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COLLEGE LAKES	**5104 FLATROCK DRIVE FAYETTEVILLE, NC 28311**

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed October 6, 2023. The complaints were substantiated (intakes #NC00206394 and #NC00207988). Deficiencies were cited. This facility is licensed for the following rule area: 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 4 current clients. This survey originally closed on October 5, 2023 but was reopened on October 6, 2023, due to an additional complaint.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (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	V 108		

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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 equivalence for relieving airway obstruction.
(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.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure 4 of 8 current staff (#1, #2, #5 and the Qualified Professional/Director of Services (QP/DS) and 1 former staff (FS #10) had training to meet the needs of the clients. The findings are:

Review on 9/19/23 of client #1's record revealed:
- 32 year old male admitted 8/2006.
- Diagnoses of Autism, Smith Magenis and Intellectual Developmental Disability, severe.

Review on 9/19/23 of client #2's record revealed:
- 31 year old male admitted 7/2006.
- Diagnoses of Autism and Intellectual Developmental Disability, mild.

Review on 9/19/23 of client #3's record revealed:
- 27 year old male admitted 3/09/06.
- Diagnoses included Autism, Intellectual/Developmental Disability, moderate; Attention Deficit Hyperactivity Disorder, Seizure

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Disorder, and Citrullinemia.

Review on 9/19/23 of client #4's record revealed:
- 20 year old male admitted 2/18/23.
- Diagnoses included Autistic Disorder, and Intellectual/Developmental Disability, unspecified.

Review on 9/27/23 of staff #1's personnel record revealed:
- Date of hire 5/01/23.
- Hired as a Direct Support Professional.
- No documentation of client specific training to meet the needs of the clients.
- No "Competencies and Supervision of Paraprofessionals" form for each client signed by staff #1 and the QP/DS.

Review on 10/04/23 of staff #5's personnel record revealed:
- No documented hire date; undated application for employment; signed "Employment Agreement" dated 9/06/23.
- Direct Support Professional as listed on the Division of Health Service Regulation (DHSR) Client and Staff Census completed 9/19/23 by the Licensee and the QP/DS.
- No documentation of client specific training to meet the needs of the clients.
- No "Competencies and Supervision of Paraprofessionals" form for each client signed by staff #5 and the QP/DS.

Review on 9/27/23 of FS #10's personnel record revealed:
- Application date of 2/10/23.
- Hired as a Direct Support Professional.
- No documentation of client specific training to meet the needs of the clients.
- No "Competencies and Supervision of Paraprofessionals" form for each client signed by

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V 108	Continued From page 3 FS#11 and the QP/DS. Review on 10/4/23 of the QP/DS's record revealed: - Hire Date of 6/27/16. - 6/8/16 signed job description for the QP position. - No documentation of client specific training to meet the mental health needs of client #4. During interview on 10/04/23 staff #1 stated he had training in autism, but he could not recall the title of the training. Attempted interview on 10/04/23 with FS #11 was unsuccessful due to no working number. Interview on 10/4/23 the QP/DS stated: - The Licensee had not completed a job description for the DS position yet. - All trainings were documented in the personnel files that were provided.	V 108		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including:	V 109		

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V 109	Continued From page 4 (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on interview and record review, 1 of 1 Qualified Professional/Director of Services (QP/DS) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Refer to V108 regarding staff training. Refer to V112 regarding client treatment plans. Refer to V113 regarding client records.	V 109		

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Refer to V114 regarding emergency drills.

Refer to V117 regarding medication labeling.

Refer to V118 regarding medication administration.

Refer to V133 regarding criminal history checks.

Refer to V736 regarding facility maintenance.

Refer to V742 regarding client privacy

Review on 9/19/23 and 10/4/23 of the QP/DS's file revealed:
-Hire date was 6/27/16.
-Trainings- Person Centered Planning 4/19/18; Intellectual Disability Overview 4/11/18; Communication Essentials 1/26/17; Autism and COVID-19 7/23/20; Abuse 9/26/16; Guidelines for Effective Documentation 7/6/16.
-The QP's job description dated 6/8/16 responsibilities included:

"Major Responsibilities: Assist and support people with realizing their goals and attaining personal outcomes...with developing and/or maintaining a social support network...maintaining their health and well-being...with direction of their services and making informed choices...ensure that people have a safe environment in which to live and work free of abuse, neglect and exploitation...be an advocate for people with disabilities...participate and use knowledge gained through training programs...

Specific Duties and Responsibilities: Coordinate the supervision of all Support Specialist...Coordinate services for all individuals and their families...Access implementation of provider services...identify any necessary

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changes in policies or systems to ensure optimum services...Assist and provide input and guidance to the CEO (Chief Executive Officer) and the Operations Manager regarding the hiring, retention and termination of employees... Utilize knowledge and advanced training to perform your duties and responsibilities."

Interviews on 9/19/23, 9/20/23, 9/27/23, 10/04/23 and 10/5/23 the QP/DS stated:
- She was "acting" as the QP for the facility and was responsible for supervision of staff and overall operations of the facility.
- "When I figured out that he (client #4) was turning off the alarm and going out the window I had them let him sleep up front . . . he's becoming a liability, we've had a lot of bad publicity because of him . . . "
- Client #4 eloped on 7/27/23 and "was out of the house no longer than 20 minutes" and was found "one street over . .. If they don't tell me, I don't know. I didn't know [staff #1] was there like that (working alone). Something like that is beyond my control."
- Client #4 eloped from school twice in the spring of 2023.
- "We don't have anything to do with what goes on at school, they do their own incident reports."
- "You can't ask me in September about something that happened in July or March . . . I'm just not going to remember."
- "There have been times when I didn't have 2 staff . . . I would go myself or call someone in, but it might not be right away because third shift is a hard shift to get someone to cover . . . staff might have to be alone for about an hour. If staff can get there in 30 - 45 minutes, I'm not going. It takes me about 30 something minutes to get there. I'm not going to just pop up and put my shoes on and run out of the house, no I'm going

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V 109	Continued From page 7 to get myself together before I go . . . " - " . . . I tell them (facility staff) to do a level 1 if they (clients) succeed in getting out of the house, but I can't make them do it. I go over there and talk to the staff who were there at the time of the incident and get the information and try to figure out how and why he got out of the house . . . " - Clients #1 and #2 "don't have property destructive behaviors;" she did not know how the holes in client #1's bedroom walls happened. - The damage to the facility walls came from a former client who was discharged in "January or February" 2023. - "I don't go to that home as much . . . maybe once or twice a week, if that. I have managers at my houses that way I don't have to do it." - The bathroom door was reported last week, that's when he told me about it;" she did not know how or why the bathroom door was off the hinges. - On 10/04/23 she was "on shift with a client" who was "at work at the office" and she could not return to the facility for the survey; she did not know what time the client's work day ended and she didn't know the client's break time. During interview on 9/19/23 the Licensee stated the QP/DS had total responsibility for the facility.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.	V 112		

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V 112	Continued From page 8 (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews, observation and interviews the facility failed to develop and implement strategies affecting 2 of 4 current clients (#3 & #4). The findings are: Review on 9/19/23 of client #4's record revealed: - 20 year old male admitted 2/18/23. - Diagnoses included Autistic Disorder, and Intellectual/Developmental Disability, unspecified. - Admission assessment dated 2/01/23 included " . . . is known to elope or wander off . . . " - "Update to Individual Support Plan" completed by the LME/MCO Care Coordinator implementation date 2/18/23 included ". . .	V 112		

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Residential Supports Enhanced Rate . . . Level 4 is requested . . . "
- At his previous residential placement " . . . [client #4] has experienced 2 reported elopement episodes . . . [Client #4] was able to leave the home through a window which was equipped with an alarm. By the time the one staff on duty responded [client #4] had exited, and law enforcement was required. Staff could not pursue due to other members being in the household. One incident included entering a neighbor home during the night. Fortunately, the homeowner realized [client #4] did not present as a threat . . . "
- ISP "Start Date 6/1/2023" included ". . . His currently requires level 4 Residential Supports . . . Lacks safety awareness. Lacks judgment . . . At risks of victimization . . . "
- "Short Range Goals/Interventions" effective 6/01/23 included ". . . Refrain from elopement from house and while in community . . . Staff will make sure to monitor individual at all times. Individual should be monitored at least every 15min (minutes) to avoid him from leaving from staff . . . "
- No strategies/interventions to address enhanced staffing or client #4's continued disablement of window alarms.

