Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-299	A. BUILDING: ______ B. WING ______	R 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINS HOME	1517 PARKS VILLAGE ROAD ZEBULON, NC 27597

(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, complaint and follow up survey was completed on 12/5/23. The complaint was substantiated (Intake #NC00209429). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000	**V108:** Staff has received training for continued education as required by rule 10A NCAC 27G .0202. This training and review encompassed general organizational review, clients' rights and confidentiality, personal care, medication administration, infectious disease, bloodborne pathogens, refresher CPR/FA training, seizure management, incident reporting, and additional training appropriate to meet the mh/dd/sa needs of the client as specified in the treatment /habilitation plan. Additionally, a policy has been developed for identifying, reporting, investigating, and controlling infectious and communicable diseases of personnel and clients. The Qualified Professional (QP) in conjunction with the AFL Provider of the home ensured this was completed as required by rule 27G . 0202 (F-1) Personnel requirements. The QP will monitor to ensure compliance of this rule upon hire during orientation and annually thereafter. RECEIVED MAR 05 2024 DHSR-MH Licensure Sect	
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 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,	V 108		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ROSA WILKINS TITLE CEO/Owner (X6) DATE

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V 108	Continued From page 1 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 interview, the facility failed to ensure that 1 of 1 staff (Alternative Family Living (AFL) Provider) received training in bloodborne pathogens, client rights, infectious diseases and updated training in cardiopulmonary resuscitation (CPR) and first aid. The findings are: Review on 11/29/23 of the AFL Provider's personnel record revealed: - Employed: June 1995 - A CPR and First Aid training that expired in 2019 - No documentation of Bloodborne Pathogens, Infectious Diseases or Client Rights training being completed Interview on 11/29/23 the AFL Provider reported: - "I've been trying to retire the last four years" - "I know I'm out of compliance...tell the truth, I didn't think anyone (the State) would come out" - She didn't renew any of her trainings because she let everything go and gave up her license about a year ago - She did not update her trainings when she renewed her license around April 2023	V 108		

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V 108	Continued From page 2 - She planned on continuing to renew her license - She would get her trainings completed This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living - Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 108		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision	V 110	V110 A qualified professional (QP), has been employed to provide the required supervision for the paraprofessional staff as per rule .0104 of 10A NCAD 27G. Additionally, the QP has demonstrated competencies in technical, knowledge, cultural awareness, analytical skills, decision-making, interpersonal skills, communication skills and clinical skills. The QP employed has training and experience in the formation of goals, progress notes, person centered plan for the population served. The paraprofessional, through training, re-training, and orientation, demonstrates the knowledge, skills and abilities required by the population served as required by rule 10A NCAC 27G . 204. The AFL Provider and QP has ensured and will continue to ensure that this rule is met.	

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V 110	Continued From page 3 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 staff (Alternative Family Living (AFL) Provider) was supervised by a Qualified Professional (QP). The findings are: Review on 11/29/23 of the AFL Provider's personnel record revealed: - Employed: June 1995 - no documentation of supervision notes from a QP Interview on 11/29/23 & 12/5/23 the AFL Provider reported: - She had a QP in 2021 - 2022, but he left - She acknowledged that she knew she was supposed to have been supervised by a QP - She was only focused on retiring and didn't look for another QP - She would start looking for a QP to supervise her Interview on 12/4/23 the former QP reported: - He was never the QP for this facility - The AFL Provider looked into hiring him as her QP but never did - He met with the AFL Provider between 2021 and 2022, 2 or 3 times to see what her needs were in the facility This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living - Scope	V 110		

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V 110	Continued From page 4 (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 110		
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. (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.	V 112	V112 A person centered plan has been developed for and in partnership with the clients in the facility by the QP. The plan includes 1)anticipated client outcomes to be achieved based on the services provided and projected date of achievement, 2)The plan encompasses long term and short term goals with intervention strategies and appropriate corresponding staff responsibilities. The plan will be reviewed bi-annually and annually in consultation with the client and legally responsible person. The review will include the basis for the evaluation in regards to the outcome achievement and written consents that will be updated annually. The QP will ensure this is done.	

