| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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<br><br>An annual survey was completed on August 15, 2023. Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.<br><br>This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients. | V 000 | | |
| V 105 | 27G .0201 (A) (1-7) Governing Body Policies<br><br>10A NCAC 27G .0201 GOVERNING BODY POLICIES<br>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:<br>(1) delegation of management authority for the operation of the facility and services;<br>(2) criteria for admission;<br>(3) criteria for discharge;<br>(4) admission assessments, including:<br>(A) who will perform the assessment; and<br>(B) time frames for completing assessment.<br>(5) client record management, including:<br>(A) persons authorized to document;<br>(B) transporting records;<br>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;<br>(D) assurance of record accessibility to authorized users at all times; and<br>(E) assurance of confidentiality of records.<br>(6) screenings, which shall include:<br>(A) an assessment of the individual's presenting problem or need;<br>(B) an assessment of whether or not the facility can provide services to address the individual's needs; and | V 105 | Received by MHL & C 9/14/23 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 105 | Continued From page 2 | V 105 | | |

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

Review on 8/9/23 of the Division of Health Service Regulation's facility folder revealed:
- No documentation of a CLIA waiver

Review on 8/10/23 of Client #3's record revealed:
- Admitted: 10/18/19
- Diagnoses: Major Depression, Cognitive Impairment and History of Alcohol Abuse
- Physician's order dated 4/19/23 revealed:
  - Accu-Chek guide test strips, use one test strip twice a day
  - Accu-Chek Softclix Lancets use to test blood sugar (BS) twice daily

Interview on 8/10/23 Client #3 reported:
- He was diabetic
- Staff checked his BS every other day

Interview on 8/10/23 staff #1 reported:
- Client #3 was "borderline diabetic"
- She checked client #3's BS every other day