Review on 9/19/23 of client #4's "Behavior Support & Intervention Plan" electronically signed by client #4's Guardian 3/21/23 and the Qualified Professional/Director of Services (QP/DS) 3/24/23 revealed:
- ". . . Behaviors addressed/supported in this Plan: Elopement, Property Destruction, Self-injurious behavipr . . . "
- ". . . Given that [client #4] has eloped through his bedroom window during unstructured time, keep him engaged during waking hours. Note

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that he typically wakes at 5:00 am and should be engaged at that time."
- " . . . When Elopement Occurs 1. Follow [client #4] and encourage him to return to his residence. 2. If he is not within sight, immediately call the police for assistance . . . Restrictions Window chimes/alarm on bedroom window, front door, and rear door."

Observations on 9/19/23 at approximately 11:32 am and on 10/04/23 at approximately 12:26 pm revealed no alarm on the front door of the facilty.

Review on 9/19/23 and 10/04/23 of the North Carolina Incident Response Improvement System (IRIS) for 3/03/23 - 10/05/23 revealed:
- Level II incident reports dated 3/13/23, 8/08/23, and 8/28/23 regarding client #4.
- 3/13/23: client #4 eloped through his bedroom window and broke into a neighbor's home and was trying to watch television 3/06/23, time of incident 1:30 am.; duration of absence not documented; local law enforcement was involved.
- 8/08/23: client #4 "disarmed the alarm on the window in his bedroom and quietly eloped out the window" on 8/03/23, time of incident "unknown;" duration of absence not documented; local law enforcement was involved.
- 8/29/23: client #4 ". . . disarmed the alarm on the window and left out . . ." on 8/19/23, time of incident "unknown;" duration of absence not documented.

Review on 10/02/23 of an email from client #4's Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator revealed:
- She was notified of incidents by the Qualified Professional/Director of Services (QP/DS) as follows:

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V 112	Continued From page 11 8/25/23 "eloped" 8/03/23 "eloped" 6/15/23 "elopement attempt" 6/13/23 "elopement attempt" 6/07/23 "elopement attempt" 5/18/23 "elopement attempt" 3/07/23 "eloped" 2/18/23 "moved to Shinelight" (Licensee) Review on 9/19/23 of "General Event Reports" (internal level I incident reports) completed by the facility 3/03/23 - 9/19/23 regarding client #4 revealed: - 7/27/23 completed by staff #1: client #4 ". . . woke up around 430am and walked out the back door or the house. - He was gone for about 20 - 30 minutes. He was then found 3 blocks away with the assistance of local police." Staff # 4 was listed as a witness to the incident. The report was reviewed by the QP/DS 8/24/23. - 8/03/23 4:15 am completed by staff #3: ". . . Sent back to room after getting water. Proceeded to room without incident. He did however turn off the alarm, remove the sensor off the wall, and then opened the window and exited the building. The police came by with [client #4] and found him at the [local convenience store]. He also closed the window behind him so his intent was clear. The window lock was also bypassed by [client #4] (the little plastic piece you have to push in to open the window) . . . [client #4] interloping from his bedroom was not discovered until after he was brought back to the house by law enforcement . . . Corrective Actions Taken: Not allowed in room for rest of the morning and is being kept under a tight watch. Plan of future Corrective Actions: I recommend alarm systems that are nailed or screwed into the fram of the window or even the permanent	V 112		

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sealing of the window to prevent incident." The QP/DS was notified of the incident by telephone 8/03/23 at 4:20 am. The duration of client #4's absence was not documented.
- 8/25/23 12:00 am completed by staff #1: ". . . After going to check on him about 15 min (minutes) later, staff noticed that [client #4] had left the house out his window. He had disarmed the alarm . . . Corrective Actions Taken: [client #4] is remaining out in the living room to be in staff eyesight at all times to include when he is sleeping . . . ;" the duration of client #4's absence was not documented; the report was approved by QP/DS 8/31/23 2:31 pm.

Review on 9/20/23 of a shift communication note ("T-Log") dated 8/06/23 revealed staff #4 reported ". . . This morning around 3am resident attempted to run away . . . Going out of the window in his bedroom . . . " Incident was "Reported on 08/06/23 12:00 am."

Review on 9/19/23 and 9/20/23 of client #3's record revealed:
- 27 year old male admitted 3/09/06.
- Diagnoses included Autism, Intellectual/Developmental Disability, moderate; Attention Deficit Hyperactivity Disorder, Seizure Disorder, and citrullinemia.
- Individual Support Plan (ISP) completed by client #3's Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator, implemented 1/01/23 included "Long-Range Goal 3: [client #3] receives assistance with personal care and independent living skills . . . Where am I now: . . . [client #3] is getting better with completing some activities such as showering . . . Hand over hand is needed to assure the task is completed as [client #3] will not wash himself if left to complete himself . . . has a toileting

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schedule every hour . . . "
- "Short Range Goals/Interventions" effective 1/01/22 included ". . . Short Range Goal . . . complete personal hygiene 2 times a day . . . target date 12/31/23 . . . Intervention: . . . Individual will gather all items needed before entering the bathroom. Individual, with assistance from staff will wash each body part thoroughly, to include washing his hair. After shower individual will dry off with his towel . . . Staff will provide assistance as needed."
- No evidence an hourly toileting schedule was developed.

Review on 9/27/23 of a photograph taken 9/22/23 provided by Anonymous Staff #2 (AS #2) showed feet identified as client #3's feet, with heavy black coloring from an unknown cause that covered the natural color of his skin.

During interview on 9/27/23 AS#2 stated:
- Some staff were not assisting the clients with personal hygiene tasks.
- The photograph of client #3's feet was taken when he was in bed asleep.

During interview on 9/22/23 staff #1 stated:
- He had worked at the facility since April 2023 and only worked 3rd (overnight) shift.
- Client #4 "goes out his bedroom window, sometimes he sneaks out the back door."
- Client #4 eloped twice while he was working.
- In August he was working alone and client #4 eloped out his bedroom window.
- He waited for another staff to "come in at midnight" and then went out in his car to look for client #4.
- He saw the local Police in the neighborhood and followed them.
- Client #4 was found "a couple of blocks away" in

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a driveway.
- He transported client #4 back to the facility.
- He did not call the police, "the homeowner called."
- He did a "level 3 incident report because the police were involved" and he sent the level 3 report to the QP/DS.
- He could not remember the date of the other elopement incident.
- He was working with another staff member, but "I'm not entirely sure" who the second staff was.
- He was administering medications, and the second staff was cooking breakfast.
- He thought client #4 went into the bathroom but he snuck out the back door.

During interview on 9/22/23 staff #1 stated one of his duties was to assist clients with "hygiene tasks."

During interview on 9/22/23 staff #4 stated:
- On 8/06/23 client #4 "tried to go out his bedroom window, but I got him on his way out."
- He thought staff #1 did a level I incident report.
- Client #4 was able to ". . . go out the window and I found him at the next corner" but he could not recall the date of the incident.
- The facility's staffing pattern of 2 staff per shift "started a few months ago but I can't remember the specific date."
- He "heard about" client #4's elopement on 3/06/23 but he was not working and did not know who was working or any details about the incident.

During interview on 9/28/23 client #4's LME/MCO Care Coordinator stated:
- The LME/MCO provided an "enhanced rate for extra staff" due to client #4's eloping behaviors.
- Enhanced staffing was a condition required for

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client #4's admission to the facility due to his history of eloping and breaking into a neighbor's house.
- The Licensee was being reimbursed at the enhanced rate.
- She was aware "that there were times" when there were less than 2 staff present at the facility.
- Client #4's team met recently and discussed the installation of window alarms and motion sensors; the LME/MCO would "pay for" the items; potential vendors were identified and the vendor information was provided to the QP/DS.