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V 112	Continued From page 5	V 112		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure current treatment plans were developed and implemented for 3 of 3 clients (#1 - #3). The findings are:

Review on 11/29/23 of client #1's record revealed:
- Admitted: 3/7/23
- Diagnoses: Schizophrenia, unspecified type
- No residential treatment plan

Review on 11/29/23 of client #2's record revealed:
- Admitted: 2/21/02
- Diagnoses: Mental Retardation, Hypertension, Diabetes Mellitus, Hyperlipidemia, Osteoporosis, Tremors, Non-Hodgkin's Lymphoma, and Obesity
- A document from the Adult Day Program titled "Service Plan" dated 5/23//23 that listed goals for the Adult Day Program only and did not contain any client or family history or client's presenting problems
- No residential treatment plan

Review on 11/29/23 client #3's record revealed:
- Admitted: 8/17/96
- Diagnoses: Hip Replacement, Intellectual Disability, Chronic Kidney Disease, Hyperlipidemia, Osteoporosis, Tachycardia, and Leukocytopenia
- A document from the Adult Day Program titled "Service Plan" dated 8/16/23 that listed goals for the Adult Day Program only and did not contain any client or family history or client's presenting problems
- No residential treatment plan

Interview on 12/1/23 the Director of the Adult Day Program reported:
- Anything that was done for the clients was for

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V 112	Continued From page 6 the Adult Day Program only - The "Service Plan is strictly" for the Adult Day Program - All assessments are "in-house" and they are non-clinical - The Adult Day Program had nothing to do with the group homes - Assessments gave them an idea of the clients' needs while at the Adult Day Program Interview on 11/29/23 the AFL Provider reported: - The Adult Day Program normally developed the clients' treatment plans - "I never thought anyone (the State) would come out" - Confirmed that no treatment plan had been completed for the group home other than the document titled "Service Plan" completed by the Adult Day Program This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living - Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	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;	V 113		

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V 113	Continued From page 7 (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; (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 observation, record review and interview, the facility failed to maintain complete	V 113	V113 A person centered plan has been developed for the clients in the facility by the QP. The plan includes 1)anticipated client outcomes to be achieved based on the services provided and projected date of achievement, 2)The plan encompasses long term and short term goals with intervention strategies and appropriate corresponding staff responsibilities. The plan will be reviewed bi-annually and annually in consultation with the client and legally responsible person. The review will include the basis for the evaluation in regards to the outcome achievement and written consents that will be updated annually. Blood sugar checks that have been performed twice daily for client #2, and any new admission where this is required, using, a glucometer that displays dates and times, will be documented on the MAR. The results of the BS check will be documented on the MAR. A log book as been implemented for maintaining of daily aide task sheets and grids that inform of the services provided by the paraprofessional. The QP will review the log book monthly to ensure compliance.	

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V 113	Continued From page 8	V 113		

records affecting 3 of 3 clients (#1 - #3). The findings are:

Review on 11/29/23 of client #1's record revealed:
- Admitted: 3/7/23
- Diagnosis: Schizophrenia, unspecified type
- no documentation of services provided
- no documentation of progress notes

Review on 11/29/23 of client #2's record revealed:
- Admitted: 2/21/02
- Diagnoses: Intellectual Disability, Hypertension, Diabetes Mellitus, Osteoporosis, Tremors, Non-Hodgkin's Lymphoma, and Obesity
- no documentation of services provided
- no documentation of progress notes
- physician's order dated 9/6/23 revealed: Check Blood Sugar (BS) twice daily
- no written documentation of BS results

Observation on 11/29/23 at approximately 12:00pm revealed: the Alternative Family Living (AFL) Provider showed the glucometer that had the BS readings and the date and times the BS was checked

Review on 11/29/23 of client #3's record revealed:
- Admitted: 8/17/96
- Diagnoses: Intellectual Disability, Hip Replacement, Chronic Kidney Disease, Hyperlipidemia, Osteoporosis, Tachycardia, and Leukocytopenia
- no documentation of services provided
- no documentation of progress notes

