset" with what staff #1 has been doing regarding medication administration, "He knows better." Interview on 5/30/23 the Licensee/RN stated: -She was a Registered Nurse and did her staff medication administration trainings. -Had observed staff #1 give medications as well as the QP. -Trained staff to go to each clients' basket one at a time. -Go line by line down the MAR while placing that medication in a cup. -Watch the client take the medication and then initial the MAR before moving to the next client. -Had no issues when checking the MAR and medications in her monitoring visits. -Monitored and reviewed medications and MARs every three months unless there was an issue. -Would go by once a month if clients had lots of medication changes to check for accuracy. -Trained specifically on not leaving medications out for clients because she had that issue in the past and used that as an example when training. -Was told by the QP about client #4 possibly missing his medications. -Went to the facility and checked the medication and they were all present and no missed initials on the MAR. -Client #4 told the QP he had not missed any medications. -Had concerns with staff #1 being in his room all	V 118		

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the time and had addressed that with him.
-Took him off the schedule as a "warning" before terminating him.
-Spoke to him about staying in his room and he said he would stop.
-Had stopped by the facility unannounced two days ago (5/15/23) and staff #1 was in the bathroom, not in his room.
-Spoke to the clients and had asked was staff #1 staying in his room a lot and they denied he had.
-After finding out all the issues with staff #1, he was removed from the facility on 5/19/23 and terminated on 5/22/23.

Review on 6/2/23 of Plan of Protection dated 6/2/23 completed by the QP revealed the following:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? The previous staff was relieved of responsibility for this home on Friday, May 26, 2023. Incoming staff will receive immediate training on appropriate and approved methods of medication administration practices, medication storage, timely and specific documentation on mars, blood sugars documentation, following Dr's orders as written and other medication requirements (having physicians orders at the facility). Additionally, the facility will provide ongoing training at least weekly for the next 30 days and then monthly afterwards on medication requirements as listed above. This will continue for a period of 90 days. The training will continue to focus on medication administration, documentation on MARs, medication storage and any other areas requiring training to ensure staff competency. Staff will receive more in-depth training by a registered nurse with the next 23 days. Any future deviations from proper medication procedures will result in

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consequences, up to and including termination.

-Describe your plans to make sure the above happens.
The RN or designee will review medication administration practices and procedures and the MARs with the staff upon hire and will also conduct observations of the medication administration procedures at least once weekly. The administrator will ensure that all medications practices & procedures are followed by doing direct observations at least weekly for the next 30 days."

This deficiency constitutes a re-cited deficiency.

Client #1, #2, #3, #4 & #5 were admitted to the facility with diagnoses which included Type 2 Diabetes Mellitus, Schizoaffective Disorder, Schizophrenia, Mild Mental Retardation and Hypertension. All the clients disclosed staff #1 left medications on the kitchen table in labeled cups at various times for clients to take while he was in his bedroom. Client #2 and client #3 had to wake up staff #1 several times to get their medications. Client #2 had an order to check his blood sugar once a day in the mornings and kept his own blood sugar log in his room. Client #2's MAR was not documented from 5/1/23-5/12/23 showing his blood sugar was checked. Once staff #1 was made aware of the missing dates, he falsified blood sugar readings. Client #4 had disclosed to his day program he had missed several days of medications and was concerned about having behaviors as a result. Client #4 did show some mild behavior changes while at the day program during those days and admitted to not being able to rest well. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An

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V 118	Continued From page 15 administrative penalty of $2000.00 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 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a 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 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for 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. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 5 of 5 clients (#1, #2, #3, #4, #5) medications were stored in a locked cabinet. The findings are:	V 120		

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Review on 5/17/23 of client #1's record revealed:
-Admission date of 5/8/22
-Diagnoses of Schizoaffective Disorder

Review on 5/17/23 of client #1's March, April and May 2023 MAR revealed the following medications:
-Olanzapine (Schizophrenia) 10 milligram (mg)- two at bedtime
-Depakote (Bipolar) 500 mg- 1 1/2 AM and 1/2 bedtime
-Trazodone (Depression) 100 mg- 1 1/2 at night
-Paliperidone (Schizoaffective Disorder) 234 mg- Once a month.

Review on 5/17/23 of client #1's record revealed no current physician's orders in the facility.

Further review on 6/2/23 of client #1's record revealed physician orders dated 5/24/23 for the above medications were obtained during his 5/17/23 appointment.

Review on 5/19/23 of client #2's record revealed:
-Admission date of 4/19/16
-Diagnoses of Schizophrenia, Type II Diabetes and Hypertension

Review on 5/19/23 of client #2's March, April and May 2023 MAR revealed the following medications:
-Aspirin (blood thinner) 81 mg- one AM
-B 12 (vitamin supplement) 1,000- one AM
-Amlodipine Besylate (Blood Pressure) 10 mg- one AM
-Fenofibrate (Diabetes) 145 mg- one AM
-Benazepril (Blood Pressure) 40 mg- one AM
-Hydrochlorothiazide (Blood Pressure) 25 mg- one AM

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V 120	Continued From page 17 -Spironolactone (Blood Pressure) 25 mg- one AM -Vitamin D2 (Vitamin supplement) 1,000- one AM -Glipizide (Diabetes) 2.5 mg- one AM -Toprol (Heart failure and Blood Pressure) - one AM -Lorazepam (Anxiety) 1 mg- one at night -Metformin (Diabetes) 1000- twice a day -Ferrous Sulfate (Iron Supplement) 325 mg- twice a day -Potassium (supplement) 20 mg- BID -Accu Check (Blood sugar check) once at AM Review on 6/1/23 of client #2's record revealed physician orders dated 4/19/23 for the above medications. Review on 6/1/23 of client #2's order dated 2/15/22 to "check his own blood sugar." Review on 5/19/23 of client #3's record revealed: -Admission date of 5/1/19 -Diagnoses of Paranoid Schizophrenia, Mild Mental Retardation, Hypertension and Type II Diabetes Review on 5/19/23 of client #3's March, April and May 2023 MAR revealed the following medications: -Pepcid (Reflux) 20 mg- Two AM -Accu Check Test Strip (Diabetes)- Check blood sugar in the AM before breakfast -Olanzapine (Schizophrenia) 10 mg- one AM -Olanzapine- 20 mg- one at bedtime -Lisinopril (Blood Pressure) 30 mg- one AM -Simvastatin (Cholesterol) 10 mg- one at bedtime -Docusate Sodium (Constipation) 100 mg- one at bedtime -Janumet Xr (extended release) (Diabetes) 100- one AM -Hydroxyzine (Anxiety) 25 mg- once a day -PRN	V 120		

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(as needed)
-Ventolin (Asthma)- 90 mg 2 puffs 4-6 hours- PRN for wheezing
-Ibuprofen (pain reliever) 400 mg- twice a day- PRN

Review on 6/1/23 of client #3's record revealed physician orders dated 3/24/23 for the above medications.