During interviews on 9/19/23 and 10/04/23 the QP/DS stated:
- She knew of client #4's elopement history prior to his admission to the facility.
- Two staff worked each shift; "There have been times when I didn't have 2 staff . . . "
- She did not have copies of staff work schedules to support the 2 staff per shift staffing pattern.
- She did not post a work schedule for facility staff. "I just started sending individual work schedules to staff . . . I do the schedule, I give it to them and I leave it because it's not my responsibility to keep up when someone goes to work; if they can't go to work they'll call in . . . I don't keep the schedules, once the month is gone, they're gone."
- If a staff was late to report for work or failed to report for work one staff would be left to work alone until coverage could be secured; she couldn't "make staff report to work" as scheduled.
- Client #4's team met recently to discuss ways to manage his elopement behaviors.

Review on 10/5/23 of the Plan of Protection dated 10/5/23 and signed by the QP/DS revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care:

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New camera system is being installed. Air tags have been purchased. Requested for an extra staff that will be directly on him. In process of setting up meeting to meet with community along with his mother to explain about individual.
- Describe you plans to make sure the above happens. Everything is already set in stone waiting to hear back from community what day is best."

The facility served clients aged 20 - 32 with diagnoses of Autism, Intellectual/Developmental Disability, ADHD, Tourette's Syndrome, Smith-Magenis Syndrome, and Citrullinemia, with documented life skills deficits and behaviors such as elopement and property destruction. Client #3 required a toileting schedule but there was no documentation of a toileting schedule. Bed checks every 15 minutes were not completed as required and shift notes were not always completed. Client #4 had a history of elopement and breaking into a neighbor's house at his previous residential placement. Client #4's placement at the facility required enhanced staffing of 2 staff per shift due to his elopements and the associated safety risks; however, the DS/QP had no staff schedules and there was no documentation from the facility to support the LME/MCO staffing requirement was met. Client #4 had 5 documented elopements between 3/06/23 and 9/19/23 with 2 of those involving local law enforcement and 1 documented elopement attempt. During the elopement episode on 3/06/23 client #4 left the facility at 1:30 am and broke into a neighbor's home; on 8/03/23 client #4 eloped at 4:15 am and was found by local law enforcement at a convenience store across a busy street a few blocks away from the facility. He also eloped 7/27/23 at 4:30 am and was found 20 - 30 minutes later and returned by local police. He

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V 112	Continued From page 17 eloped at midnight on 8/25/23, but the duration of his absence was not documented in the incident report. With the exception of the 7/27/23 elopement there was only 1 staff on duty at the time of these elopements. Enhanced staffing was recommended for client #4 by the LME/MCO. This deficiency constitutes a Type A1 violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 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 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;	V 113		

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V 113	Continued From page 18 (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on records review and interview, the facility failed to ensure records were complete for 4 of 4 current clients (#1, #2, #3 and #4). The findings are: Review on 9/19/23 of client #1's record revealed: - 32 year old male admitted 8/2006. - Diagnoses included Autism, Smith-Magenis, Severe Intellectual Disability Disorder. - No documentation of progress towards goals. Review on 9/19/23 of client #2's record revealed: - 32 year old male admitted 7/2006 - Diagnosis included Autism, Mild Intellectual Developmental Disability and Tourette Syndrome	V 113		

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- No documentation of progress towards goals.

Review on 9/19/23 of client #3's record revealed:
- 27 year old male admitted 3/09/06.
- Diagnoses included Autism, Intellectual/Developmental Disability, moderate; Attention Deficit Hyperactivity Disorder, Seizure Disorder, and Citrullinemia.
- No documentation of progress towards goals.

Review on 10/04/23 of client #3's "ABC (Antecedent, Behavior, Consequence) Data" log revealed a single page of behavior data dated 10/01/23.

Review on 9/19/23 of client #4's record revealed:
- 20 year old male admitted 2/18/23.
- Diagnoses included Autistic Disorder, and Intellectual/Developmental Disability, unspecified.
- "Short Range Goals/Interventions" effective 6/01/23 included ". . . Refrain from elopement from house and while in community . . . Staff will make sure to monitor individual at all times. Individual should be monitored at least every 15min (minutes) to avoid him from leaving from staff . . . "
- No documentation of client #4's 15 minute checks.
- No documentation of progress towards goals.
- No documentation of team meeting discussions of client #4's safety needs.

Review on 10/04/23 of client #4's "ABC Data" log revealed a single undated page of behavior data.

During interview on 10/04/23 the Qualified Professional/Director of Services (QP/DS) stated:
- Staff documented clients #3 and #4's behaviors on the ABC Data sheets daily; the data sheets included behaviors such as "one of them banging

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their head, something like small or a really targeted behavior, I'll say that."
- She collected the data sheets weekly; the completed data sheets were provided to the person "who writes the behavior plans" monthly.
- The data sheets from previous weeks were "all over" her office. She was not going to return to her office that day.

During Interviews on 9/20/23, 10/04/23 and 10/05/23 the (QP/DS) stated:
- Facility staff were supposed to complete "T-logs" which were similar to shift communication notes in Therap; staff did not consistently complete "T-logs."
- "I can't make nobody do nothing, they know the expectations;" most staff communication was "word of mouth."
- "I don't go to that home as much . . . maybe once or twice a week, if that. I have managers at my houses that way I don't have to do it."
- She removed the manager from the facility work schedule "because of issues as far as his duties and things like that."
- Client #4's 15 minute checks were not documented by staff; "We used to document them in Therap (electronic record platform), but we don't do that anymore . . . since [client #4] has been here we check him every 15 minutes but don't document it."
- Client #4's team met recently to discuss ways to manage his elopement behaviors and " . . . how to keep him safe . . . "

No additional behavior data was provided for review before the completion of the survey process.

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V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings: Review on 9/19/23 of facility fire and disaster drill records from 9/1/22- 8/31/23 revealed: Fire Drills: - 1st quarter (September 2022 - November 2022): No documented fire drills. - 2nd quarter (December 2022 - February 2023): No documented fire drills for 3rd shift. - 3rd quarter (March 2023 - May 2023): No documented fire drills for 1st shift. - 4th quarter (June 2023 - August 2023) 2023: No documented fire drills for 3rd shift. Disaster Drills:	V 114		

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V 114	Continued From page 22 - 1st quarter (September 2022 - November 2022): No documented disaster drills. - 2nd quarter (December 2022 - February 2023): No documented disaster drills for 3rd shift. - 3rd quarter (March 2023 - May 2023): No documented disaster drills for 1st shift. - 4th quarter (June 2023 - August 2023) 2023: No documented disaster drills for 3rd shift. Due to client #1's limited communication skills he was not able to participate in an interview. During interview on 9/20/23 client #2 stated: - He went outside for fire drills. - When asked about disaster drills he stated "I'm going to [department store] tomorrow." Client #2's interview was limited due to his repeating of information. Interview on 9/20/23 staff #2 stated she had seen drills documented, but had not participated in a drill and had not worked during a drill. Interview on 9/19/23 and 9/20/23 the Qualified Professional/Director of Services stated: - Shifts at the facility were: 8:00am-4:00pm, 4:00pm-8:00pm and 8:00pm-8:00am. - Three different disaster drills were completed monthly and fire drills are completed monthly. - Completed 2022 fire and disaster drill were at another facility. She would provide them for the surveyor to review. - She was unable to get the 2022 drills as requested.	V 114		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 117		

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REQUIREMENTS
(b) Medication packaging and labeling:
(1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible;
(2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate;
(3) The packaging label of each prescription drug dispensed must include the following:
(A) the client's name;
(B) the prescriber's name;
(C) the current dispensing date;
(D) clear directions for self-administration;
(E) the name, strength, quantity, and expiration date of the prescribed drug; and
(F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.