Interview on 11/29/23 & 12/5/23 the AFL Provider reported:
- "I used to document progress on goals"
- "I understand this, I know this (that documentation is required) but I don't do it"

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V 113	Continued From page 9 - She would hire a Qualified Professional to help her with the paperwork This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living - Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 113		
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	**V118** A medication administration record (MAR) has been requested from the pharmacist for all clients. Currently, a paper MAR has been used to document manually, all prescribed medications administered. The manually entered information documented includes the 1)client's name, 2) strength and quantity of the drug administered, 3)instruction for administering the drug, 4)date and time the drug is administered and the name and initials of the staff administering the drug. Training has been done by an RN for proper medication administration and documentation. Additionally, a log book has been implemented to document and compile doctor's orders, appointments, and discharge summaries. The paraprofessional will ensure these files are current, up-to-date, and properly documented. The QP will review the MAR and log book monthly to ensure accuracy, and compliance.	

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with a physician.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure MARs were kept current for 3 of 3 clients (#1 - #3). The findings are:

Review on 11/29/23 of client #1's record revealed:
- Admitted: 3/7/23
- Diagnosis: Schizophrenia, unspecified type
- Physician order dated 10/23/23:
  - Carbamazepine 100 milligrams, 1 tablet daily (mood)
  - Bupropion XL 300 milligrams, 1 tablet daily (depression)
  - Hydrochlorothiazide 300 milligrams, 1 tablet every day (blood pressure)
  - Metformin ER 500 milligrams, 1 tablet daily (diabetes)
  - Atorvastatin 40 milligrams, 1 tablet daily (cholesterol)
  - Albuterol Sulfate, 2 puffs every four hours as needed (bronchodialator)
- No MARs at the facility

Review on 11/29/23 of client #2's record revealed:
- Admitted: 2/21/02
- Diagnosis: Intellectual Disability, Hypertension, Diabetes Mellitus, Osteoporosis, Tremors, Non-Hodgkin's Lymphoma, and Obesity
- Physician order dated 9/6/23:
  - Calcium 600 milligrams, 1 tablet daily (supplement)
  - Metformin 500 milligrams, 2 tablets with

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breakfast, 1 tablet with dinner, daily (diabetes)
- Pravastatin 10 milligrams, 1 tablet every night at bedtime (cholesterol)
- Low dose Aspirin, 1 tablet daily (heart)
- Valsartan 40 milligrams daily (high blood pressure)
- Boniva 150 milligrams, Take every 30 days (osteoporosis)
- No MARs at the facilty

Review on 11/29/23 of client #3's record revealed:
- Admitted: 8/17/96
- Diagnosis: Intellectual Disability, Hip Replacement, Chronic Kidney Disease, Hyperlipidemia, Osteoporosis, Tachycardia, and Leukocytopenia
- Physician order dated 5/15/23:
  - Aspirin 81 milligrams, daily (heart)
  - Allergy relief 10 milligrams (allergies)
  - Pravastatin 10 milligrams, 1 tablet daily (cholesterol)
  - Calcium 600 milligrams plus Vitamin D3 20 micrograms, daily (supplement)
- No MARs at the facility

Interview on 11/29/23 client #1 reported:
- Was not able to provide clear and consistent information regarding her medication

Interview on 11/29/23 clients #2 and #3 reported:
- They take their medications daily
- The AFL provider gave them their medications daily

Interview on 11/29/23 & 12/5/23 the AFL Provider reported:
- Stopped using MARs but wasn't sure when
- Could not find any previous MARs
- Knew that she was supposed to document medication administration on a MAR

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V 118	Continued From page 12 - Gave clients medications daily - "I just got so burned out" - "I just got caught up in retiring" Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician. This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living - Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a	V 289	**V289** Staff has received training for continued education as required by rule 10A NCAC 27G .0202. This training and review encompassed general organizational review, clients' rights and confidentiality, personal care, medication administration, infectious disease, bloodborne pathogens, refresher CPR/FA training, seizure management, incident reporting, and additional training appropriate to meet the mh/dd/sa needs of the client as specified in the treatment /habilitation plan. Additionally, a policy has been developed for identifying, reporting, investigating, and controlling infectious and	