Review on 5/17/23 of client #4's record revealed:
-Admission date of 8/19/19
-Diagnoses of Schizophrenia and Diabetes Type II

Review on 5/17/23 of client #4's March, April and May 2023 MAR revealed the following medications:
-Olanzapine 15 mg- two at bedtime
-Metoprolol (Blood Pressure) 100 mg- twice a day
-Advair (Asthma) 100- twice a day
-Trulicity (Diabetes) 1.5 mg- inject once a week
-Albuterol (Asthma) 90 mg- two puffs every 4-6 hours PRN
-Docusate Sodium (Constipation) 100 mg- once a day PRN
-Check blood sugar in the mornings
-Vitamin D3 (Supplement) 400 mg- one a day
-Diltiazem (Blood Pressure) 120 mg- one a day
-Aspirin (Blood Thinner) 81 mg- one a day
-Ezetimibe (Cholesterol) 10 mg- one a day
-Synjardy (Diabetes) XR 12.5-1000 mg- one AM
-Valsartan (Blood Pressure) 120 mg- one a day
-Vitamin B6 (Supplement) 100 mg- one a day
-Atorvastatin (Cholesterol) 80 mg- one at bedtime
-Montelukast Sodium (Asthma) 10 mg- one at bedtime

Review on 6/1/23 of client #4's record revealed physician orders dated 8/26/22 for the above

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medications.

Review on 5/17/23 of client #5's record revealed:
-Admission date of 4/1/21
-Diagnoses of Schizophrenia, Hepatitis C and Chronic back pain

Review on 5/17/23 of client #5's March, April and May 2023 MAR revealed the following medications:
-Olanzapine 20 mg- one at bedtime
-Haldol (Schizophrenia) 5 mg- twice a day
-Gabapentin (mood) 600 mg- Three times a day

Review on 6/1/23 of client #5's record revealed physician orders dated 3/24/23 for the above medications.

Observation on 5/17/23 at 10:30 AM of client #1, #2, #3 #4 & #5's medication baskets revealed white medium size styrofoam cups with each client name hand written on them.

Interview on 5/17/23 client #1 stated:
-Staff #1 stayed in his room all day.
-Took his medication daily.
-Staff #1 would put the medication out on the kitchen table in a styrofoam cup with their names on it.
-Staff #1 would leave the medications on the table and he would take his medications when he woke in the mornings.
-Not sure when staff #1 placed the medications in the cups.
-Staff #1 would be in his room while the medications were left on the kitchen table.
-He knew which medications were his.
-Not aware if anyone had taken others medications.
- Had always taken his medications from the cup

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with his name on it.
-Some mornings staff #1 would come to their room to give them their medications from that styrofoam cup.
-Staff #1 would also leave the evening medications in a cup on the kitchen table too.
-They were supposed to get their medications at 7:00 AM, but staff #1 would sometimes not give it until 11:00 AM.
-On occasion client #2 would wake staff #1 to give them their medications.
-This happened maybe once or twice in the past.

Interview on 5/17/23 client #2 stated:
-Took his medications daily.
-Took his medications daily between 7AM-8AM and then 6:30 PM-7:00 PM.
-Staff #1 put their medications in a cup with their name on it and placed it on the kitchen table.
-Staff #1 would tell them to check their cups to make sure it was their correct medications.
-Sometimes staff #1 would leave the medications on the kitchen table so when they woke, it was there to take.
-Staff #1 told them he took medications too.
-He would tell them he was sick and would stay in his bedroom.

Interview on 5/17/23 client #3 stated:
-Staff #1 gave them their medications in a cup that he would leave on the kitchen table.
-Staff #1 would place the cup with their name on it on the kitchen table then go back to his room.
-Staff #1 sometimes took the medications to their room and handed it to them.
-"Usually" he left the cups on the kitchen table and would tell them their medications were on the table.
-Had to wake staff #1 "sometimes in the mornings" to give them their medications.

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Interview on 5/17/23 client #4 stated:
-Staff #1 used to leave his medications in a cup on the kitchen table for them to take.
-Had walked in the kitchen and seen client medications in styrofoam cups with no staff around.
-Not aware of anyone taking the wrong medications.
-"Thought" staff #1 got into trouble for leaving the medications out, but not sure.

Interview on 5/19/23 client #5 stated:
-Slept late on most days.
-Would wake up and not sure where staff #1 was.
-Would find his medications on the kitchen table with his name on the cup.
-Some days staff #1 brought his medications to his room to take.

Interview on 5/17/23 and 5/19/23 staff #1 stated:
-Had been working in the facility for one year.
-Gave clients their medications daily.
-Got up at 6:30AM to get the clients medications to hand out at 7:30 AM.
-Took the medications to each client.
-Would use a styrofoam cup to place their medications in and hand it to them.
-Had not put the clients medications on the table for them to take.

Interviews between 5/17/23-6/3/23 the QP stated:
-Had concerns about staff #1 in the past few months regarding him staying in his room all the time.
-Addressed this with the Licensee/Registered Nurse (RN) and he was taken off the schedule for two weeks.
-The Licensee/RN brought staff #1 back on shift without letting her know.

