STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 August 18, 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 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 118	Continued From page 1 (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 and interview the facility failed to administer medications as ordered and maintain a current MAR for three of three audited clients (#1, #2, #4). The findings are: Finding #1 Review on 8/16/23 of client #1's record revealed: -35 year old male. -Admitted on 3/9/20. -Diagnoses of Autism Spectrum Disorder, Turret's Disorder, Intermittent Explosive Disorder, Severe Intellectual Disability, Bipolar Disorder II with disassociate personality episodes and Functional Neurological Symptom Disorder and Conversion Disorder. Review on 8/16/23 and 8/17/23 of client #1's signed physician orders revealed: 10/18/22 - Benztropine 1 milligram (mg) three times daily. (mood/mental) - Quetiapine 300 mg twice daily increase to 400 mg twice daily on 6/23/23. (Bipolar) 12/5/22 - Ferrous Sulfate 325 mg daily. (Iron) 1/20/23 - Divalproex 500 mg 2 tablets every morning and 1 tablet at bedtime. (Bipolar) - Melatonin 5 mg at bedtime. (sleep) 3/6/23 - Lisinopril 5 mg daily. (Hypertension) 3/24/23 - Paliperidone 3 mg every morning.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 118	Continued From page 2	V 118		

(Schizophrenia)
- Clonazepam 1 mg twice daily. (Anxiety)
3/27/23 - Metformin 500 mg twice daily. (Diabetes)
6/23/23 -Buspirone 15 mg twice daily for anxiety.
8/2/23 - Xarelto 20 mg daily. (Blood clots)

Review on 8/16/23 of client #1's MARs from 6/1/23 - 8/16/23 revealed the following blanks:
-Benztropine 1 mg on 7/22/23 and 7/23/23 at 7am 8/14/23 and 8/15/23 at 2pm and 7pm.
-Quetiapine 400 mg and Clonazepam 1 mg on 7/16/23, 7/22/23, 7/23/23 at 7am and 8/14/23, 8/15/23 at 7pm.
-Divalproex 500 mg and Buspirone 15 mg on 7/22/23, 7/23/23 at 7am and 8/14/23 and 8/15/23 at 7pm
-Melatonin 5 mg on 8/14/23, 8/15/23.
-Ferrous Sulfate 325 mg, Lisinopril 5 mg, Paliperidone 3 mg, Xarelto 20 mg on 7/16/23, 7/22/23, 7/23/23.
-Metformin 500 mg on 8/14/23, 8/15/23 at 7pm and 7/16/23, 7/22/23, 7/23/23 at 7am and 6/27/23-6/30/23 at 7pm.
-Blanks initially observed on August MAR were documented as administered after a request for copies was made.

Interview on 8/16/23 client #1 stated he took his medications daily.

Finding #2
Review on 8/16/23 of client #2's record revealed:
-29 year old male.
-Admitted on 12/20/11.
-Diagnoses of Moderate Intellectual Disability, Bipolar Disorder II, Obsessive Compulsive Disorder, Intermittent Explosive Disorder and Enuresis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 118	Continued From page 3 Review on 8/16/23 and 8/17/23 of client #2 signed physician orders revealed: -10/29/22 - Mupirocin 2 % Ointment apply to affected area three times daily. (Skin infections) -11/30/22 - Oxcarbazepine 600 mg twice daily. (seizure) 1/11/23 - Clonazepam 1 mg three times daily. -1/31/23 - Docusate Sodium 100 mg twice daily. (Stool) -5/26/23 - Metformin 500 mg twice daily. -5/31/23 - Hydrocortisone 2. 5 % ointment apply at thin layer to the affected areas topically twice daily for two weeks. (skin irritation) - Ketoconazole 2% Cream apply to the affected area twice daily for two weeks. (skin infections) -6/1/23 - Risperidone 1 mg three times daily. (Bipolar) Review on 8/16/23 of client #2's MARs from 6/1/23 - 8/16/23 revealed: -Docusate Sodium 100 mg, Metformin 500 mg, Oxcarbazepine 600 mg was blank on 8/14/23, 8/15/23 at 7pm. -Mupirocin 2 % Ointment, Risperidone 1 mg and Clonazepam 1 mg was blank on 8/15/23 at 2pm and 8/14/23, 8/15/23 at 7pm. -Hydrocortisone 2. 5 % ointment was administered daily at 7pm for the month of June and twice daily from 8/1/23 - 8/13/23. Interview on 8/16/23 client #2 stated: -He received his medications every morning, afternoon and right. Finding #3 Review on 8/16/23 of client #4's record revealed: -34 year old male. -Admitted on 12/9/11. -Diagnoses of Autism Spectrum Disorder,	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 118	Continued From page 4 Tourette Disorder, Anxiety Disorder unspecified, Obsessive Compulsive Disorder and Attention Deficit Hyperactivity Disorder, inattentive type. Review on 8/16/23 and 8/17/23 of client #4's signed physician orders revealed: -1/4/23 - Quetiapine 400 mg at bedtime. (Schizophrenia) -4/1/23 - Fluticasone Propionate 50 micrograms (mcg) 2 puffs in each