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V 289	Continued From page 13 developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).	V 289	communicable diseases of personnel and clients. In addition, training on resident assessment using the resident assessment manual was used to clarify this process. A review on assessment of clients upon admissions, the client's capability of having unsupervised time in the community was provide to assist staff to better understand this process. A qualified professional (QP), has been employed to provide the required supervision for the paraprofessional staff as per rule .0104 of 10A NCAD 27G. Additionally, the QP has demonstrated competencies in technical, knowledge, cultural awareness, analytical skills, decision-making, interpersonal skills, communication skills and clinical skills. The QP employed has training and experience in the formation of goals, progress notes, person centered plan for the population served. The paraprofessional, through training, re-training, orientation, demonstrates the knowledge, skills and abilities required by the population served as required by rule 10A NCAC 27G . 204. The AFL Provider and QP has ensured and will continue to ensure that this rule is met.	

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V 289	Continued From page 14 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide services for the care, habilitation, and rehabilitation for 3 of 3 clients (#1 - #3) who have a mental illness or developmental disability. The findings are: A. Cross-reference: 10A NCAC 27G .0202 Personnel Requirements (V108). Based on record review and interview, the facility failed to ensure that 1 of 1 staff (Alternative Family Living (AFL) Provider) received training in bloodborne pathogens, client rights, infectious diseases and updated training in cardiopulmonary resuscitation (CPR) and first aid. B. Cross-reference: 10A NCAC 27G .0204 Training/Supervision Paraprofessionals (V110). Based on record review and interview, the facility failed to ensure 1 of 1 staff (Alternative Family Living (AFL) Provider) was supervised by a Qualified Professional (QP). C. Cross-reference: 10A NCAC 27G .0205 Assessment/Treatment/Habilitation Plan (V112). Based on record review and interview the facility failed to ensure a current treatment plan was developed and implemented for 3 of 3 clients (#1 - #3). D. Cross-reference: 10A NCAC 27G .0206 Client Records (V113). Based on record review and interview, the facility failed to maintain complete records affecting 3 of 3 clients (#1 - #3). E. Cross-reference: 10A NCAC 27G .0209 Medication Requirements/Administration (V118). Based on record review and interview the facility	V 289	A person centered plan has been developed for the clients in the facility by the QP. The plan includes 1)anticipated client outcomes to be achieved based on the services provided and projected date of achievement, 2)The plan encompasses long term and short term goals with intervention strategies and appropriate corresponding staff responsibilities. The plan will be reviewed bi-annually and annually in consultation with the client and legally responsible person. The review will include the basis for the evaluation in regards to the outcome achievement and written consents that will be updated annually. A medication administration record (MAR) has been requested from the pharmacist for all clients. Currently, a paper MAR has been used to document manually, the administration of all drugs administered. The manually entered information documented includes the 1)client's name, 2) strength and quantity of the drug administered, 3)instruction for administering the drug, 4)date and time the drug is administered and the name and initials of the staff administering the drug. Additionally, a log book has been implemented to document and	