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-No clients had mentioned to her about their medications being left out on the table for them to take on their own.
-"Popped" up at the facility at different times and was there several times a month.
-She and the Licensee/RN checked the MARs and had not noticed any missed initials for medications.
-Never noticed any medications sitting out on the table.
-Staff #1 had been trained in medication administration.
-Always told staff to never leave medications out for clients and had used this same example over the years.

Interview on 5/30/23 the Licensee/RN stated:
-She was a Registered Nurse and did her staff medication administration trainings.
-Had observed staff #1 give medications as well as the QP.
-Trained staff to go to each clients' basket one at a time.
-Go line by line down the MAR while placing that medication in a cup.
-Watch the client take the medication and then initial the MAR before moving to the next client.
-Had no issues when checking the MAR and medications in her monitoring visits.
-Monitored and reviewed medications and MARs every three months unless there was an issue.
-Would go by once a month if clients had lots of medication changes to check for accuracy.
-Trained specifically on not leaving medications out for clients because she had that issue in the past and used that as an example when training.

This deficiency is cross referenced into 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118) for a Type A1 rule

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V 120	Continued From page 23 violation and must be corrected within 23 days.	V 120		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) 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. 131E-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 investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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This Rule is not met as evidenced by:
Based on record review and interview the facility failed to notify Health Care Personnel Registry (HCPR) of an allegation of neglect for one of two staff (staff #1). The findings are:

Review on 5/24/23 of staff #1's record revealed:
-Hire date of 3/24/23

Interview on 5/23/23 the Qualified Professional (QP) stated staff #1 was terminated on 5/22/23.

Refer to V366 for failure to complete for Incident Response Requirements:
-Police report dated 4/7/23 where the girlfriend was picked up at the facility on a Involuntary Commitment order and staff #1 was intoxicated.
-Interviews regarding the girlfriend's use of drugs and alcohol while in the facility.
-Interviews regarding staff #1's intoxication on 4/7/23 in the facility.

Interview on 5/31/23 the Qualified Professional (QP) stated:
-She had not completed an Incident Response Improvement System (IRIS) report regarding staff #1's behaviors while working in the facility.
-Knew she needed to complete the IRIS so it

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would go to Health Care Personnel Registry (HCPR) but was not sure how to do with all the clients names and incidents not having an exact date.
-Will do one now and use the date of the 4/7/23 incident when the police went out to the facility and observed staff #1 intoxicated.
-Will include all other information regarding his neglect in that incident report so HCPR can investigate.

Interview on 5/30/23 the Licensee/Registered Nurse (RN) stated:
-The QP was responsible for completing incident reports and HCPR.
--Learned of the girlfriend visiting the home and police serving IVC on her from QP on 5/19/23.
-Not sure if the incident report for that was completed.

V 291 — 27G .5603 Supervised Living - Operations — V 291

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

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the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.
(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.

This Rule is not met as evidenced by:
Based on record review, interview and observation the facility failed to provide activities to foster community inclusion for three of five audited clients (#1, #2, & #5). The findings are:

Review on 5/17/23 of client #1's record revealed:
-Admission date of 5/8/22
-Diagnosis of Schizoaffective Disorder

Further review on 5/17/23 of client #1's treatment plan dated 6/2/23 revealed:
-Unsupervised time in the community to engage in activities...attend Narcotics Anonymous (NA) and Alcoholic Anonymous (AA) meetings...

Review on 5/18/23 of client #2's record revealed:
-Admission date of 4/19/16
-Diagnoses of Schizophrenia, Type II Diabetes

Further review on 5/17/23 of client #2's treatment plan dated 4/2/23 revealed "utilize unsupervised time to engage in planned appointments, meeting

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with friends, going out to preferred places."

Review on 5/17/23 of client #5's record revealed:
-Admission date of 4/1/21
-Diagnoses of Schizophrenia, Hepatitis C and Chronic back pain

Review on 5/17/23 of client #5's treatment plan dated 3/17/23 revealed:
-"Focus his attention on engaging in an activity."

Observation on 5/17/23 from 9:00 AM until 11:00 AM clients #1, #2 and #5 were sitting around in the home from their bedroom, den and outside smoking.

Observation on 5/19/23 from 8:00 AM until 11:30 AM client #1, #2 and #5 were in the den, bedroom and outside smoking throughout the morning.

Observation on 6/2/23 from 9:00 AM- 11:30 AM client #1, #2 and #5 were in the den, bedroom and outside smoking throughout the morning.

Interview on 5/17/23 client #1 stated:
-Did not attend a day program.
-Sometimes went out to the store sometimes when they get paid.
-"Mostly stay here (in the facility)."

Interview on 5/17/23 client #2 stated:
-Went to the store "occasionally" and to his doctor appointments.
-Staff did not have a car to go out with.
-Walked to the store when he needed things.

Interview on 5/17/23 client #5 stated:
-Did not go anywhere during the day.
-Would go to his doctor appointments.

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-Did not have any unsupervised time to walk to the store.

Interview on 5/17/23 staff #1 stated:
-Did not have a vehicle at the home.
-"Clients sit around and sometimes they take walks."
-The Qualified Professional (QP) took the clients to their appointments and sometimes they had telehealth appointments.
-Two clients (#3 and #4) attended a day program and the others (#1, #2, and #5) stayed at home during the day.
-Client #5 had walked off in the past.
-Client #5 did not seem upset when he left, "think it was boredom."
-He and the clients would sometimes walk to the store.

Interview on 5/19/23 the QP stated:
-Client #1 and #2 had unsupervised time to go out in the community.
-Staff #1 should have been motivating them to get out of the facility for outings.
-Client #1 can take the bus out in the community during his unsupervised time.
-Client #1 had not attended AA/NA for awhile.
-Client #5 refused to attend a day program and did not have unsupervised time in the community.
-Staff #1 could request the company van to come get them if they needed to get out.

Interview on 5/30/23 the Licensee/Registered Nurse (RN) stated:
-Two clients in the home attended a day program.
-There was a park down the street they could walk to and had done so once in the past year.
-Could send a van over to take them to a shopping center and grocery store.
-The clients got paid once a month and would

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send them to the store using a car service.
-Had a staff that could take the van over to take them out or would get a car service to take them out.

