

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL033-132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/19/2024
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS CITY STATE ZIP CODE

OPEN ARMS FAMILY SERVICES, INC

1649 HARPER STREET  
ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS  An annual survey was completed on 1/19/24. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.  This facility is licensed for 4 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.	V 000	① - Assessment was completed but not filed. In the future assessment will be conducted, filed and briefed. ② Proper diagnosis assigned, right client assessed and admitted before within 30 days. ③ Orientation of new clients with the staff must be conducted prior to admission. ④ Medication of new resident must be established, and supplied upon admission. ⑤ Pharmacy will be faxed with new resident information. ⑥ LPHS nurses conducted monthly and quarterly check with staff and residents. ⑦ Follow up with staff and client records weekly. ⑧ Worked with staff to maintain clean house and environment weekly. ⑨ Contracted with K&K Construction to fix the kitchen floor and bathroom.	2/1/24 2/15/24 2/15/24 2/30/24
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan  10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history, and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

ALPHONSUS NGWADOM, *Alphonse Ngwadam* CEO

2/5/2024

STATE FORM

6899

GW6K11

If continuation sheet 1 of 10



Division of Health Service Regulation  
STATE FORM



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL033-132	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  R 01/19/2024
--	--	--	---

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STATE ZIP CODE

OPEN ARMS FAMILY SERVICES, INC

1649 HARPER STREET  
ROCKY MOUNT, NC 27801

(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 111	Continued From page 2 -Did not leave the documents in the facility for the staff. -Client #2 was assessed for unsupervised time and could have five hours in the community. -Client #2 did not have any aggressive behaviors and seemed to be doing well. -Told staff #1 about client #2's diagnoses.	V 111	-QP will avail resident records such as unsupervised time. -General Orientation to staff should be given on or immediately a new resident is admitted.	1/17/24
V 118	27G 0209 (C) Medication Requirements  10A NCAC 27G 0209 MEDICATION REQUIREMENTS (c) Medication administration. (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug, (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation	V 118		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL033-132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/19/2024
NAME OF PROVIDER OR SUPPLIER  OPEN ARMS FAMILY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1649 HARPER STREET ROCKY MOUNT, NC 27801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 3 with a physician.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure one of two clients (#1's) medication was administered on the written order of a physician. The findings are:</p> <p>Review on 10/10/24 of client #1's record revealed: -Admission date of 2/7/23 -Diagnoses of Schizoaffective Disorder, Bipolar, History of Substance Use, Mild Intellectual Disability (IDD), Hypertension, Aphasia, Right sided Hemiplegia</p> <p>Review on 1/10/24 of Physician orders dated 9/11/23-12/11/23 revealed the following AM medications: -Aspirin 81 mg ( blood thinner) -Hydrochlorothiazide (anxiety) 12.5 mg -Lipitor (cholesterol) 80 mg -Norvasc (blood pressure) 5 mg -Vistaril (anxiety) 50 mg -Zoloft (depression) 25 mg</p> <p>Observation on 1/10/24 at 10:00 am the above medications were not present in the facility. Bubble packs were present that were filled on 12/13/23.</p> <p>Interview on 1/10/24 staff #1 stated: -Ran out of client #1's AM medications yesterday. -Today is the only day she had missed them.</p>	V 118	<p>-QP ensures that resident medication is available as prescribed.</p> <p>-Pharmacy supplies medication to the facility every month between the 10th and 13th of every month.</p> <p>-QP will ensure that refills of any resident medication is done before it goes out.</p> <p>-QP ensures that every week and monitor resident medication supply.</p> <p>-QP will ensure that calls to pharmacy to refill and supply of medication is done immediately upon notice of finished medication.</p> <p>-QP will follow up 3 days before medication of any resident goes out.</p>	<p>1/13/24</p> <p>every week.</p> <p>1/13/24</p>