This Rule is not met as evidenced by:
Based on record review, observation and interview the facility failed to ensure medications for administration were labeled as required for 1 of 4 current clients (#3). The findings are:

Review on 9/19/23 of client #3's record revealed:

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V 117	Continued From page 24 - 27 year old male admitted 3/09/06. - Diagnoses included Autism, Intellectual/Developmental Disability, moderate; Attention Deficit Hyperactivity Disorder, Seizure Disorder, and Citrullinemia. - Physician's order signed 8/14/23 for oxcarbazepine (seizure disorder) 300 milligrams (mg)/5 milliliters (ml), take 19 ml twice daily. Observation on 9/19/23 at 11:30 am of client #3's medications revealed a bottle of liquid oxcarbazepine with the manufacturer's label but no pharmacy label with the client's name; the prescriber's name; the current dispensing date; the name, strength, quantity, and expiration date of the prescribed drug; the name, address, and phone number of the pharmacy; and the name of the dispensing practitioner. During interview on 9/19/23 the Licensee stated she could not answer questions about the clients' medications because she did not work in the facilty. During interview on 9/20/23 the Qualified Professional/Director of Services stated: - "I pick medications up from the pharmacy now to make sure everything that's supposed to be there is there." - She did not know where the pharmacy label for client #3's oxcarbazepine was. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 117		
V 118	27G .0209 (C) Medication Requirements	V 118		

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10A NCAC 27G .0209 MEDICATION REQUIREMENTS
(c) Medication administration:
(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.
(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.
(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.
(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:
(A) client's name;
(B) name, strength, and quantity of the drug;
(C) instructions for administering the drug;
(D) date and time the drug is administered; and
(E) name or initials of person administering the drug.
(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.

This Rule is not met as evidenced by:
Based on record reviews, observations and interviews the facility failed to (1) ensure

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V 118	Continued From page 26 medications were administered as ordered by a Physician, (2) ensure medications administered were recorded on the MARs immediately after administration for 4 of 4 current clients (#1, #2, #3, and #4). The findings are: Cross Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (Tag V117). Based on record review, observation and interview the facilty failed to ensure medications for administration were labeled as required for 1 of 4 current clients. Review on 9/19/23 of client #1's record revealed: - 32 year old male admitted 8/2006. - Diagnoses included Autism, Smith-Magenis, and Severe Intellectual Disability Disorder. Review on 9/19/23 of a signed FL2 and signed medication orders for client #1 revealed: - 4/23/23: Adderall XR (extended release) (stimulant) 30mg, 1 every morning - 4/24/23: Sertraline (mood) 100mg, 1 daily - 4/24/23: Sertraline 50mg, 1 daily with 100mg Zoloft - 12/14/22: Quetiapine Fumarate 50mg, (antipsychotic) 2 every morning, 2 at evening and 2 at bedtime. Review on 9/19/23 of client #1's MARs for July 2023-September 2023 revealed: - Adderall XR 30 milligrams (mg); no staff documented administration 9/1/23 at 7:00 am with no documented explanation for the blank. - Quetiapine ER 50mg; no staff documented administration 9/1/23, 9/16/23-9/18/23 at 7:00 am with no documented explanation for the blanks. - Sertraline 100mg; no staff documented administration 9/1/23 at 7:00 am with no documented explanation for the blank.	V 118		

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V 118	Continued From page 27 - Sertraline HCL 50mg; no staff documented administration 9/1/23 at 7:00 am with no documented explanation for the blanks. - Quetiapine ER 50mg; no staff documented administration 9/1/23, 9/4/23-9/7/23, 9/10/23-9/18/23 at 1:00 pm with no documented explanation for the blanks. Review on 9/19/23 of client #2's record revealed: - 32 year old male admitted 7/2006 - Diagnoses included Autism, Mild Intellectual Developmental Disability and Tourette Syndrome Review on 9/19/23 of signed medication orders for client #2 revealed: - 4/21/23: Amantadine 100mg, (anti viral) 1 twice daily. - 7/26/23: Aripiprazole 5mg, (antipsychotic) 1 every day- then in 7 days-1 twice daily. - 5/8/23: Simply Saline nasal Mist, (congestion) 1 puff each nostril daily. - 5/25/23: Topiramate 100mg, (tourettse syndrome) 1 at bedtime. - 4/13/23: Loratadine 10mg, (allergy) 1 daily. - No physician orders to administer or discontinue Mupirocin 2% Ointment (skin infections) apply twice daily and triple antibiotic ointment- 8:00 am, apply daily. Review on 9/19/23 of client #2's MARs for July 2023-September 2023 revealed: - Amantadine 100mg; no staff documented administration 7:00 am 9/1/23, 9/18/23; 7:00 am: 9/17/23, 9/18/23, with no documented explanation for the blanks. - Aripiprazole 5mg; no staff documented administration 7:00 am 9/1/23- 9/7/23, 9/18/23; 7:00 pm 9/1/23-9/6/23; 9/17/23-9/18/23, with no documented explanation for the blanks. - Simply Saline nasal Mist spray; no staff	V 118		

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documented administration 9/1/23-9/19/23 7:00 am, with no documented explanation for the blanks.
- Topiramate 100mg; no staff documented administration 9/17/23-9/18/23 at 7:00 pm, with no documented explanation for the blanks.
- Mupirocin; no staff documented administration 9/1/23- 9/18/23, no designated time, with no documented explanation for the blanks.
- Loratadine 10mg; no staff documented administration 9/1/23, 9/18/23 7:00 am, with no documented explanation for the blanks.
- Triple Antibiotic Ointment; no documented administration 9/1/23-9/19/23 8:00 am, with no documented explanation for the blanks.

Review on 9/19/23 of signed medication orders for client #3 revealed:
- 4/01/23: Daily Vite (multivitamin) take 1 tablet daily.
- 4/14/23: levocarnitine (citrullinemia) 1 milligram (mg)/10 milliliters (ml) take 5 ml twice daily; Calcium 600 (supplement) take 1 tablet daily.
- 4/17/23: lurasidone (anti-psychotic) 20 mg take 1 tablet at 1:00 pm and 7:00 pm and 1 and 1/2 tablet (30 mg) at 4:00 pm; lurasidone 80 mg take 1 tablet every morning; mirtazipine (antidepressant) 15 mg take 1 tablet at bedtime; hydroxyzine (antihistamine) 25 mg take 1 tablet three times daily (7:00 am, 4:00 pm, and 7:00 pm).
- 8/14/23 oxcarbazepine (anti-convulsant) 300 mg/5 ml take 19 ml twice daily.
- No order for oxcarbazepine 300mg/5ml take 19 ml twice daily signed or dated prior to 8/14/23.
- 8/22/23 arginine (citrullinemia) 100 mg/ml take 60 ml twice daily.
- No order for arginine 100 mg/ml take 60 ml twice daily signed or dated prior to 8/22/23.
- No signed/dated orders for: hydroxyzine 50 mg

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three times daily; sodium benzoate 10% (hyperammonemia) take 70 ml twice daily.

Review on 9/19/23 of client #3's MARs for July 2023 - September 2023 revealed:
- Daily Vite take 1 tablet daily (7:00 am).
- No staff documentation of administration of Daily Vite 9/18/23 with no documented explanation for the blanks.
- Hydroxyzine: July and August MARs "25 mg 1 tablet by mouth at 7am and one by mouth at 4 pm and one by mouth 7pm;" September MAR "50 mg (handwritten) one by mouth 7am and 1 by mouth at 4 pm and 1 by mouth at 7pm;" staff documentation of administration 9/02/23 - 9/17/23 at 7:00 am; and 9/01/23 - 9/07/23 and 9/09/23 - 9/17/23 at 4:00 pm and 7:00 pm.
- No staff documentation of administration of hydroxyzine 50 mg by mouth (7:00 am, 4:00 pm and 7:00 pm) on 9/01/23 7:00 am; 9/08/23 4:00 pm and 7:00 pm; 9/14/23 4:00 pm; and 9/18/23 7:00 am, with no documented explanation for the blanks.
- Levocarnitine 1 mg/ml take 5 ml twice daily (7:00 am and 7:00 pm); transcription on July MAR, with the daily administration blocks lined through with no staff documentation of administration for the month of July.
- No staff documentation of administration of levocarnitine 1 mg/ml take 5 ml twice daily 8/16/23 7:00 pm; 9/01/23 7:00 am; 9/17/23 7:00 pm; 9/18/23 7:00 am and 7:00 pm, with no documented explanation for the blanks.
- Lurasidone 20 mg "take 1 tablet by mouth 1pm and one and a half tablet by mouth at 4pm and one tablet by mouth 7pm."
- No staff documentation of administration of lurasidone 20 mg 1 tablet at 1:00 pm and 7:00 pm and 1 and 1/2 tablet at 4:00 pm on 9/18/23 1:00 pm, 4:00 pm, and 7:00 pm with no