V 366 — 27G .0603 Incident Response Requirments — V 366

10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS
(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:
(1) attending to the health and safety needs of individuals involved in the incident;
(2) determining the cause of the incident;
(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;
(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;
(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;
(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall

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develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues

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identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;
(D) the Department;
(E) the client's legal guardian, as applicable; and
(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to implement their policy governing their response to Level I, II, and III incidents. The findings are:

A. Review on 5/17/23 of client #5's record revealed:
-Admission date of 4/1/21
-Diagnoses of Schizophrenia, Hepatitis C and Chronic back pain

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-Served 33 years in prison for murder and burglary
-History of substance use

Review on 5/18/23 of police report dated 4/23/23 at 7:32 PM regarding client #5 revealed:
-"[Client #5] left the residence around 6:30 PM and never returned. I [staff #1] wanted to notify you since he is assigned here. I did not see which way he went.
-4/24/23 at 2:53 PM- located by [neighboring town] police department."

Review on 5/18/23 of Incident Response Improvement System (IRIS) database revealed no level II incident report completed regarding client #5's elopement.

Interview on 5/19/23 Staff #1 stated:
-A few weeks ago client #5 walked off thirty minutes after he had eyes on him.
-Last saw client #5 sitting on the couch.
-Looked for him again and was told by client #2 he left the facility and walked off.
-Contacted the Qualified Professional (QP) and the police.
-It was in the early afternoon hours when he left the facility.
-Client #5 was located the next day in a neighboring town.
-Once client #5 returned he told him he met someone and lost track of time.
-"He (client #5) knew what he was doing because he had three bags with him."
-Client #5 did not tell anyone where he was going.
-Did not smell of alcohol or under the influence when he returned.

Interview on 5/19/23 client #5 stated:
-Left the facility about a month ago.

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-Was not upset, just went walking.
-Did not take any items with him when he left.
-Had walked off one other time but it had been a "while ago.'

Interview on 5/25/23 client #5's guardian stated:
-Was informed a few weeks ago by the QP that client #5 had eloped from the facility.
-Client #5 did not have unsupervised time and had a history of elopement.
-"Surprised" client #5 had eloped as he had been doing so well.
-Had not eloped in a year.

B. Review on 5/19/23 of police report dated 4/7/23 revealed"
-"...Mental Commitment...This report contains information regarding an involuntary mental commitment. The female subject (the girlfriend) was staying at the male halfway house located above. She was transported without incident to [local hospital.]"
-"I was dispatched to an involuntary commitment in regards to a [the girlfriend] who was using cocaine and drinking heavily for a few days. [The girlfriend] was at a male only halfway house located at 5040 Kaplan Drive. When I arrived on scene one of the males living there let me in to speak with the house manager whom [the girlfriend] was staying with. [The girlfriend] was in the bedroom and appeared to be intoxicated. [The girlfriend] willingly walked to my patrol vehicle and I transported her to [local hospital] without incident. At the hospital [the girlfriend] confirmed she used cocaine and had been drinking all day."

Review on 5/31/23 of Incident Response Improvement System (IRIS) database revealed no level II incident report completed regarding

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incident regarding the girlfriend being picked up at the facility on IVC order and staff #1 being intoxicated on 4/7/23.

Interview on 5/23/23 a police officer with local police department stated:
-Served an IVC order at the facility on 4/7/23 approximately 8:50 PM for the girlfriend.
-Apparently the girlfriend lived with another guy (the boyfriend) who knew she was there using drugs with staff #1 and he was concerned for her safety.
-There was an attempt the day before to serve the IVC at the facility for the girlfriend and she ran out the back door and got away.
-Reviewing his body camera video, he arrived at the facility, going to the front door and a gentleman answered the door.
-Asked the gentleman who answered the door, was "[staff #1] there" and he was told by the gentleman he was in his room.
-Then asked the gentleman was there a female in the home, and he said he was not sure.
-The gentleman told him where staff #1's room was located and he knocked on the door
-When staff #1 opened the door, "they were both intoxicated."
-"They (the girlfriend and staff #1) had obviously been partying together, there were alcohol bottles on the shelf."
-The girlfriend stated they had been to a bar drinking alcohol and then returned to the facility.
-The girlfriend stated she had been drinking all day and was using cocaine.
-The girlfriend then lit a cigarette at which time he asked her not to and she continued to smoke it.
-Staff #1 looked very sleepy as if he had been "up for days and it was only 8:50 PM."
-Staff #1 did not look sober, he "seemed lethargic and words were slurred."

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-Staff #1's button up shirt was half buttoned and his shorts were hanging low around his hips as he looked "disheveled."
-Staff #1 stated he and the female (the girlfriend) were dating and her boyfriend (the boyfriend) she lived with was upset she was there.
-Staff #1 was cooperative and helped the female pack her clothes.
-Only allowed the girlfriend to pack one bag and noticed she had other clothes in the room.
-Staff #1 then walked with them out of the facility and placed the girlfriend's bag in the patrol car.
-Staff #1 then gave her a kiss.
-As they walked through the facility, noticed one male client sitting on the couch.
-Transported the girlfriend to a local hospital

Interviews on 5/18/23 through 5/31/23 the QP stated:
-Client #5 had eloped a month ago.
-Contacted the legal guardian.
-Client #5 was found the next day in a neighboring local town.
-Client #5 was taken to the hospital for check up and was released.
-Client #5 had not eloped in about a year.
-Did not complete a level II incident report for his elopement.
-Client #5 had been walking in the neighborhood with no issues.
-Did not put any new measures in place to address his elopement because this was a one time incident with him.
-Had been discussing with the guardian some unsupervised time to walk to the store and back.
-Was not aware of staff #1 having his girlfriend (the girlfriend) in the home and the use of alcohol and drugs.
-Once learning the information on 5/19/23 regarding the incident on 4/7/23 she had not