Interview on 8/14/23 & 8/15/23 the Qualified Professional (QP) reported:
- Client #3 had his BS checks every other day by staff
- She did not know if the facility had a CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 105 | Continued From page 3<br>waiver and would need to ask the Licensee about that<br>- Confirmed there was no CLIA waiver for the facility<br><br>Interview on 8/15/23 the Licensee reported:<br>- She and the QP were talking about the CLIA waiver yesterday, 8/14/23, and she was hearing about this for the first time<br>- Confirmed they didn't have a CLIA waiver and would be getting one for the "very first time" | V 105 | | |
| V 108 | 27G .0202 (F-I) Personnel Requirements<br><br>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS<br>(f) Continuing education shall be documented.<br>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:<br>(1) general organizational orientation;<br>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;<br>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and<br>(4) training in infectious diseases and bloodborne pathogens.<br>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their | V 108 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 108 | Continued From page 4<br>equivalence for relieving airway obstruction.<br>(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to ensure 1 of 2 audited paraprofessionals (#2) was trained to meet the mh/dd/sa needs of the clients. The findings are:<br><br>Review on 8/10/23 staff #2's record revealed:<br>- Employed: 12/12/18<br>- Title: House Manager<br>- No documentation of current first aid, bloodborne pathogens, or infection control training<br><br>Interview on 8/14/23 staff #2 reported:<br>- She had CPR (Cardiopulmonary resuscitation), First Aid, medication management, and bloodborne pathogens training<br>- She could not remember the other trainings she had completed<br><br>Interview on 8/15/23 the Licensee reported:<br>- She would tell staff #2 that she needed the updated trainings<br>- Staff was responsible for paying for their trainings<br>- She kept track of the trainings and let the staff know when trainings were due<br>- She would make sure staff #2 completed | V 108 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 108 | Continued From page 5<br>those trainings before she came back to work in September 2023 for her shift | V 108 | | |
| V 114 | 27G .0207 Emergency Plans and Supplies<br><br>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES<br>(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.<br>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.<br>(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.<br>(d) Each facility shall have basic first aid supplies accessible for use.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure that fire and disaster drills were conducted quarterly on each shift. The findings are:<br><br>Review on 8/10/23 of the fire and disaster drill log book revealed:<br>- Face sheet on the front of the log book revealed the 3 shifts for the facility:<br>- first shift 7am - 3pm<br>- second shift 3:05pm - 11:00pm<br>- third shift 11:05pm - 7am<br>- No fire drills were conducted on 3rd shift from January 2022 - July 2023 | V 114 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 114 | Continued From page 6<br>- One disaster drill was completed between January 2022 - July 2023<br><br>Interview on 8/10/23 staff #1 reported:<br>- She didn't do fire or disaster drills<br>- They were conducted the first week of each month when staff #2 worked<br><br>Interview on 8/14/23 staff #2 reported:<br>- Been working there almost 5 years<br>- She had been doing fire drills since she started working in the facility<br>- She used to do the disaster drills and thought that staff #1 had starting doing them<br>- Confirmed that she had not done any disaster drills this year, 2023<br><br>Interview on 8/14/23 the Qualified Professional (QP) reported:<br>- She put a schedule of when the fire and disaster drills were supposed to be conducted<br>- The schedule was varying shifts and times<br>- The facility was up to date on fire drills<br>- She reviewed the fire and disaster drills every time she visited the facility<br>- Last visit to the facility was July 2023<br>- She knew the fire drills were done but couldn't recall about the disaster drills<br><br>Interview on 8/15/23 the Licensee reported:<br>- The staff checked the fire and disaster drill logs<br>- They did fire and disaster drills every 3 months<br>- She and the QP were responsible for making sure the fire and disaster drills were completed<br>- She last checked the fire and disaster drill log last month, July 2023, and "to tell the truth I wasn't focused on the disaster drills and just making sure that the fire drills are done" | V 114 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 114 | Continued From page 7<br>- Would talk to staff to make sure that both fire and disaster drills were conducted<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 114 | | |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(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:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug.<br>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 8<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to administer medications on the written order of a physician for 1 of 3 audited clients (#3). The findings are:<br><br>Review on 8/10/23 of client #3's record revealed:<br>- Admitted 10/18/19<br>- Diagnoses of Major Depression Disorder, Cognitive Impairment, and History of Alcohol Abuse<br>- Physician's order dated 4/19/23:<br>- Accu-Chek Softclix Lancets use to test blood sugar (BS) twice daily (BID)<br>- Accu-Chek Guide Test Strips take 1 strip BID by miscellaneous route as directed for 90 days<br>- Metformin HCL 500 milligrams take 1 tablet by mouth once daily (Diabetes)<br><br>Review on 8/15/23 of an email received on 8/15/23 from the Qualified Professional (QP) revealed:<br>- A physician's order dated 8/27/21: "This letter is to inform that [client #3] to check blood sugar every other day"<br><br>Review on 8/10/23 at 2:04pm of client #3's BS logs revealed:<br>- BS was only documented 14 out of 60 opportunities in June 2023 with results ranging from 79-128<br>- BS was only documented 8 out of 62 opportunities in July 2023 with results ranging from 89-102 | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 9<br>- BS was only documented 4 out of 19 opportunities from August 1-10, 2023 with results ranging from 90-101<br><br>During interview on 8/10/23 client #3 reported:<br>- He was a diabetic<br>- Staff #1 checked his BS once a day every other day<br><br>During interview on 8/10/23 staff #1 reported:<br>- She started working in the facility 3 years ago<br>- Client #3 was a pre-diabetic and his BS was "usually good"<br>- She checked client #3's BS once every other day and had been checking it like that since she started in the facility<br>- A previous staff told her to check client #3's BS once every other day<br>- She checked client #3's BS once every other day in June 2023, but she "forgot to document" the results on the BS log<br>- Client #3's BS was "not supposed to be checked twice a day (BID)"<br>- The physician's orders dated 4/18/23 and MARs were "not right" because client #3's physician told her every other day, but she could not recall when<br><br>During interview on 8/14/23 staff #2 reported:<br>- Client #3 was a diabetic and she's been checking his BS once every other day for the last two years<br>- Staff #1 told her that client #3's physician's order was to check every other day, but she had not seen the order herself<br>- Client #3's MAR "still saying twice a day"<br>- She spoke to the Licensee about client #3's BS checks listed as BID on the MAR but should could not recall when<br>- The Licensee told staff #2 that she would | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 10<br>"look into it"<br><br>During interview on 8/14/23 the QP reported:<br>- She visited the facility monthly and reviewed the clients' record, medication, and MAR<br>- "I can't recall off the top of my head" which clients were diabetic<br>- She was unaware that client #3 did not have a diagnosis of diabetes listed in his client record<br>- She could not recall how often client #3 was supposed to check his BS<br>- She was unaware of client #3's physician's order to check his BS BID<br>- She planned to look at client #3's physician's order and MAR when she got to the facility<br>- She was unaware that both staff #1 and staff #2 were checking client #3's BS once every other day<br>- "We (facility staff) need to go by the order"<br><br>During interview on 8/15/23 the Licensee reported:<br>- She and the QP were responsible for reviewing the clients' medications, physician orders, and MARs<br>- She reviewed the clients' medications, physician orders, and MARs monthly<br>- Client #3 was pre-diabetic<br>- She could not recall why his pre-diabetic diagnosis was not listed in his record<br>- Client #3's BS checks were "PRN" (as needed)<br>- Client #3 checked his BS whenever he "felt bad" and requested for it to be checked<br>- She recalled a previous staff telling her "a while ago" that client #3's BS was supposed to be checked once every other day<br>- She was unaware of client #3's physician order to check his BS BID | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 513 | Continued From page 11 | V 513 | | |
| V 513 | 27E .0101 Client Rights - Least Restictive Alternative<br><br>10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE<br>(a) Each facility shall provide services/supports that promote a safe and respectful environment. These include:<br>(1) using the least restrictive and most appropriate settings and methods;<br>(2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others;<br>(3) providing choices of activities meaningful to the clients served/supported; and<br>(4) sharing of control over decisions with the client/legally responsible person and staff.<br>(b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:<br>(1) using the intervention as a last resort; and<br>(2) employing the intervention by people trained in its use.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed failed to use the least restrictive and most appropriate method for 2 of 3 audited clients (#1 and #2). The findings are:<br><br>Review on 8/10/23 of the "House of Blessings 2 LLC Residents Smoke Times" (no date) revealed | V 513 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 513 | Continued From page 12 | V 513 | | |