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V 118	Continued From page 30 documented explanation for the blanks; the September MAR included "D = Day Program" handwritten above the daily administration blocks with "D" documented for the 1:00 pm dose 9/01/23, 9/04/23 - 9/08/23, and 9/11/23 - 9/15/23. - Lurasidone 80 mg "take one by mouth every morning" (7:00 am). - No staff documentation of administration of lurasidone 80 mg 1 tablet every morning 7/26/23, 9/01/23 9/13/23, 9/14/23, 9/18/23, with no documented explanation for the blanks. - Mirtazipine 15mg 1 tablet at bedtime (7:00 pm) with no staff documentation of administration 9/18/23 and no documented explanation for the blank. - Oxcarbazepine 300 mg/5 ml take 19 ml twice daily (7:00 am and 7:00 pm); transcription on the July 2023 MAR with the daily administration blocks lined through with no staff documentation of administration for the month of July; staff documented administration of the medication twice daily 8/01/23 - 8/13/23. - No staff documentation of administration of oxcarbazepine 300 mg/5ml take 19 ml twice daily 9/01/23 (7:00 am); 9/18/23 7:00 am and 7:00 pm, with no documented explanation for the blanks. - Calcium 600 take 1 tablet daily (7:00 am), no staff documentation of administration 9/01/23 and no documented explanation for the blank. - Arginine 100 mg/ml take 60 ml twice daily (7:00 am and 7:00 pm). - No staff documentation of administration of arginine 100 mg/ml take 60 ml twice daily 9/01/23 7:00 am; 9/15/23 7:00 pm; 9/18/23 7:00 pm, with no documented explanation for the blanks. - Sodium benzoate 10% take 70 ml twice daily (7:00 am and 7:00 pm). - No staff documentation of administration of sodium benzoate 10% take 70 ml twice daily 9/01/23 7:00 am; 9/14/23 7:00 am; 9/15/23 7:00	V 118		

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pm; 9/17/23 7:00 am; and 9/18/23 7:00 pm, with no documented explanation for the blanks.

Observation on 9/19/23 at 11:30 am of client #3's medications revealed:
- Daily Vite 1 tablet daily, dispensed 8/30/23.
- Hydroxyzine 50 mg 1 tablet at 7:00 am, 1 at 4:00 pm and 1 at 7:00 pm, dispensed 8/30/23.
- Levocarnitine 1 mg/ml take 5 ml twice daily, dispensed 9/09/23.
- Lurasidone 20 mg 1 tablet at 1:00 pm, 1/2 tablet at 4:00 pm, and 1 tablet at 7:00 pm, dispensed 11/16/22.
- Lurasidone 80 mg "take 1 every morning," dispensed 5/23/23.
- Mirtazapine 15 mg 1 tablet at bedtime, dispensed 8/08/23.
- Oxcarbazepine 300 mg/5 ml no pharmacy label.
- Calcium 600 1 tablet daily, dispensed 8/30/23.
- Arginine 100 mg/ml 60 ml twice daily, dispensed 8/22/23.
- Sodium Benzoate 10% 70 ml twice daily, dispensed 9/14/23.

Review on 9/19/23 of client #4's record revealed:
- 20 year old male admitted 2/18/23.
- Diagnoses included Autistic Disorder, and Intellectual/Developmental Disability, unspecified.
- Medication orders signed by the physician and dated as follows:
  - 4/10/23 trazodone (sedative) 150 mg 1 tablet at bedtime.
  - 4/13/23 oxcarbazepine 150 mg 3 tablets twice daily.
  - 4/17/23 hydroxyzine 25 mg 1 tablet at bedtime; lorazepam (sedative) 1 mg 2 tablets at bedtime.
  - 4/25/23 citalopram (antidepressant) 40 mg 1 tablet daily.
  - 5/02/23 guanfacine (high blood pressure) 2 mg 1 tablet at 2:00 pm and 4:00 pm daily.

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V 118	Continued From page 32 - 7/11/23 vitamin C (antioxidant) 500 mg 1 tablet daily for 90 days. - 9/26/23 Probiotic formula (digestive health) 1 capsule daily; no order signed or dated prior to 9/26/23. - No signed /dated physician's orders for aripiprazole (anti-psychotic) 10 mg 1 tablet daily; hydroxyzine 25 mg 1 capsule at bedtime as needed; oxcarbazepine 150 mg 1 tablet twice daily. Review on 9/19/23 of client #4's MARs for July 2023 - September 2023 revealed: - Aripiprazole 10 mg daily (7:00 am); documented as administered daily 9/02/23 - 9/14/23, 9/18/23; 8/01/23 - 8/31/23; 7/01/23 - 7/31/23. - No staff documentation of administration of aripiprazole 10 mg daily 9/15/23 - 9/18/23, with no documented explanation for the blanks. - Citalopram 40 mg 1 tablet daily (7:00 am), no staff documentation of administration 9/01/23, 9/15/23 - 9/18/23 with no documented explanation for the blanks. - Guanfacine 2 mg: July 2023 MAR "take 1 tablet by mouth at 2 pm and at 4 pm daily;" August 2023 MAR "take one tab (tablet) at 2pm and 4 pm daily" with the administration times handwritten as 4:00 pm and 7:00 pm over white out correction fluid; September 2023 MAR "take one tablet at 2pm and 4pm (lined out) 7pm daily". - No staff documentation of administration of guanfacine 2 mg twice daily 9/08/23 7:00 pm; 9/15/23 - 9/18/23 2:00 pm and 7:00 pm, with no documented explanation for the blanks. - Hydroxyzine 25 mg 1 tablet at bedtime (7:00 pm); not included on July 2023 MAR. - No staff documentation of administration of hydroxyzine 25 mg at bedtime 9/15/23 - 9/18/23, with no documented explanation for the blanks. - Hydroxyzine 25 mg at bedtime as needed; staff	V 118		

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documentation of administration daily 9/01/23 - 9/14/23; staff documentation of administration daily 7/01/23 - 7/31/23.
- Lorazepam 1 mg 2 tablets at bedtime (7:00 pm) with no staff documentation of administration 9/15/23 - 9/18/23 and no documented explanation for the blanks.
- Oxcarbazepine 150 mg "take one tablet by mouth twice daily" (7:00 am and 7:00 pm).
- No staff documentation of administration of oxcarbazepine 150 mg 1 tablet twice daily 9/01/23 7:00 am; 9/15/23 - 9/18/23 7:00 am and 7:00 pm, with no documented explanation for the blanks.
- No transcriptions for oxcarbazepine 150 mg 3 tablets by mouth twice daily as ordered 4/13/23.
- Probiotic formula 1 capsule daily (7:00 pm) with no staff documentation of administration 9/15/23 - 9/18/23 and no documented explanation for the blanks.
- Staff documentation of administration of probiotic formula 1 capsule daily 7/01/23 - 8/31/23.
- Trazodone 150 mg 1 tablet at bedtime (7:00 pm) with no staff documentation of administration 9/15/23 - 9/18/23 and no documented explanation for the blanks.
- Vitamin C 500 mg 1 tablet daily for 90 days (7:00 am) with no staff documentation of administration 9/15/23 - 9/18/23 and no documented explanation for the blanks.

Observation on 9/19/23 at 11:00 am of client #4's medications revealed:
- Aripiprazole 10 mg 1 tablet daily, dispensed 8/23/23.
- Citalopram 40 mg 1 tablet daily, dispensed 8/23/23.
- Guanfacine 2 mg 1 tablet by mouth at 2:00 pm and 1 tablet by mouth at 4:00 pm, dispensed

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9/16/23.
- Hydroxyzine 25 mg 1 tablet at bedtime, dispensed 8/23/23.
- Hydroxyzine 25 mg 1 capsule at bedtime as needed, dispensed 8/16/23.
- Lorazepam 1 mg 2 tablets at bedtime dispensed 9/05/23.
- Oxcarbazepine 150 mg 3 tablets by mouth two times daily, dispensed 8/23/23.
- Probiotic formula 1 capsule daily, dispensed 8/23/23.
- Trazodone 150 mg 1 tablet at bedtime, dispensed 8/23/23.
- Vitamin C 500 mg 1 tablet daily for 90 days, dispensed 8/14/23.

During interviews on 9/22/23 and 10/04/23 staff #1 stated:
- He was trained in medication administration.
- Medications were always available.
- If a client refused a medication he could usually get the client to take it.