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V 289	Continued From page 15 failed to ensure MARs were kept current for 3 of 3 clients (#1 - #3). F. Cross-reference: 10A NCAC 27G .5602 Supervised Living - Staff (V290). Based on record review, observation and interview, the facility failed to assess 1 of 3 client's (#1) capability of having unsupervised time in the community. G. Cross-reference: 10A NCAC 27G .0603 Incident Response Requirements (V366). Based on record reviews and interviews, the facility failed to implement a policy governing their response to Level II incident reports as required. H. Cross-reference: 10A NCAC 27G .0604 Incident Reporting Requirements (V367). Based on record review and interview the facility failed to report level II incidents to the the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours. I. Cross-reference: 10A NCAC 27E .0107 Client Rights - Training on Alternative to Restrictive Intervention (V536). Based on record review and interview the facility failed to ensure 1 of 1 staff (AFL Provider) had an annual training in Alternatives to Restrictive Interventions. J. Cross-reference: 10A NCAC 27G .0304 Minimum Furnishings (V774). Based on observation and interview, the facility failed to ensure that 1 of 3 client's (#1) bedroom had minimum furnishings. Review on 12/5/23 of the Plan of Protection dated 12/5/23 and signed by the AFL Provider revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care: - Wilkins Home will be hiring a QP starting	V 289	compile doctor's orders, appointments, and discharge summaries. The paraprofessional will ensure these files are current, up-to-date, and properly documented. The QP will review the MAR and log book monthly to ensure accuracy, and compliance. Upon completion of the exit interview, a repairman was called to repair the window that would not stay up. As of 11/30/23, the window has been repaired. Additionally, a dresser has been placed inside of #1 bedroom. The above was completed and its continued compliance will be ensured by the QP and in collaboration with the AFL Provider and staff. Staff received training on incident reporting for clarity on 1) What is an incident, 2) the levels of incidents (I, II, III) and what each level means, 3) provider category (A & B), and 4) reporting requirements. A policy has been implemented regarding incident reporting. The QP will be notified of any unusual or unexpected incidents immediately. An incident report will be completed. The Wilkins Home staff will utilize the Policies and Procedures adopted by the N.C. Division of MH/DD/SAS to document deaths, restrictive interventions and/or incidents on forms DHHS Incident and Death Report and/or DHHS Restrictive Intervention Details Report Death Reporting.	

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V 289	Continued From page 16 11/5/23. I will start my correction of action today and it involves all the deficiencies. Describe your plans to make sure the above happens. - Wilkins Home will be hiring staff to help with the correction of action. I will start this plan of action today 12/5/23. buying a dresser for [client #1's] room or clearing out the dresser in the room and removing my closes. Window in [client #3's] room has been repaired. Wilkins Home will ask the local pharmacy for Mar (Medication Administration Record) sheets documentation will start today as well as my training. I will be calling around to reschedule." This facility served clients with Schizophrenia, Intellectual Disabilities, Hypertension, Diabetes Mellitus, Hyperlipidemia, Osteoporosis, Tremors, Non-Hodgkin's Lymphoma, Obesity, Hip Replacement, Chronic Kidney Disease, Tachycardia, and Leukocytopenia. The AFL Provider did not have current training in CPR/First Aid, bloodborne pathogens, infectious diseases and alternatives to restrictive interventions. The AFL Provider was not supervised by a QP. There were no treatment plans for the 3 clients to address their residential needs. Client records did not contain documentation of services provided by the facility. Clients #1 - #3 did not have MARs. Client #1 rode public transportation by herself to and from her day program without being assessed for unsupervised time. Client #3 had a fall in which she fractured her hip and was hospitalized that was not reported to the Incident Response Improvement System (IRIS). Client #1 did not have a dresser or nightstand of her own and had clothes in storage totes that were against the wall in her room. This deficiency constitutes a Type A1 rule violation for serious neglect and must be	V 289		

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V 289	Continued From page 17 corrected within 23 days, an administrative penalty of $1,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or	V 290		

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V 290	Continued From page 18 more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to assess 1 of 3 client's (#1) capability of having unsupervised time in the community. The findings are: Review on 11/29/23 of client #1's record revealed: - Admitted: 3/7/23 - Diagnosis: Schizophrenia, unspecified type - No documentation of an assessment for unsupervised time Observation on 11/29/23 at approximately 3:10pm revealed client #1 arrived to the facility on public transportation without staff, got off of the van with her walker and proceeded to walk to the front door and inside the facility. Interview on 11/29/23 client #1 reported: - "I go to the day program" - "I catch the bus to the program every day"	V 290	**V290** Training on resident assessment using the resident assessment manual as a tool,was used to clarify this process. A review on assessment of clients upon admissions, and the client's capability of having unsupervised time in the community, was reviewed. Staff received training on documenting information obtained on the FL2, any hospital records that accompany the resident, or any documents from prescribing practitioner or Licensed Health Professional Support, resident observations, and interviews with family and the resident. The review and training in resident assessment was conducted by an RN. The QP and the AFL provider ensured this review and training occurred. All staff employed will receive this training during orientation. The QP will ensure this is done.	