the following smoking schedule:
- 7-8am, 10am, 12-1pm, 3pm, 5-6pm, and 7-8pm

Review on 8/10/23 of client #1's record revealed:
- Admitted 6/9/20
- Diagnoses of Major Depressive Disorder, Brief Psychotic Disorder, Agitation, Delusions, and Feelings of Worthlessness

Review on 8/10/23 of client #1's smoke schedule (no date) signed by the Licensee revealed:
- "The staffs are to be in charge and responsible for [client #1] cigarettes"
- "On the 9th of month, [client #1] start off with 200 Cigarettes. 1. [client #1] is to have 6 cigarettes a day. 2. [client #2] is to take 4 Cigarettes to PRS (Psychosocial Rehabilitation) Program. 3. [client #1] is to have 2 more cigarettes before going to bed. 4. [client #1] is to have 6 cigarettes on Saturday 5. [client #1] is to have 6 cigarettes on Sunday....I need this to be signed off by incoming staff. Thanks. [Licensee]"

During interview on 8/10/23 client #1 reported:
- She smoked cigarettes
- Staff #1 kept her cigarettes

Review on 8/10/23 of client #2's record revealed:
- Admitted 12/26/22
- Diagnoses of Allergic Rhinitis, Insomnia, Resting Tremor, Schizoaffective Disorder, Bipolar-Type, Mild Intellectual Disability Disorder, Chest Wall Pain, Knee Instability, and Posttraumatic Stress Disorder