During interview on 9/20/23 staff #2 stated:
- She was trained in medication administration and had administered medications once.
- Medications were always available.
- If there was a blank on the MAR it "means someone has not signed it and that is an error and I should call my supervisor [the QP/DS] and [the Licensee]. I'm calling everybody."
- The QP/DS "picked up" the medications and "there is usually about a week of overflow available."

During interview on 9/20/23 staff #4 stated:
- He was trained in medication administration.
- He administered morning medications and the medications were always available.

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V 118	Continued From page 35 During interview on 9/19/23 the Licensee stated she could not answer questions about the clients' medications because she did not work in the facility. During interviews on 9/20/23 and 9/27/23 the Qualified Professional/Director of Services (QP/DS) stated: - She did not go to the facility "as much" as she did a sister facility; "maybe once or twice a week if that." - "I have managers at my houses;" she "took the manager off the the schedule" at the facility due to job performance issues. - The "management team" was responsible for monitoring the MARs for accuracy and completion. - Since there was no manager at the facility she was responsible for making sure the MARs accurately reflected the Physician's orders and for ensuring accurate documentation of medication administration. - "I pick medications up from the pharmacy now to make sure everything that's supposed to be there is there." - The "clients don't refuse meds (medications) that I've been told" and she "did not have any issues" when she administered medications at the facility. - Client #3 took medications at the day program; "1:00 pm is the only thing that should be blank." - The same MAR used at the facility was taken to the day program and the 1:00 pm medications were documented when administered at the day program. - "I can't make nobody do nothing; they know the expectations." - She provided the doctors' orders that were available for review. - Client #2's mupirocin and triple antibiotic	V 118		

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ointment were discontinued.

Review on 10/05/23 of the Plan of Protection dated 10/05/23 written by the QP/DS revealed:
- "What immediate action will the facility take to ensure the safety of the consumers in your care? Staff meeting will be conducted next week to meet with staff per medication requirements. This will be a refresher for each staff to ensure competency. Date will be set by [Licensee].
- Describe your plans to make sure the above happens: Lead staff will be responsible for checking MARS on a daily basis to ensure all signatures are present House Manager will be responsible for monitoring lead staff."

Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the Physician.

The facility served clients aged 20 - 32 with diagnoses of Autism, Intellectual/Developmental Disability, ADHD, Tourette's Syndrome, Smith-Magenis Syndrome, and citrullinemia. Medications prescribed for the clients included anti-psychotics, anti-depressants, anti-convulsants, antihistamines and other medications for medical conditions. From July 1 - September 19, 2023, there were 172 instances of no documentation of administration of prescribed medications for the four clients served. The MARs also included transcriptions for 2 medications that did not accurately reflect current physician's orders. One bottle of an anti-convulsant had no pharmacy label. The facility also failed to maintain copies of current medication orders. This deficiency constitutes a type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative

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V 118	Continued From page 37 penalty of $2000.00 is imposed. If the violation is not corrected within 23 days and 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 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	V 132		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE LAKES	**5104 FLATROCK DRIVE FAYETTEVILLE, NC 28311**

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V 132	Continued From page 38 Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel and failed to complete the 5-Working Day Report, investigate and protect clients after allegations of abuse. The findings are: Review on 9/19/23 and 10/5/23 of the Incident Response Improvement System (IRIS) revealed no level III incident reports for the facility 3/02/23 - 10/05/23. Review on 9/19/23 of a Division of Health Service Regulation statement of deficiencies dated 3/02/23 revealed: - Incidents of serious abuse and neglect were reported to the Qualified Professional/Director of Services (QP/DS) on 12/07/22 and 12/09/22 with no incident reports completed and no documentation of HCPR notification. Review on 9/20/23 of documentation provided by	V 132		

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V 132	Continued From page 39 the QP/DS revealed: - An e-mail from the HCPR dated 4/18/23 revealed HCPR's acknowledged receipt of an "Initial Allegation Report" regarding client #1 via fax on 4/11/23. - An undated handwritten "Health Care Personnel Registry 5-Working Day Report" completed by the QP/DS. The allegation of abuse of client #1 by a former staff was not substantiated by the facility. - No documentation of receipt of the 5-Day Working Report by the HCPR. - No documentation of HCPR notification of allegation of abuse of former client #5. Interview on 9/19/23 and 10/4/23 the QP/DS stated: - She is responsible for completing IRIS reports. - The facility did report to the HCPR after the 3/2/23 survey. - She received a letter from HCPR about the accused staff. - "I did not know it was a level III, it's the first time it had happened." - She didn't know when the alleged abuse of clients took place. This deficiency constitutes a re-cited deficiency and must be corrected within 23 days. This deficiency is cross referenced into 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (V512) for a Failure to Correct Type A1 rule violation.	V 132		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT.	V 133		

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V 133	Continued From page 40 (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five	V 133		

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V 133	Continued From page 41	V 133		

business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.
(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:
(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the

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V 133	Continued From page 42 commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in	V 133		

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V 133	Continued From page 43 any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section	V 133		

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V 133	Continued From page 44 shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct a criminal history record check as required for 1 of 8 audited staff (#5). The findings are: Review on 10/04/23 of the Division of Health Service Regulation (DHSR) Client and Staff Census completed 9/19/23 by the Licensee and Qualified Professional/Director of Services (QP/DS) revealed staff #5 was listed as a Direct Support Professional. Review on 10/04/23 of staff #5's personnel record revealed: - No documented hire date; undated application for employment; signed "Employment Agreement"	V 133		

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V 133	Continued From page 45 dated 9/06/23. - No documented evidence of a request for a criminal history check. Interview on 9/27/23 staff #5 stated she had worked at the facility for about 4 weeks. Interview on 9/27/23 the QP/DS stated "here's the records, what's in here is what we have. I do my job."	V 133		
V 366	27G .0603 Incident Response Requirments 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	V 366		

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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 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

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(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 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 record reviews and interviews, the facility failed to document their response to level III incidents. The findings are:

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V 366	Continued From page 48	V 366		

Review on 9/19/23 of a Division of Health Service Regulation statement of deficiencies dated 3/02/23 revealed:
- Incidents of serious abuse and neglect were reported to the Qualified Professional/Director of Services (QP/DS) on 12/07/22 and 12/09/22 with no incident reports completed.

Review on 9/19/23 and 10/4/23 of the North Carolina Incident Response Improvement System (IRIS) website revealed no Level III incident reports were submitted to the LME/MCO from 3/02/23 thru 10/04/23.

Review on 9/19/23 - 10/5/23 of the facility records from 3/02/23 - 10/05/23 revealed no level III incident reports were completed by the facility.

Review on 9/20/23 of documentation provided by the QP/DS revealed:
- An e-mail from the Health Care Personnel Registry (HCPR) dated 4/18/23 revealed HCPR's acknowledged receipt of an "Initial Allegation Report" regarding client #1 via fax on 4/11/23.
- An undated handwritten "Health Care Personnel Registry 5-Working Day Report" completed by the QP/DS. The allegation of abuse of client #1 by a former staff was not substantiated by the facility.
- No documentation of internal investigations of allegations of abuse made in December 2022.
- No documentation of the facility's response to allegations of abuse reported in December 2022.

Interview on 9/19/23 and 10/04/23 the QP/DS stated:
- She is responsible for completing IRIS reports.
- The facility did report to the HCPR after the 3/2/23 survey.
- She received a letter from HCPR about the accused staff.