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V 366	Continued From page 36 completed a level II incident report. -Relieved staff #1 of his duties and removed him from the home on 5/19/23 and he was terminated on 5/22/23. -Did training with staff #2 on 5/19/23 regarding ethics, supervision and client rights. Interview on 5/30/23 the Licensee/Registered Nurse (RN) stated: -The QP was responsible for completing incident reports. -Was not aware the QP had not completed a level II incident report for client #5's elopement. -Not sure if client #5 eloping could have been prevented. -Staff had to shower and use the rest room, so there would be time where client #5 could take advantage of that. -"If [client #5] wants to leave, he will, but it has been a while." -Learned of the girlfriend visiting the home and police serving IVC on her and staff #1's intoxication from QP on 5/19/23. -Not sure if the incident report for that was completed.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A 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 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	V 367		

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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 may 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 of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A

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providers shall send a copy of all level III incidents involving a client 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 death 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 or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to notify the local management entity of all

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Level II and Level III incidents within 72 hours of becoming aware of the incidents. The findings are:

A. Review on 5/17/23 of client #5's record revealed:
-Admission date of 4/1/21
-Diagnoses of Schizophrenia, Hepatitis C and Chronic back pain
-Served 33 years in prison for murder and burglary

Review on 5/18/23 of Incident Response Improvement System (IRIS) database revealed no level II incident report completed regarding client #5's elopement.

Refer to V366 for failure to complete for Incident Response Requirements:
-Police report dated 4/23/23 where client #5 eloped from the facility.
-Interviews regarding client #5's elopement.

B. Review on 5/31/23 of Incident Response Improvement System (IRIS) database revealed no level II incident report completed regarding incident regarding the girlfriend being picked up at the facility on IVC order on 4/7/23.

Refer to V366 for failure to complete for Incident Response Requirements:
-Police report dated 4/7/23 where the girlfriend was picked up at the facility on a Involuntary Commitment order.
-Interviews regarding the girlfriend drug and alcohol use in the facility.
-Interviews regarding staff #1's intoxication on 4/7/23 in the facility.

Interviews on 5/18/23 through 5/31/23 the

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V 367	Continued From page 40 Qualified Professional (QP) stated: -Client #5 had eloped a month ago. -Contacted the legal guardian. -Client #5 was found the next day in a neighboring local town. -Client #5 was taken to the hospital for check up and was released. -Client #5 had not eloped in about a year. -Did not complete a level II incident report for his elopement. -Client #5 had been walking in the neighborhood with no issues. -Had been discussing with the guardian about some unsupervised time to walk to the store and back. -Was not aware of staff #1 having his girlfriend in the home and the use of alcohol and drugs. -Once learning the information on 5/19/23 regarding incident on 4/7/23 where police picked up the girlfriend on IVC, had not done a level II incident report. -Relieved staff #1 of his duties and removed him from the home on 5/19/23 and he was terminated on 5/22/23. -Did training with staff #2 on 5/19/23 regarding ethics, supervision and client rights. Interview on 5/30/23 the Licensee/Registered Nurse stated: -The QP was responsible for completing incident reports. -Was not aware the QP had not completed a level II incident report for client #5's elopement. -Not sure if client #5 eloping could have been prevented. -Learned of the girlfriend visiting the home and police serving IVC on her and staff #1's intoxication from QP on 5/19/23. -Not sure if the incident report for that was completed.	V 367		

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V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of	V 500		

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restrictive interventions.
(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:
(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);
(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and
(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report an instance of alleged or suspected neglect to the County Department of Social Services (DSS) as required. The findings are:

Review on 5/24/23 of staff #1's record revealed:
-Hire date of 3/24/23

Interview on 5/23/23 the Qualified Professional (QP) stated staff #1 was terminated on 5/22/23.

Refer to V366 for failure to complete for Incident Response Requirements:
-Police report dated 4/7/23 where staff #1's

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V 500	Continued From page 43 girlfriend was picked up at the facility on a IVC order. -Interviews regarding staff #1's girlfriend drug and alcohol use in the facility. -Interviews regarding staff #1's intoxication on 4/7/23 in the facility. Interview on 6/1/23 the Qualified Professional (QP) stated: -Had not reported the allegations of neglect by staff #1 to the county DSS. -Had relieved staff #1 of his duties on 5/19/23 once they were made aware of the incidents. -Did an internal investigation and officially terminated staff #1 on 5/22/23. -Was waiting for survey to be completed to know all the evidence gathered before reporting the neglect.	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree	V 512		

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V 512	Continued From page 44 of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record review, observation and interview one of two staff (#1) subjected five of five clients (#1, #2, #3, #4, #5) to neglect. The findings are: Review on 5/24/23 of staff #1's record revealed: -Hire date of 3/24/23 as a Paraprofessional Interview on 5/23/23 the Qualified Professional (QP) stated staff #1 was terminated on 5/22/23. Review on 5/17/23 of client #1's record revealed: -Admission date of 5/8/22 -Diagnosis of Schizoaffective Disorder Review on 5/18/23 of client #2 revealed: -Admission date of 4/19/16 -Diagnoses of Schizophrenia, Type II Diabetes, Double amputee Review on 5/18/23 of client #3's record revealed: -Admission date of 5/1/19 -Diagnoses of Paranoid Schizophrenia, Mild Mental Retardation, Hypertension and Type II Diabetes -Registered Sex Offender Review on 5/17/23 of client #4's record revealed: -Admission date of 8/19/19	V 512		

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V 512	Continued From page 45 -Diagnoses of Schizophrenia and Diabetes Type II Review on 5/17/23 of client #5's record revealed: -Admission date of 4/1/21 -Diagnoses of Schizophrenia, Hepatitis C and Chronic back pain -Served 33 years in prison for murder Below are examples of staff #1 subjecting the clients to neglect: A. Review on 5/19/23 of police report dated 4/7/23 revealed" -"...Mental Commitment...This report contains information regarding an involuntary mental commitment. The female subject (the girlfriend) was staying at the male halfway house located above. She was transported without incident to [local hospital.]" -"I was dispatched to an involuntary commitment in regards to a [the girlfriend] who was using cocaine and drinking heavily for a few days. [The girlfriend] was at a male only halfway house located at 5040 Kaplan Drive. When I arrived on scene one of the males living there let me in to speak with the house manager whom [the girlfriend] was staying with . [The girlfriend] was in the bedroom and appeared to be intoxicated. [The girlfriend] willingly walked to my patrol vehicle and I transported her to [local hospital] without incident. At the hospital [the girlfriend] confirmed she used cocaine and had been drinking all day." Interview on 5/18/23 a police officer with the local police department stated: -Had several calls to the facility address. -A call on 3/25/23 at 5:30 AM female (the girlfriend) at the home using drugs. "Officer went to the home, an all male group home and no	V 512		

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female in the house or drugs.
-A call on 4/6/23, "Caller concerned for girlfriend (the girlfriend) at this location hiding in a room with [staff #1]"
- "Officer responded to this location, she did not come to the door, no crime, so couldn't make her."