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL033-132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/19/2024
NAME OF PROVIDER OR SUPPLIER  OPEN ARMS FAMILY SERVICES, INC		STREET ADDRESS CITY STATE ZIP CODE 1649 HARPER STREET ROCKY MOUNT, NC 27801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 4  -Called the pharmacy last week to order client #1's medication and could not "get through." -Called back yesterday and ordered which was to be delivered yesterday as well. -There was a really bad storm yesterday and last night so wondered if that effected the delivery -Planning to call the pharmacy this morning to follow up.  Interview on 1/19/24/23 the Licensee/Qualified Professional stated -Client #1's medication was delivered to one of his other facilities. -The medication was taken to the facility on 1/10/24 for client #1. -Client #1 only missed one day of medications and resumed her medications on 1/11/24.  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118	- QP will work with pharmacy staff to ensure medication is supplied on time. - QP will assist with staff to ensure that resident gets help at Emergency hospital - QP will check on other facilities to ensure that other resident medication is not re-routed. - QP will assist in bringing the missing medication to its proper designation and address.	1/17/24
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int.  10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.	V 536		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL033-132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/19/2024
NAME OF PROVIDER OR SUPPLIER  OPEN ARMS FAMILY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1649 HARPER STREET ROCKY MOUNT, NC 27801		
(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 536	Continued From page 5  (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior, and	V 536	<p>- QP is working with the Express Care Pharmacy group to provide training of staff at Almarah Family Care.</p> <p>- QP has scheduled a 2/7/24 training with the LHPs nurse to conduct review of residents' medications and compliance.</p> <p>- QP is working to schedule a First Aide, CPR, and NCI intervention training in the weeks of February 5 - February 10, 2024.</p>	



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL033-132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/19/2024
--	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OPEN ARMS FAMILY SERVICES, INC

1649 HARPER STREET  
ROCKY MOUNT, NC 27801

(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 536	Continued From page 6  (g) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe) (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee	V 536	<p>— QP has set appointment with [REDACTED] with Express Care to provide training for staff at Almarh Family Care between the weeks of February 7 - Feb 14, 2024.</p> <p>— Training including NCI, CPR, First Aid and General Orientation.</p>	<p>2/7/24</p> <p>↓</p> <p>2/14/24</p>



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/19/2024
	MHL033-132		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

OPEN ARMS FAMILY SERVICES, INC

1649 HARPER STREET  
ROCKY MOUNT, NC 27801

(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 536	Continued From page 7  performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers.	V 536		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL033-132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/19/2024
NAME OF PROVIDER OR SUPPLIER  OPEN ARMS FAMILY SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1649 HARPER STREET ROCKY MOUNT, NC 27801		
(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 536	Continued From page 8  This Rule is not met as evidenced by: Based on record review an interview the facility failed to ensure one of one (#1) staff's training in Alternative to Restrictive Interventions was current.  Review on 1/10/24 and 1/19/24 revealed -Hire date of 12/15/23 -Alternative to Restrictive Intervention dated 10/2/22  Interview on 1/10/24 staff #1 stated: -Could not remember when she last had Alternative to Restrictive training. -Had worked at different facilities over the years and had lots of trainings. -The Licensee/Qualified Professional (QP) had her training certificates. -Had some trainings before she started work with the clients. -Also had trainings from her previous job.  Interview on 1/10/24 the Licensee/QP stated: -Not aware of staff #1's training expired. -Will schedule her a training in Alternative to Restrictive Interventions.	V 536	<p>— Staff will need NC Intervention and CPR training in February.</p> <p>— QP will monitor staff file to ensure training and record is up to date</p> <p>— The internal audit will happen every month.</p>	2/1/24
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.	V 736		2/28/24



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  <b>MHL033-132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/19/2024</b>
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS CITY STATE ZIP CODE

**OPEN ARMS FAMILY SERVICES, INC**

**1649 HARPER STREET  
ROCKY MOUNT, NC 27801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 9  This Rule is not met as evidenced by: Based on observations and interview the facility failed to ensure the home in a safe, clean and attractive manner. The findings are:  Observation on 1/10/24 at 10:30 AM revealed: -Kitchen floor had a soft sunken area by the refrigerator. -There were small holes in the laminate in the kitchen floor. -The paint on the ceiling in the bathroom and client #2's room was popping off and was separating from the ceiling. -Client bathroom tub had mildew throughout. -Chain link fence at driveway entrance was falling down.  Interview on 1/19/24 the Licensee/Qualified Professional stated: -Had not noticed the paint popping off the ceiling. -The heat in the home made the paint pop off the walls. -Will walk through the home to make sure it is maintained. -Had not noticed the kitchen floor sinking or having holes. -Will instruct staff to clean the bathroom. -The fence out from fell a few months ago during the last hurricane.	V 736	<p><del>Qp</del> QP has contracted K&amp;K Construction company to assess, evaluate and fix the floor if needed.</p> <p>QP also observed and worked on the bathroom floor to fix the pilling paint on the wall.</p> <p>QP monitored and daily instructed the staff to clean the bathroom every day.</p> <p>QP will inspect the bathroom weekly.</p> <p>QP Fixed the falling fence at the entrance of the compound.</p>	2/7/24           2/10/24