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V 290	Continued From page 19 Interview on 11/29/23 the AFL Provider reported: - Client #1 did not have unsupervised time - Client #1 did not go anywhere in which she needed unsupervised time because she was either at the facility or at the Adult Day Program - Didn't know client #1 needed an assessment for unsupervised time to ride public transportation to the Adult Day Program by herself This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living - Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 290	**V366** On 10/22/2023, staff and clients were preparing to leave the facility for appointments. Client # 3 was walking too fast toward the door and tripped and fell. It should be noted, this is not a regular occurrence. AFL Provider/Staff quickly assisted client #3 off the floor and transported her to UNC urgent care. X-rays revealed no fractures but at the direction of the Urgent care staff AFL Provider/Staff transported client #3 to Duke Raleigh hospital where x-rays revealed a hip fracture. AFL Provider/ Staff did not use the IRIS system to report the level II incident within the appropriate time frame. Staff received training on incident reporting for clarity on 1) What is an incident, 2) the levels of incidents (I, II, III) and what each level means, 3)provider category (A & B), and 4)reporting requirements. A policy has been implemented regarding incident reporting.	
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	V 366		

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V 366	Continued From page 20 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall 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	V 366	The QP will be notified of any unusual or unexpected incidents immediately. An incident report will be completed. The Wilkins Home staff will utilize the Policies and Procedures adopted by the N.C. Division of MH/DD/SAS to document deaths, restrictive interventions and/or incidents on forms DHHS Incident and Death Report and/or DHHS Restrictive Intervention Details Report Death Reporting. All Level One Incident Reports will be documented in the facility incident log manual. All Level Two and Three Incident Reports that jeopardizes the health, safety and well being or causes death of a consumer will be submitted to the Incident Reporting and Improvement System (IRIS). Level 2 Incidents will be submitted to IRIS within 72 hours of the incident. Level 3 Incidents will be submitted to IRIS within 24 hours and reported to the Home LME, including Death reporting. The QP and the AFL/ Provider and staff will ensure compliance with this mandate.	

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V 366	Continued From page 21 preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues 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:	V 366		

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V 366	Continued From page 22 Based on record reviews and interviews, the facility failed to implement a policy governing their response to Level II incident reports as required. The findings are: Review on 11/29/23 of client #3's record revealed: - Admitted: 8/17/96 - Diagnosis: Intellectual Disability, Hip Replacement, Chronic Kidney Disease, Hyperlipidemia, Osteoporosis, Tachycardia, and Leukocytopenia Review on 11/29/23 of the Urgent Care summary dated 10/22/23 revealed: - Client #3 was seen for a fall - Referred to the local emergency room (ER) 10/22/23 Review on 11/29/23 of the Rehabilitation Center's notes dated 10/27/23 revealed: - Diagnosed and admitted to the hospital for a fractured hip - Discharged 10/27/23 from the hospital to the rehabilitation facility Review on 11/29/23 of the facility records regarding Client #3's fractured hip injury sustained on 10/22/23 revealed: - No documentation revealing the following: - Health and safety needs of the individual involved - Determined the cause of the incident - Developed and implemented corrective measures to prevent similar incidents - Assigned a person to be responsible for implementation of the corrections and preventive measures - Maintaining documentation - No documentation that an Incident Response Improvement System (IRIS) was	V 366		

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V 366	Continued From page 23 completed regarding client #3's hip fracture sustained on 10/23/23 Interview on 11/29/23 & 12/5/23 the Alternative Family Living Provider reported: - She didn't have any Level II incidents to report - Client #3 fell in October 2023 in the facility - Client #3 complained of knee pain - Transported client #3 to a local Urgent Care - Urgent Care x-rayed client #3's knee - Urgent Care referred client #3 to the ER because she was still complaining of pain - The ER x-rayed client #3's hip and determined her hip was fractured - Client #3 underwent surgery and treatment of hip fracture This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living - Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	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	V 367	V367 On 10/22/2023, staff and clients were preparing to leave the facility for appointments. Client # 3 was walking too fast toward the door and tripped and fell. It should be noted, this is not a regular occurrence. AFL Provider/Staff quickly assisted client #3 off the floor and transported her to UNC urgent care. X-rays revealed no fractures but at the direction of the Urgent care staff AFL Provider/Staff transported client #3 to Duke Raleigh hospital where x-rays revealed a hip fracture.	