Interview on 5/17/23 client #1 stated:
-Staff #1 stayed in his room all day.
-Not sure why he did not come out of his room.
-Staff #1's girlfriend (the girlfriend) came to the facility two to three times a week.
-The girlfriend would stay in the facility two to three days in staff #1's room.
-Had not met her, only in passing said "hello."
-"Occasionally" would see a beer can on the kitchen table, "not sure whose it is, maybe [staff #1]'s girlfriend."
-Staff #1 and the girlfriend were usually in his bedroom.
-Staff #1 had been having the girlfriend come visit since he started working there about a year ago.

Interview on 5/17/23 client #2 stated:
-Staff #1 stayed in his room during the day.
-Staff #1 would come out of his room four to five times a day to check on them.
-Staff #1's girlfriend (the girlfriend) came by about two times a month and she would go back to staff #1's room.
-Not sure if the girlfriend stayed the night because he took his medications at 7:00 PM and went to bed.

Interview on 5/17/23 client #3 stated:
-Staff #1 "stays in his room a lot."
-Staff #1 stayed up all night long watching television and talking on his phone.
-Could hear staff #1 talking to a female on the

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phone at night.
-Staff #1 had his "wife" (the girlfriend) come over and she would stay in his bedroom.
-Would see the girlfriend in the facility and she would stay two to three hours.
-Not sure if the girlfriend stayed all night.

Interview on 5/17/23 client #4 stated:
-The girlfriend was at the facility with staff #1 and the police came and took her away.
-Staff #1 had a back door entrance to his room where people can come and go without the clients seeing anyone.
-Staff #1's daughter did come by and go into staff #1's bedroom entrance to bring him stuff.
-Saw beer cans in the trash "a long time ago."
-Looked like a "twelve pack" and not sure whose it was.
-Staff #1 "really don't say much because he is not around...he doesn't supervise us."

Interview on 5/17/23 client #5 stated:
-Had not seen the girlfriend in the home but had heard her voice in staff #1's bedroom at night.
-Not sure how she entered the facility.
-Not sure how often she visited the facility.

Interview on 5/25/23 client #5's legal guardian stated:
-Client #5 had a history of substance use.
-Client #5 and his wife had murdered a doctor to steal his prescription pad to write for illicit medications.
-Client #5 did not have unsupervised time in the home or the community.
-Client #5 did need staff supervision and to check on him at least every thirty minutes while he was outside smoking.

Interview on 5/17/23 staff #1 stated:

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-His daughter and ex wife would come by to bring him groceries, but they did not come inside the facility.
-No females came over to the home and hung out in his room.
-Did not have a girlfriend.
-No one came over to drink alcohol or use illicit drugs.
-Not sure where this information is coming from regarding him having a female friend visiting him in the facility.

Interview on 5/19/23 the boyfriend stated:
-His girlfriend (the girlfriend) had been staying in the facility with staff #1 for 3-4 months.
-His girlfriend (the girlfriend) would tell him that she was going to stay a few days with some girlfriends in Raleigh to party.
-Had paid for transportation to the facility address.
-Had picked her up several times from the facility address where she exited out of the front door while men were outside smoking.
-She had been on drugs and drinking while staying in the facility.
-Started to get suspicious of the home when he went to pick her up.
-After seeing the men outside smoking, he asked "was this a crack house?"
-She eventually told him it was a group home and staff #1 was the administrator.
-The girlfriend told him there were clients there that was a client who was a double amputee, another client was a registered sex offender and a third client who had murdered someone.
-She stated she and staff #1 would go to a local bar and come back to party in the back room that staff #1 lived in.
-She stated staff #1 was who she got her drugs from.

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-She stated to him she liked going over there because staff #1 would stay up and party all night.
-She stated that staff #1 would refer to one client as "fat a*s."
-Was concerned for her safety in this home with the clients' history which is why he called the police to remove her.
-Had called the police at the end of March 2023 and early April 2023 to report her in the facilty where she was drinking and using drugs.
-The police attempted to pick her up, but when they arrived she would not go to the door.
-Did an IVC on her on April 6, 2023 and she was picked up at the facility on April 7, 2023.
-When the police served her with the IVC order, she was drunk and had been using cocaine.
-The police transported her to a local hospital where he then picked her up.
-Called the police for an IVC because he felt no one was going to do anything about his girlfriend (the girlfriend) being in the home and using drugs.
-Staff #1 called his girlfriend (the girlfriend) two days ago asking why they were trying to get him in trouble.
-Staff #1 has been calling her for the last three days trying to get the girlfriend to go back over there.
-Has refused to give the girlfriend money to pay for transportation to get there.
-She still had clothing items at the facility.
-She had not been over there in about three weeks.

Further interview on 5/19/23 staff #1 stated:
-He slept from 12:30 AM and woke at 6:30 AM.
-Would try to take a 45 minute nap prior to lunch.
-Client #5 did require 30 minute checks during the day inside and outside of the facility.
-Took a sleep aid at night to help him sleep as he

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had issues falling asleep.
-Did not recall any instances where the police had been out regarding a female visitor.
-A police officer did come by on a Saturday because he had a female visitor (the girlfriend) that had stopped by.
-The girlfriend was in his bedroom and would not come out to meet with the police.
-The girlfriend had only been in the facility for about thirty minutes.
-Would not risk having a guest because that would cause problems.
-The girlfriend did frequent a bar and pool hall down the street from the facility, but did not come by after that.
-Had been "hanging out" with the girlfriend for the last 2 1/2 months.
-No one had been drinking in the facility unless it was client #5 walking to the store and bought a beer.
-Was off for two weeks, a few weeks ago and the girlfriend had not been back to the facility.
-Did not recall any situations where clients had to wake him for their medications.
-Not sure how the girlfriend would know personal information about the clients.
-Never told her confidential information regarding the clients unless he mentioned it "in passing."
-Did not remember ever having a conversation with the girlfriend about the clients.