nostril daily. (allergy) -Lithium 450 mg two tablets at bedtime. (Bipolar) -7/10/23 - Melatonin 3 mg two tablets at bedtime. Review on 8/16/23 of client #4's MARs from 6/1/23 - 8/16/23 revealed: -Fluticasone Propionate 50 mcg was not administered from 6/1/23 - 6/30/23 and 8/1/23 -8/15/23. -Lithium 450 mg, Melatonin 3 mg, Quetiapine Extended Release (ER) 400 mg were blank on 8/15/23. Interview on 8/16/23 client #4 stated: -He received his medications every morning and night. Interview on 8/16/23 and 8/17/23 the Program Manager stated: -The clients received their medications daily. -No client had refused any medications. -Blanks on the MARs were from staff not completing documentation on the MAR after the medication was administered. -Client #2 was last seen for skin condition on 5/31/23. -There were no additional physician orders for Hydrocortisone 2.5% and Ketoconazole medications after 5/31/23. -The facility had client #2 seen by his primary physician whenever he had skin irritation.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 118	Continued From page 5 -Client #4 received his Fluticasone Propionate 50 mcg as needed. -She had documented some medications as administered on MARs when she noticed blanks after the review. Interview on 8/17/23 the Qualified Professional stated: -The clients received their medications daily. -All staff were responsible for reviewing the MARs. -There should not have been any blanks on the MARs. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by:	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 121	Continued From page 6 Based on record reviews and interviews the facility failed to obtain drug regimen reviews for 3 of 3 audited clients (#1,#2,#4) who received psychotropic medications. The findings are: Finding #1 Review on 8/16/23 of client #1's record revealed: -35 year old male. -Admitted on 3/9/20. -Diagnoses of Autism Spectrum Disorder, Tourette Syndrome, Intermittent Explosive Disorder, Severe Intellectual Disability, Bipolar Disorder II with disassociate personality episodes and Functional Neurological Symptom Disorder and Conversion Disorder. -No drug regimen review documented in the past 6 months. Review on 8/16/23 of client #1's current drug regimen revealed: -Haloperidol 10 milligram (mg) twice daily as needed. (Tourette Syndrome) -Benztropine 1 mg three times daily. (mood/mental) -Aspirin 81 mg daily. (pain) -Buspirone 15 mg twice daily for anxiety. -Divalproex 500 mg 2 tablets every morning and 1 tablet at bedtime. (Bipolar) -Ferrous Sulfate 325 daily. (Iron) -Haloperidol 100 mg injection every 4 weeks. -Lisinopril 5 mg daily. (Hypertension) -Melatonin 5 mg at bedtime. (Sleep) -Metformin 500 mg twice daily. (Diabetes) -Paliperidone 3 mg every morning. (Schizophrenia) -Quetiapine Fumarate 400 mg 2 tablets twice daily. (Bipolar) -Xarelto 20 mg daily. (Blood clots) -Clonazepam 1 mg twice daily. (Anxiety) -Invega Sustenna 234 mg injection monthly.	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 121	Continued From page 7 (Schizophrenia) Finding #2 Review on 8/16/23 of client #2's record revealed: -29 year old male. -Admitted on 12/20/11. -Diagnoses of Moderate Intellectual Disability, Bipolar Disorder II, Obsessive Compulsive Disorder, Intermittent Explosive Disorder and Enuresis. -No drug regimen review documented in the past 6 months. Review on 8/16/23 of client #2's current drug regimen revealed: -Cetirizine 10 mg as needed for allergy. -Atorvastatin 40 mg daily. (cholesterol) -Docusate Sodium 100 mg twice daily. (Stool) -Lisinopril 2.5 mg daily. -Metformin 500 mg twice daily. -Omeprazole 20 mg daily. (heartburn) -Oxcarbazepine 600 mg twice daily. (seizure) -Risperidone 1 mg three times daily. (Bipolar) -Vitamin D2 2000 unit daily. (Supplement) -Clonazepam 1 mg three times daily. Finding #3 Review on 8/16/23 of client #4's record revealed: -34 year old male. -Admitted on 12/9/11. -Diagnoses of Autism Spectrum Disorder, Tourette Disorder, Anxiety Disorder unspecified, Obsessive Compulsive Disorder and Attention Deficit Hyperactivity Disorder, inattentive type. -No drug regimen review documented in the past 6 months. Review on 8/16/23 of client #4's current drug regimen revealed: -Hydroxyzine 50 mg at bedtime. (anxiety)	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 121	Continued From page 8 -Bupropion 300 mg daily. (Depression) -Cetirizine 10 mg daily for allergies. -Fluticasone Prop 50 micrograms (allergy) -Lithium 450 mg 2 tablets at bedtime. (Bipolar) -Melatonin 3 mg at bedtime. -Naproxen 500 mg as needed. (pain) -Quetiapine 400 mg at bedtime. (Schizophrenia) Interview on 8/16/23 the Program Manager stated: -Medication reviews were completed by the pharmacy every year. -The pharmacy was scheduled to complete their review at the end of the month. -Each client attended medication management appointments with their psychiatrist. Interview on 8/16/23 and 8/17/23 the Qualified Professional stated: -Clients were seen for their medication management appointments every 6 months. -The provider used the facility's coordination of care form to document changes during the client's appointment.	V 121		
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 record review, observations and interviews the facility was not maintained in a safe, clean and attractive manner. The findings are:	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 736	Continued From page 9 Review on 8/16/23 of client #1's record revealed: -35 year old male. -Admitted on 3/9/20. -Diagnoses of Autism Spectrum Disorder, Tourette Syndrome, Intermittent Explosive Disorder, Severe Intellectual Disability, Bipolar Disorder II with disassociate personality episodes and Functional Neurological Symptom Disorder and Conversion Disorder. Observation on 8/16/23 between 9:56 am - 10:30am during a tour of the facility revealed: -The light fixture cover was missing in the laundry room. -The handle was broken off the freezer. -The hall bathroom toilet lid had a horizontal crack across the top. -The hall bathroom had 1 of 3 light bulbs missing from the vanity mirror. -Client #3's bedroom dresser was missing 4 knobs and 1 knob missing from his chest dresser. -Client #1's bedroom side by side windows had the lower sash portion of the window covered in Plexiglas. The Plexiglas was about 2 inches below the window locks to the base of the window seal. -Client #4's bathtub water spout was loose and not affixed to the surface bathtub. Observation and Interview on 8/17/23 between 12:05 pm - 12:50 pm of client #1's bedroom windows revealed: -Side by side windows with an upper and lower sash. -Each window had Plexiglas screwed in each of the 4 corners into the frame of the window seal. -The Plexiglas extended the width of the window and the height was about 2 inches below the lower sash lock.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 736	Continued From page 10 -The lower sash was able to rise up however the Plexiglas prevented egress. -The upper sash was only able to come down about 15 inches. -The upper sash was able to tilt inward about 4 inches. -The lower sash that was covered by the Plexiglas prevented the upper sash to fully tilt inward. -The Program Manager stated the upper part of the window was able to come down however, upon observation, and measurement it only came down about 15 inches. -The Program Manager stated she was unable to fully tilt the upper sash because the lower sash needed to be tilted first. Interview on 8/17/23 client #1's Care Coordinator stated: -She had been client #1's care coordinator since 2008/2010. -Client #1 was known to break glass. -She did not recall a treatment meeting asking about Plexiglas being installed. -She does not agree with Plexiglas being over client #1's window and that would be a client rights concern for her. Interview on 8/16/23 and 8/17/23 the Program Manager stated: -Client #1 was very aggressive . -The facility placed Plexiglas over client #1's windows to prevent him from breaking the glass. -The facility had a meeting with the guardian and care coordinator and decided the Plexiglas was the best way to prevent the client from breaking the window. -She was unable to recall when the Plexiglas was placed over client #1's window. -Client #1 had not had any physically aggressive	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 736	Continued From page 11 behaviors or property destruction in the past 3 to 6 months. Interview on 8/17/23 the Qualified Professional stated: -The Plexiglas was placed on client #1's window shortly after client #1 was admitted. -The facility was attempting to prevent injury of client #1 and prevent client #1 from breaking the window. -The facility had a fire inspection completed and the fire marshall was not concerned about egress. -The facility had "more qualified professionals" who observed the Plexiglas in client #1's bedroom