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V 367	Continued From page 24 Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A 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	V 367	AFL Provider/Staff did not use the IRIS system to report the level II incident within the appropriate time frame. Staff received training on incident reporting for clarity on 1) What is an incident, 2) the levels of incidents (I, II, III) and what each level means, 3)provider category (A & B), and 4)reporting requirements. A policy has been implemented regarding incident reporting. The QP will be notified of any unusual or unexpected incidents immediately. An incident report will be completed. The Wilkins Home staff will utilize the Policies and Procedures adopted by the N.C. Division of MH/DD/SAS to document deaths, restrictive interventions and/or incidents on forms DHHS Incident and Death Report and/or DHHS Restrictive Intervention Details Report Death Reporting. All Level One Incident Reports will be documented in the facility incident log manual. All Level Two and Three Incident Reports that jeopardizes the health, safety and well being or causes death of a consumer will be submitted to the Incident Reporting and	

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V 367	Continued From page 25 becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to report level II incidents to the the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours. The findings are:	V 367	improvement System (IRIS). Level 2 Incidents will be submitted to IRIS within 72 hours of the incident. Level 3 Incidents will be submitted to IRIS within 24 hours and reported to the Home LME, including Death reporting. The QP and the AFL/Provider and staff will ensure compliance with this mandate.	

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V 367	Continued From page 26 Review on 11/29/23 of the Urgent Care summary dated 10/22/23 revealed: - Client #3 was seen for a fall - Referred to the local emergency room (ER) 10/22/23 Review on 11/29/23 of the Rehabilitation Center's notes dated 10/27/23 revealed: - Diagnosed and admitted to the hospital for a fractured hip - Discharged 10/27/23 from the hospital to the rehabilitation facility Review on 11/28/23 of the Incident Response Improvement System (IRIS) revealed: - No submissions from this facility Review on 11/29/23 of client #3's record revealed: - Admitted: 8/17/96 - Diagnosis: Intellectual Disability, Hip Replacement, Chronic Kidney Disease, Hyperlipidemia, Osteoporosis, Tachycardia, and Leukocytopenia Review on 11/29/23 of facility records regarding client #3's fractured hip injury sustained on 10/22/23 revealed: - No documentation that a report was submitted in IRIS - No documentation that the LME/MCO was notified Interview on 11/29/23 & 12/5/23 the Alternative Family Living Provider reported: - She never completed any Level II IRIS reports - "I never had to do that (IRIS)." - "Not sure if that's my duty or the duty of a QP (Qualified Professional)" - Confirmed that she had not completed an	V 367		

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V 367	Continued From page 27 IRIS report for client #3's fall on 10/22/23 This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living - Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
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. (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	V 536	**V536** Staff will receive training on alternatives to physical restraints and seclusion within 14 days of hiring and whenever it is determined that retraining is warranted throughout the year. 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) (10A NCAC 27E .0107) and authorized instructor. Staff training and competence in: a. The use of positive behavioral supports. b. Communication strategies for defusing and deescalating potentially dangerous behavior. c. Monitoring vital indicators. d. Administration of CPR. e. Debriefing with client and staff. f. Methods for determining staff competence, including qualifications of trainers and training curricula. g. Other areas to ensure the safe and appropriate use of restraints and seclusion. (2) Other matters relating to the use of physical restraint or seclusion of clients necessary to ensure the safety of clients and others.	

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V 536	Continued From page 28 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 (9) 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.	V 536	Staff will receive retraining and demonstrate competency annually. Staff member has received evidence based protective intervention training (EBPI) The AFL Provider and the QP will ensure compliance with this training mandate.	