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V 366	Continued From page 49 - She submitted a level II incident report; ". . . at the time we were just finding out about the incident and apparently it had been happening . . . I don't know when it happened . . . " - She did not "know it was a level III, it's the first time it had happened." This deficiency constitutes a re-cited deficiency and must be corrected within 23 days. This deficiency is cross referenced into 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (V512) for a Failure to Correct Type A1 rule violation.	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 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;	V 367		

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V 367	Continued From page 50 (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 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.	V 367		

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	MHL026-964	A. BUILDING: ______ B. WING ______	R 10/06/2023

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V 367	Continued From page 51 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 record reviews and interviews, the facility failed to ensure critical incident reports were submitted to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are: Review on 9/19/23 and 10/4/23 of the North Carolina Incident Response Improvement System (IRIS) website revealed no Level III incident reports were submitted to the LME/MCO from 3/02/23 thru 10/04/23. Review on 9/19/23 of a Division of Health Service	V 367		

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V 367	Continued From page 52 Regulation statement of deficiencies dated 3/02/23 revealed: - Incidents of serious abuse and neglect were reported to the Qualified Professional/Director of Services (QP/DS) on 12/07/22 and 12/09/22 with no incident reports completed. Interview on 9/19/23 and 10/4/23 the Qualified Professional/Director of Services (QP/DS) stated: - She was responsible for completing IRIS reports. - She submitted a level II incident report in March 2023 regarding an allegation of abuse of a former client. - "I did not know it was a level III, it's the first time it had happened." This deficiency constitutes a re-cited deficiency and must be corrected in 23 days. This deficiency is cross referenced into 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (V512) for a Failure to Correct Type A1 rule violation	V 367		
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	V 500		

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V 500	Continued From page 53 (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 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	V 500		

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V 500	Continued From page 54	V 500		

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 review and interviews, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS) affecting 1 of 2 current clients (#2) and 1 of 1 former clients (FC #5). The findings are:

Review on 9/19/23 of a Division of Health Service Regulation (DHSR) statement of deficiencies dated 3/02/23 revealed:
- Incidents of serious abuse and neglect were reported to the Qualified Professional/Director of Services (QP/DS) on 12/07/22 and 12/09/22 with no incident reports completed and no documentation of DSS notification.

Review on 9/19/23 and 10/4/23 of facility records 3/02/23 - 10/04/23 revealed no documentation of DSS notification of an allegation of abuse of former client #5 by former staff #11 (FS #11). No documentation of allegations of abuse against former staff #11. No documented investigation of an allegation of abuse of former client #5.

Review on 9/19/23 and 10/4/23 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level III incident reports were submitted for the facility 3/02/23 thru 10/04/23.

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V 500	Continued From page 55 Interview on 9/19/23 and 10/4/23 the Qualified Professional/Director of Services (QP/DS) stated: - She was responsible for completing the IRIS reports. - The facility did not show documentation that the allegation of abuse had been reported to the local DSS after the 3/2/23 DHSR survey. - She "did not know it was a level III, it's the first time it had happened." - "DSS investigated before the state came." This deficiency constitutes a re-cited deficiency and must be corrected within 23 days. This deficiency is cross referenced into 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (V512) for a Failure to Correct Type A1 rule violation.	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 56	V 512		

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 reviews and interviews, the Qualified Professional/Director of Services (QP/DS) failed to protect 1 of 2 current clients (#1) and 1 of 1 former client (#5) from abuse.
The findings are:

Cross Reference: G.S. 131E-256 Health Care Personnel Registry (V132). Based on record reviews and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel and failed to investigate allegations of abuse.

Cross Reference: 10A NCAC 27G .0603 - Incident Response Requirements for Category A & B Providers (V366). Based on record reviews and interviews the facility failed to document their response to level I, level II, and level III incidents.

Cross Reference: 10A NCAC 27G .0604 - Incident Reporting Requirements For Category A & B Providers (V367). Based on record reviews and interviews, the facility failed to report incidents to the Local Management Entity/Managed Care Organization (LME/MCO) as required.

Cross Reference: 10A NCAC 27D .0101 - Client

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V 512	Continued From page 57	V 512		

Rights (V500). Based on record review and interviews, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS).

Review on 9/19/23 of a DHSR statement of deficiencies dated 3/02/23 revealed:
- Incidents of serious abuse and neglect were reported to the QP/DS on 12/07/22 and 12/09/22 with no incident reports completed and no documentation of HCPR notification.

Review on 9/20/23 of documentation provided by the QP/DS revealed:
- An e-mail from the HCPR dated 4/18/23 revealed HCPR's acknowledged receipt of an "Initial Allegation Report" regarding client #1 via fax on 4/11/23.
- An undated handwritten "Health Care Personnel Registry 5-Working Day Report" completed by the QP/DS; the allegation of abuse of client #1 by former staff #11 was not substantiated by the facility.
- No documentation of receipt of the 5-Day Working Report by the HCPR.
- No documentation of HCPR notification of allegation of abuse of former client #5.

Interview on 3/2/23 the QP/DS stated:
- Former staff #11 was no longer employed at the facility.
- She did not know she was supposed to report the allegation because she did not know about it.
- She had not notified the local Department of Social Services of the allegation after the survey, she had no documentation of the facility's response to the level III incident and had not reported the allegation to the LME/MCO as required.

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V 512	Continued From page 58	V 512		

This deficiency constitutes a re-cited deficiency and must be corrected within 23 days

Review on 10/5/23 of Plan of Protection signed by the QP/DS and dated 10/5/23 revealed:
- "What immediate action will the facility take to ensure the safety of the consumers in your care? Report will be submitted for incident. DSS report was made also the HCR (Health Care Registry) report was made. Make sure that all reports are reported within the time frame expected by the rules. This includes DSS, HCR and incident reports.
- Describe your plans to make sure the above happens. QP (QP/DS) will collect report and submit DSS paperwork to whomever requires it. QP will make sure to investigate and make sure to get all details of incident reports on any type of report from all DSP (Direct Support Professional) in the event of any incidents."

The facility served clients aged 20 - 32 with diagnoses of Autism, Intellectual/Developmental Disability, ADHD, Tourette's Syndrome, Smith-Magenis Syndrome, and Citrullinemia. After the previous DHSR survey that resulted in a Type A1 on 3/2/23 the QP/DS was aware of an allegation of abuse but continued to fail to complete an internal investigation and notify the health care personnel registry. The QP/DS did not provide any documentation that showed the facility's response to the allegation. The QP/DS did not notify DSS of any incidents. The LME/MCO was not notified and the level III reporting to IRIS was not completed. By not conducting internal investigations of allegations of abuse as required, the QP/DS failed to ensure the safety and protection of the clients. This deficiency constitutes a Failure to Correct the Type A1 rule violation originally cited for serious

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V 512	Continued From page 59 neglect. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	V 512		
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 grounds was not maintained in a safe, clean, orderly manner and free from offensive odors. The findings are: Observations on 9/19/23 at approximately 11:32am and 10/4/23 at approximately 12:30 pm revealed: - Nickel sized brown circular stains in various sizes on the ceiling above the bulletin board by the activity table. - Approximate 2 inch and 3 inch holes in the wall on both sides of the bulletin board; wall receptacle under bulletin board had no cover and the plug was hanging out. - The wall beside the doorway into the kitchen had a softball sized hole by the receptacle and a softball sized hole at the bottom by the baseboard. - Approximately 2-3 foot (ft) long rips and tears in the carpet in the living room and the vent under the window was covered in rust. - Approximately 12 ft long cracks on the ceiling above the activity table; 16 light chandelier had 12 bulbs not working and 2 bulbs missing.	V 736		

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V 736	Continued From page 60 - An end table in the living room was missing the glass top and was observed on 10/4/23 still missing the glass top but with a blue covering on top of it. - The living room wall by the sectional couch and on the side of the window had 3 holes in it; one approximately 8 inch square hole in the drywall exposed the exterior brick; there was a white plastered area beside the dining table; the sectional sofa had a pronounced v-shaped sag in one section, the arm rest padding was missing from under the intact upholstery. - Dust covered the return vent above the bulletin board. - Light fixture at front porch had no cover. - Kitchen window above sink had 3-4 dead bugs, cabinet door beside stove missing knob, cabinet and drawer under microwave missing knob, the hood above the stove was discolored in several areas and the light bulb was exposed, brown residue covered several areas of the underside of the hood, and brown residue appeared splattered on the wall behind the stove. - The oven had spills and pieces of foil in the bottom. - The counter to the right of the stove was missing 2 drawers at the top and a door at the bottom. - The yellow kitchen wall had white and tan plastered unfinished repair areas under the paper towel dispenser. - The vinyl floor covering in the kitchen was separated at the seams. - In a separate room off from the kitchen, there were 3 mattresses and 2 doors laying up against a wall, a folded metal bed frame was laying on the floor, a lamp had a broken lamp shade, the right wall had a cover missing from the receptacle. - Carpet throughout the facility had various sizes	V 736		