without concern. Review on 8/17/23 of a Plan of Protection (POP) completed by the QP and dated 8/17/23 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? PRECEDING ACTION: THE FACILITY HAD NO VOLATIONS ACCORDING TO [Local City] FIRE DEPARTMENT IN SEPTEMBER 2022. (SEE ATTACHEDMENT) MITIGATING ACTION: ITEM IN QUESTION WAS REMOVED IN THE PRESENCE OF THE SURVER DURING THE TIME OF SURVEY. CORRECTIVE ACTION: ITEM WILL NOT RETURN TO THEE AREA IN QUESTION AT ANY POINT MOVING FORWARD. PROVIDER WILL EXPLORE OPTIONS, AND IF NECESSARY, REPLACE THE CURRENT GLASS WITH BREAK RESISTANCE WINDOWS. -Describe your plans to make sure the above happens." Provider did not respond, left blank. Review on 8/17/23 of a revised POP completed by the QP and Program Director and dated 8/17/23 revealed:	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 736	Continued From page 12 -"What immediate action will the facility take to ensure the safety of the consumers in your care? Plexglass only affected the bottom half of the window, the top half of the window is easily removable for egress purpose to the exterior of the home as evidence by no violation According to [Local City] Fire Department in September 2022 (See Attachment) Plexglass was removed while the surveyor was still in the facility. Residental Director presented the Plexglass to surveyor as evidence of removal. -Describe your plans to make sure the above happens. (Plexglass) will not return to the area in question at any point moving forward. Provider will explore options, and if necessary, replace the current glass with break resistance windows. URS management (Licensee) and facility director shall be responisible for insuring that the Plexy Glass is not put at any window location in the home." The facility had a census of 4 clients. Client #1's diagnoses included Autism Spectrum Disorder, Tourette Syndrome, Intermittent Explosive Disorder, Severe Intellectual Disability, Bipolar Disorder II with disassociate personality episodes and Functional Neurological Symptom Disorder and Conversion Disorder. Client #1 had his own bedroom with side by side windows. The facility had placed Plexiglas over the bottom sash of both windows to prevent client #1 from breaking the windows. The lower sash was able to rise up however, the Plexiglas prevented egress. The upper sash was only able to come down about 15 inches. The upper sash was able to tilt inward about 4 inches. The lower sash that was covered by the Plexiglas prevented the upper sash to fully tilt inward. The top sash did not allow for egress by having only 15 inches of opening from the top of the window in the event of an emergency. This	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 736	Continued From page 13 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 for $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 736		
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 water temperatures were not maintained between 100-116 degrees Fahrenheit in areas where clients were exposed to hot water. The findings are: Observation on 8/16/23 between 9:56 am - 10:30 am revealed: -The hot water temperature at the kitchen sink measured 122 degrees Fahrenheit. -The hot water temperature in the hall bathroom measured 126 degrees Fahrenheit at the sink and bathtub. Observation on 8/16/23 between 4:31 pm - 4:40 pm revealed:	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH CAROL	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 752	Continued From page 14 -The hot water temperature in the bathroom of client #4's bedroom measured 84 degree Fahrenheit at the sink. Observation on 8/17/23 between 10:00am - 5:00 pm revealed: -No plumber was at the facility during this time. Interview on 8/16/23 the Program Manager stated: -The facility checked the hot water heater monthly. -The hot water heater was set at the lowest setting. -She contacted the plumber to request the water heater be serviced. Interview on 8/17/23 the Program Manager stated: -The plumber was at the facility. -The thermostat had to be taken off and realigned. -The plumber drained all the water out of the water heater and planned to return later to check the temperatures. -"If the temperatures are still higher then a new piece would be ordered." Interview on 8/17/23 the Qualified Professional stated: -The facility had a plumber check the hot water. -The surveyor should recheck the hot water at the facility.	V 752		