Interview on 5/23/23 a police officer with local police department stated:
-Served an IVC order at the facility on 4/7/23 approximately 8:50 PM for the girlfriend.
-Apparently the girlfriend lived with another guy who knew she was there using drugs with staff #1 and he was concerned for her safety.
-There was an attempt the day before to serve the IVC at the facility for the girlfriend and she ran

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ABSOLUTE HOME-KAPLAN DRIVE	5040 KAPLAN DRIVE RALEIGH, NC 27606

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V 512	Continued From page 51	V 512		

out the back door and got away.
-Reviewing his body camera video, he arrived at the facility, going to the front door and a gentleman answered the door.
-Asked the gentleman who answered the door, was "[staff #1] there" and he was told by the gentleman he was in his room.
-Then asked the gentleman was there a female (the girlfriend) in the home, and he said he was not sure.
-The gentleman told him where staff #1's room was located and he knocked on the door
-When staff #1 opened the door, "they were both intoxicated (staff #1 and the girlfriend)"
-"They had obviously been partying together, there were alcohol bottles on the shelf."
-The girlfriend stated they had been to a bar drinking alcohol and then returned to the facility.
-The girlfriend stated she had been drinking all day and was using cocaine.
-The girlfriend then lit a cigarette at which time he asked her not to and she continued to smoke it.
-Staff #1 looked very sleepy as if he had been "up for days and it was only 8:50 PM."
-Staff #1 "did not look sober, he seemed lethargic and words were slurred."
-Staff #1's button up shirt was half buttoned and his shorts were hanging low around his hips as he looked "disheveled."
-Staff #1 stated he and the female (the girlfriend) were dating and her boyfriend she lived with was upset she was there.
-Staff #1 was cooperative and helped the female pack her clothes.
-Only allowed the girlfriend to pack one bag and noticed she had other clothes in the room.
-Staff #1 then walked with them out of the facility and placed the girlfriend's bag in the patrol car.
-Staff #1 then gave her a kiss.
-As they walked through the facility, noticed one

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V 512	Continued From page 52 male client sitting on the couch. -Transported the girlfriend to a local hospital. B. Interview on 5/17/23 client #1 stated: -Been living in the home three years. -He and the other clients cooked their own breakfast and lunch. -Staff #1 stayed in his room all day. -Not sure why he did not come out of his room. -The clients woke up and made their own breakfast. -Staff #1 would come out of his room if he heard the smoke detector. -No one has ever caught anything on fire. -The clients would cook at different time because they woke up at different times. Interview on 5/17/23 client #2 stated: -Been living in the home for seven years. -Staff #1 only cooked dinner for them. -The clients cooked their own breakfast such as grits and sausage. -Would make their own sandwiches for lunch or eat leftovers. Interview on 5/17/23 client #3 stated: -Been living in the group home for five years. -They get their own breakfast as staff #1 was in his room. -Staff #1 would put out sandwich stuff for them to make for lunch. -Staff #1 would cook dinner, "if he did not forget." -Staff #1 would order them food sometimes for dinner. Interview on 5/17/23 client #4 stated: -Been living in the home for four years. -Woke up at 6:30 AM to shower and catch the bus for the day program at 8:00 AM. -Did not have breakfast in the mornings unless he	V 512		

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fixed his own because staff #1 was not awake.
-Would eat lunch at his day program daily.
-Staff #1 would fix their dinner.
-On the weekends they fixed their own breakfast and lunch.
-Would fix eggs, sandwiches or whatever was available in the home.

Interview on 5/17/23 client #5 stated:
-Been staying in the home for a year.
-Did not eat breakfast in the mornings because he slept in.
-Would eat a biscuit when he woke up.
-Made a sandwich or whatever leftovers they had for lunch.
-The other guys cooked their own breakfast and did not see staff #1 with them.
-Staff #1 cooked dinner nightly.

Interview on 5/19/23 staff #1 stated:
-Clients did not prepare their own food, he always prepared their meals.
-Some clients prefer not to eat breakfast because they slept in.
-Two clients get lunch at their day program.

Interview on 5/23/23 with the boyfriend stated:
-The girlfriend told him when she stayed at the facility with staff #1 she would prepare meals for the clients.
-She stated to him that staff #1 would be asleep and she would make them balanced meals like a salad.
-Not sure how often she cooked for the clients.
-She stated she would go through the facility and wake the clients at 8:30 AM because staff #1 was sleeping.
-She stated staff #1 was to wake up at 7:00 AM and give clients their medication and he would not.

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V 512	Continued From page 54 Interviews between 5/17/19/-6/2/23 the Qualified Profession (QP) stated: -Was not aware of staff #1 having the girlfriend or any other guest in the home. -Staff were trained on visitors policy at their orientation. -Had concerns about staff #1 in the past few months regarding him staying in his room all the time. -Addressed this with the Licensee/Registered Nurse (RN) and he was taken off the schedule for two weeks. -The Licensee/RN brought staff #1 back on shift without letting her know. -"Popped" up at the facility at different times and was there several times a month. -If she had known he was doing these things at the facility she would have immediately terminated him because that would have been a "good excuse" to fire him. -Clients had never mentioned until 5/17/23 that the girlfriend was visiting the home. -Addressed this with staff #1 and he denied the girlfriend visiting, only that his daughter and ex wife dropped off things for him. -Staff #1 should not be discussing any confidential information with the girlfriend. -Staff #1 received confidentiality training during his orientation by her. -Not heard from any clients they were cooking and preparing their own food. -Some clients could cook independently, but should not be doing so without staff supervision. -Staff #1 should have been in the kitchen while clients cooked food. -"Effective today (5/19/23), [staff #1] will be relieved of his duties and removed from the home." -Had not been pleased with staff #1 in the last	V 512		