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V 736	Continued From page 61 of dark stains. - A foul urine odor was noted in client #1's bedroom. - Client #1 had an approximately 12- 12 1/2 inch hole in the wall on the right side of his bed and another approximately 6 inch hole on the left side of his bed; 4 broken blind slats in window facing side of facility; 1 side of closet door was off track; 5 drawer dresser behind door had the second drawer broken and the bottom drawer missing and his carpet is gray with multiple light colored stains in it. Client #1 had an approximately 2 ft white plastered area behind his 6 drawer dresser and a white 3-4 ft plastered un-repaired area behind a blanket hanging on the wall, baseboards were dusty heavy dust and there were pea sized yellow stains and residue on the wall under the double window. The door to client #1's bedroom had 2-3 inch cracks in the top panels. - Hall closet at front entry of facility had no doors and 1 door laying inside the closet had a softball sized hole in it, the vents above the hall closet were partially covered in heavy dust. - The hall bathroom across from client #3's bedroom had a door frame that was cracked about 1 ft long, the bathroom door was off the hinges and inside the bathroom in front of the sink propped against the wall and the floor vent was completely covered in rust. - Client #2 had 2 softball sized holes in the walls of the his closet; the closet door was missing a panel on the top on the right side door; client #2's bathroom had no shower curtain for the shower/tub. - Client #3's bedroom had an approximately 10 inch by 8 inch hole by the light switch and 2 softball sized holes near the middle of the wall; the carpet had dark stains of varying sizes; the bedframe extended beyond the edge of the mattress/box spring and presented a safety	V 736		

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V 736	Continued From page 62 hazard. - The ceiling fan light in client #4's bedroom had no globe over the light bulb; the light fixture housing in the ceiling fan was loose and dangling. - Smoke detectors in client #3 and client #4's bedrooms beeping at regular intervals. - A towel was pinned over the laundry /bathroom window; 7 unfinished repairs of varying sizes to the laundry/bathroom walls; the shower stall and shower curtain had dark staining; the vanity ring around the shower control was loose and pulled away from the shower wall; the finish on the vanity was worn and scratched; there were no globes over the light bulbs over the sink; an approximate 3 inch long hole beside the light switch; the plate over the outlet next to the light switch was broken; the "Start/Pause" button on the washing machine was missing; very heavy lint buildup around the dryer vent hose. - The vinyl siding on the back of the facility had green staining; a bean bag type chair, an upholstered arm chair and a broken toilet in an open cardboard box were in the backyard against the back of the house; a metal bedframe behind the shrubs by the front door; a window screen was behind the shrubs propped against the front wall; an uncovered garbage container with putrid smelling garbage was behind the facility van; the facility van was missing the passenger side rear view mirror; several window screens were missing around the facility. During interview on 10/04/23 staff #1 stated the hall bathroom door had been broken and off the hinges "a couple of days, maybe a week or so." During interview on 9/22/23 staff #4 stated he did not know what happened to the bathroom door, he "came in and saw it like that."	V 736		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE LAKES	5104 FLATROCK DRIVE FAYETTEVILLE, NC 28311

(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 63 Interview on 10/5/23 the Qualified Professional/Director of Services (QP/DS) stated: - Clients don't use the hall bathroom with the door missing, "my staff redirect them from going in there." - She did not know how any of the holes got into the walls of the facility. - "I don't not work in this house;" she was "not a regular staff." - "I'm not here 24/7," she had "2 other houses and people in the community." - When asked about the mattresses laying against the wall, the QP/DS stated, "what's the problem with them being in there?" - When the QP/DS was asked on 10/4/23 to complete the walk through of the facility for additional concerns she responded "I don't have nothing to hide, so y'all go ahead. Didn't you already do a walk through with [Licensee], well I don't know either, I'm not going to keep repeating myself, go back and look at my other answers, my answers ain't going to change." - "All I know is what they turn in for work orders." This deficiency has been cited 4 times since the original cite on 2/22/21 and must be corrected within 30 days.	V 736		
V 742	27G .0304(a) Privacy 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (a) Privacy: Facilities shall be designed and constructed in a manner that will provide clients privacy while bathing, dressing or using toilet facilities. This Rule is not met as evidenced by:	V 742		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-964	A. BUILDING: ____ B. WING ____	R 10/06/2023

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V 742	Continued From page 64	V 742		

Based on observation and interview, the facility failed to provide clients privacy affecting 2 of 4 audited clients (#1, #4). The findings are:

Observations during a walk through of the facility on 9/19/23 at approximately 11:32 am and 10/5/23 at approximately 12:26 pm of the facility revealed:
- Client #1's bedroom had a double window, facing the street, with no curtains or blinds. Three of the 4 glass panes did not have privacy film.
- The inside of client #1's bedroom was visible from the front yard.
- A sheer brown curtain covered the window facing the street in client #4's bedroom. The street was clearly seen through the curtain. From the outside of the facility, in bright sunlight, the light inside client #4's bedroom was clearly seen through the curtain.

Interview on 10/5/23 the Qualified Professional/Director of Services (QP/DS) stated:
- When asked about client #1's windows QP/DS responded, "[Client #1] had some curtains on the windows but he took them down. [Client #1] is short, you can't see him out of the bottom window, Didn't you already do a walk through the other day with [Licensee]; well I don't know either."

Interview on 9/19/23 the Licensee stated the facility had a maintenance person, he was behind on repairs and his wife had recently passed so he was unavailable.

Findings	Corrective Measures	Preventive Measures	Responsible Party/ How often	Time Frame
10A NCAC 27G. 0202 Personnel Requirements	Client Specifics were located in all files for all staff for each individual in the home	Client Specifics will continue to be completed for each individual upon admission	QP	60 days
10A NCAC 27G. 0203 Competencies of Qualified Professionals and Associate professionals	QP is well aware of signed job duties	Train future QP on job duties. Make sure QP has the knowledge needed to complete job duties	Director of Services	60 days
10A NCAC 27G . 0205 Assessment and treatment/ habilitation or serviceplan	Some items have been purchased others are in progress to prevent individual from succeeding with elopement	Some items have been purchased others are in progress to prevent individual from succeeding with elopement	Admin staff	23 days
10A NCAC 27G. 0206 Client Records	Data is completed for each individual. However all of the documentation is not in the individual client records. There are different folders and books that house certain things	Data is completed for each individual. However all of the documentation is not in the individual client records. There are different folders and books that house certain things	DSP	60 days
10A NCAC 27G . 0207 Emergency Plans and Supplies	All drills were completed on each shift, each month	Continue completing drills each month on each designated shifts	DSP	60 days

10A NCAC 27G . 0209 Medication Requirements	QP was not questioned about the MAR. They only spoke to the CEO who never gives medication. There are double sheets for each person at which CEO could not explain that to the surveyors	Check labels, MARs, medications	DSP House Manager	23 days
G.S. 131 E Healthcare Personnel Allegations, & Protection	Reports were completed	Report to required offices per any allegations that occur	QP	23 days
G.S. 122C-80 Criminal History Record Check	CHR checks are completed upon hire for each staff.	CHR checks are completed upon hire for each staff.	Admin	60 days
10A NCAC 27G . 0603 Incident response requirements for category A and B providers	Reports were completed	Report to required offices per any allegations that occur	QP	23 days
10A NCAC 27G . 0604 Incident Reporting requirements for category A and B providers	Reports were completed	Report to required offices per any allegations that occur	QP	23 days

10A NCAC 27D. . 0101 Policy on rights restrictions and interventions	Reports were completed	Report to required offices per any allegations that occur	QP	23 days
10A NCAC 27D . 0304 Protection from harm, abuse, neglect or exploitation	Reports were completed	Report to required offices per any allegations that occur	QP	23 days
10A NCAC 27G. . 0303 Location and Exterior requirements	Work orders were submitted for all damages	Work orders are completed as soon as damage occurs. It is a two week turn around depending on the severity in the the event that items have to be ordered	Management Admin Staff	30 days
10A NCAC 27G. 0304 Facility Design and equipment	Individuals at the home are able to decorate their rooms anyway they choose. If they choose to not have curtains or choose to have some type of covering that is their right to do so	Individuals at the home are able to decorate their rooms anyway they choose. If they choose to not have curtains or choose to have some type of covering that is their right to do so	DSP	60 days