During interview on 8/10/23 client #2 reported:
- He smoked cigarettes during "smoke breaks"
- Staff #1 kept his cigarettes

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL091-107 | A. BUILDING: _____ B. WING _____ | R 08/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOUSE OF BLESSINGS II | 48 CHEATHAM LANE HENDERSON, NC 27537 |

| (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 513 | Continued From page 13 | V 513 | | |

During interview on 8/10/23 staff #1 reported:
- She kept client #1 and #2's cigarettes because they "will smoke a whole pack of cigarettes if they were to carry their own cigarettes"
- Clients followed a smoking schedule
- "If clients wants a cigarette after the time on the schedule, they won't get one"
- No one told her to keep the clients' cigarettes
- None of the clients' treatment plan addressed smoking

During interview on 8/14/23 the Qualified Professional reported:
- Clients did not have a physician's order to limit the amount of cigarettes they could have in a day
- The smoke breaks "seems to work for the clients because they were smoking around the clock"
- Clients can get a cigarette outside of the designated smoking time
- Clients should not be denied cigarettes, even when they request a cigarette outside the designated smoking times

During interview on 8/15/23 the Licensee reported:
- She was aware of the smoke schedule and staff #1 holding the clients' cigarettes
- Clients purchased their cigarettes with their money at the beginning of the month
- Some clients smoked their pack of cigarettes within 5 days and did not have the money to purchase more, which would cause a "behavior"
- Buying cigarettes was "expensive" and she could not "keep buying cigarettes"
- Staff was not supposed to keep the cigarettes away from the clients when they asked for them

| Rule Violation | Plan Of Correction |
|---|---|
| Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0201 Governing Body Policies (V105) Standard<br><br>*Review on 8/9/23 of the Division of Health Service Regulation's facility folder revealed: - No documentation of a CLIA waiver* | **Corrective Action:** CLIA Application Submitted for House of Blessings II DHSR.CLIA@dhhs.nc.gov |
| Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0202 Personnel Requirements (V108) Standard<br><br>*Review on 8/10/23 staff #2's record revealed: - Employed: 12/12/18 - Title: House Manager - No documentation of current first aid, bloodborne pathogens, or infection control training* | **Corrective Action:** Staff #2 first aid, blood borne pathogens/ infection control trainings have been completed and are current. Copies of all staff training certificates will be kept in employee files on site. QP and Director will ensure all trainings are renewed annually. |
| Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0207 Emergency Plans and Supplies (V114) Recite<br><br>*This Rule is not met as evidenced by: V 114 Based on record review and interview, the facility failed to ensure that fire and disaster drills were conducted quarterly on each shift.* | **Corrective Action:** Fire and Disaster Drills will be completed in full and within specified time frames as defined. Drill logs will be reviewed and confirmed monthly by QP. Staff who fail to comply with drill requirements will be subject to disciplinary action. All drill logs will be monitored monthly. |
| Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0209 Medication Requirements (V118) Standard<br><br>*This Rule is not met as evidenced by: Based on record review and interview, the facility failed to administer medications on the written order of a physician for 1 of 3 audited clients (#3).* | **Corrective Action:** The facility will ensure that all medications are administered in compliance with physician orders. The QP and house manager will compare MAR and physician orders once per month in order to ensure compliance with the physician orders. |
| Rule Violation/Tag #/Citation Level: 10A NCAC 27E .0101 Least Restrictive Alternative (V513) Standard<br><br>*This Rule is not met as evidenced by: V 513 Based on record review and interview, the facility failed to use the least restrictive and most appropriate method for 2 of 3 audited clients (#1 and #2).* | **Corrective Action:** Residents who smoke will have no restriction to accessing their cigarettes. Staff have been reminded and instructed not to prohibit resident's access. When necessary, Staff will engage with resident(s) and in order to encourage coping skills to prevent smoking excessive use. |