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V 512	Continued From page 55 few months, but had not expected all these things had been going on. Interview on 5/30/23 the Licensee/RN stated: -Staff #1 had sent her pictures of food he prepared in the past and no clients had complained of the food. -Staff #1 should have been supervising the clients while cooking. -Told staff #1 to "be available and with the clients." -Told staff #1 he could watch television with them and be outside with them at times. -Noticed when she went by the house unannounced he would come from his room, so that triggered her to ask what he was doing -Had concerns with him being in his room all the time and had addressed that with him. -Took him off the schedule as a "warning" before terminating him. -Spoke to him about staying in his room and he said he would stop. -Had stopped by the facility two days before surveyor (5/15/23) unannounced and staff #1 was in the bathroom, not in his room. -Spoke to the clients and had asked was staff #1 staying in his room a lot and they denied he had. -The QP had told her about the girlfriend on 5/19/23. -Trained staff #1 on client information and not having visitors in the home. -Trained staff #1 on boundaries of clients and not having them around friends or family. -No clients had mentioned to her or the QP of the girlfriend being in the home prior to 5/19/23. -Would have removed staff #1 "immediately" if they knew he was having visitors or using alcohol or drugs in the home. -Did not drug test staff unless they "suspect" them using.	V 512		

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-Did not do "pop ups" during the night time hours unless they had a concern.
-Had to have a back door entrance to the staff room due to fire egress for the house.
-Would look at ways to address the separate entrance along with random "pop ups' during the night hours from now on.
-After finding out all the issues with staff #1, he was removed from the facility on 5/19/23 and terminated on 5/22/23.

Review on 5/19/23 of Plan of Protection dated 5/19/23 completed by the QP revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
The staff on duty at the time of the survey was relieved of responsibility for the group home and terminated from the agency prior to today. Going forward the QP will provide training to the incoming staff on supervision needs of clients, medication requirements, confidentiality, workplace behavior ethics, clients rights, client safety, reporting procedures and protocols, positive workplace behavior ethics (no drugs or alcohol when on duty) and the policy on visitation (no visitors) for staff will be provided at hire for future employees and re-inserviced on a consistent basis. Additionally, the RN will provide training on nutritious meals and ensure that non-sweetened foods are available for all diabetics. Staff will be inserviced on this as well during the diabetes trainings

-Describe your plans to make sure the above happens.
The administrator, QP or designee will conduct pop up visits and /or interviews with a random sample of clients every day for the next 7 days to ensure staff competence, rules are being followed, rights are protected, appropriate

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supervision of clients as well as appropriate workplace behaviors of staff (no drugs, alcohol or visitors). After the initial 7 days the interviews/visits will be conducted weekly for the next 30 days."

Client #1, #2, #3, #4 & #5 were admitted to the facility with diagnoses which included Type 2 Diabetes Mellitus & Schizoaffective Disorder, Schizophrenia, Mild Mental Retardation and Hypertension. Staff #1 had been employed in the home for a year at which time he engaged in the use of alcohol and had the girlfriend staying in his room who also used illicit drugs and alcohol. Police were called to the facility on 4/7/23 to pick up the girlfriend on IVC order due to her boyfriend's concern for her safety. The girlfriend admitted to the police of her use of drugs and alcohol in the facility. The police also observed staff #1 to be under the influence and alcohol bottles were in his room during that encounter. Interviews with clients revealed the girlfriend was in the facility often and seeing beer bottles in the kitchen. Multiple interviews with clients, the QP and the Licensee/RN all confirmed staff #1 stayed in his room and not providing supervision or preparing meals for the clients. The girlfriend was aware of the client's diagnoses and had shared that information with her boyfriend in which lead to the IVC for her safety. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 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.

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V 736	Continued From page 58	V 736		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure the home was not maintained in a safe and attractive manner. The findings are: Observation on 5/17/23 of the home at 10:50 AM revealed: -Hallway bathroom had broken hand towel rack with metal piece sticking out from the wall. -Hallway bathroom tub and shower curtain had black substance build up throughout. -Back hallway bathroom had multiple patched areas that had not been painted around the toilet area. -Floors throughout the home had areas of dirt. -Dirty ash tray sitting on the back hallway bathroom countertop. -Chirping smoke detector in hallway between client bedrooms. Interview on 5/17/23 staff #1 stated: -He did the cleaning of the home. -Not aware of the areas that needed repair in the bathroom as it was like that when he started working a year ago. -The smoke detector had been chirping for about	V 736		

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a week.
-Told the Qualified Professional (QP) last week he needed a battery for it.

Interview on 5/17/23 the QP stated:
-Had come by the home several times over the last few months and noticed the floor was dirty.
-Had addressed the cleaning of the home with staff #1.
-Staff #1 had not told her he needed batteries.
-Was at the house weekly and would have brought batteries if he asked for them.

Interview on 5/30/23 the Licensee/RN stated:
-She and the QP check the home routinely.
-The QP would text her if she found issues for repairs.
-Her husband went by the house as well to check for repairs.
-Had not noticed or been told about any needed repairs.

V 752 27G .0304(b)(4) Hot Water Temperatures — V 752

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 interviews the facility failed to maintain the water temperature between

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100-116 degrees Fahrenheit. The findings are:

Observation on 10/17/23 at 10:00 AM of the following water temperatures:
-The kitchen sink was 60 degrees Fahrenheit
-The hallway bathroom sink and tub was 125 degrees Fahrenheit.
-The bathroom sink and shower located in the back hallway was 126 degrees Fahrenheit.

Interview on 10/17/23 Staff #1 stated:
-Had not checked the water temperatures.
-No clients stated the water temperature was too hot.

Interview on 10/17/23 the Qualified Professional stated:
-Not aware of the water temperatures in the home.
-Had not checked them.
-Had no reason to check them.
-The maintenance guy often checked the homes for those different things.
-Will refer these temperatures to their maintenance guy.