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V 536	Continued From page 29 (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 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	V 536		

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V 536	Continued From page 30 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 1 staff (AFL Provider) had an annual training in Alternatives to Restrictive Interventions. The findings are: Review on 11/29/23 of the AFL Provider's personnel record revealed: - Employed: June 1995 - No current training in Alternatives to Restrictive Interventions - Most recent training in Alternatives to	V 536		

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V 536	Continued From page 31 Restrictive Interventions: North Carolina Interventions (NCI) was dated 9/15/18 and valid for 1 year Interview on 11/29/23 & 12/5/23 the AFL Provider stated: - She did not have updated Alternatives to Restrictive Interventions training - She tried to get a trainer but the trainer never followed up - "Tell the truth, I didn't think anyone (the State) would come out" - She planned on getting her training completed - "I will call around to find a Qualified Professional to update my trainings" This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living - Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 536		
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, record review and interview, the facility was not maintained in a safe manner. The findings are: Review on 11/29/23 of the NC State Residential Building Code Section 310.2.1 revealed:	V 736	V736 In compliance with rule 10A NCAC 27G .0304, Minimum furnishings, a dresser has been placed in bedroom #1. Additionally the window in client #3's bedroom was repaired on 11/30/2023. Additionally, a dresser was placed in the bedroom requiring a dresser.	

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V 736	Continued From page 32	V 736		

- "Emergency Egress - Every sleeping room shall have at least one operable window or exterior door approved for emergency egress. The units must be operable without the use of key or tool to a full clear opening. If a window is provided, the sill height may not be more the 44" above the floor. These must provide clear opening of 4 square feet. The minimum height shall be 22 inches an minimum width is 20 inches (1996 Building Code). (For buildings built under the previous Residential Building Code the requirements allowed the sill height of 48" and an opening of 432 squared inches in area with a minimum dimension of 16".)

Observation on 11/29/23 at approximately 2:30pm of Client #3's bedroom revealed the following:
- There was only one window
- When the Alternative Family Living (AFL) Provider raised the window, the top window pane immediately fell on its own, down to the sill, blocking egress.
- The AFL provider struggled to restore both window panes back to the original placement
- The window would not stay open on its own

Interview on 11/29/23 the AFL Provider reported:
- The window was opened and closed only when cleaning
- Would call someone immediately to fix the window

Review on 11/29/23 of the Plan of Protection completed by the AFL Provider, dated 11/29/23 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?:
- Would call repair person to do a follow up today

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V 736	Continued From page 33 Describe your plans to make sure the above happens: - I will have my repair man to come out and assess the problem. And let me know when he can complete the job." This facilty served clients whose diagnoses included: Schizophrenia and Intellectual Disability. Client #3's bedroom only had one window. The window would not stay open on its own and was not operable as the top portion of the window fell down when the AFL Provider opened it. Client #3 would not have egress to the outside in the event of an emergency. Based on the lack of available egress, this deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. An administrative penalty of $500.00 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 736		
V 774	27G .0304(d)(7) Minimum Furnishings 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client.	V 774	In compliance with rule 10A NCAC 27G .0304, Minimum furnishings, a dresser has been placed in bedroom #1. Additionally the window in client #3's bedroom was repaired on 11/30/2023. Additionally, a dresser was placed in the bedroom requiring a dresser.	

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V 774	Continued From page 34 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that 1 of 3 client's (#1) bedroom had minimum furnishings. The findings are: Observation on 11/29/23 at approximately 2:30pm of client #1's bedroom revealed: - 2 storage totes against the wall with client #1's clothes in them - a dresser with the AFL Provider's belongings being stored Interview on 11/29/23 & 12/5/23 the Alternative Family Living (AFL) Provider reported: - Client #1 did not have a dresser because she wasn't supposed to move in - The AFL Provider's belongings were in the dresser - She would take her belongings out of the dresser and put client #1's belongings in the dresser or purchase another dresser This deficiency is cross referenced into 10A NCAC 27G .5601 Supervised Living - Scope (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 774		