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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
	MHL092-579	A. BUILDING: ______ B. WING ______	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMMANUEL HOME III	5212 SWEETBRIAR DRIVE RALEIGH, NC 27609

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 4/18/24. 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 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
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 at least quarterly and repeated for each shift. The findings are:	V 114	RECEIVED BY MHL & C 5/17/24	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eloise Doutin	Executive Director	5-14-2024

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STATE FORM 6899 KX2B11 If continuation sheet 1 of 11

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V 114	Continued From page 1 Review on 4/17/24 of the facility's fire drill log revealed: - fire drills: - 4/12/24 no time - 2/15/24 no time - 1/15/24 no time - 10/15/23 6 but no AM or PM listed - 5/23/23 no time - no fire or disaster drills documented from January 2023 - April 2023 as being completed Interview on 4/17/24 client #3 reported: - been residing in this facility for under a year - had not done a fire or disaster drill since being here Interview on 4/17/24 staff #1 reported: - been employed about 6 or 7 months - primary shift was 9pm- 9am - didn't really do fire and disaster drills on his shift - fire and disaster drills were conducted during the day - didn't know where they would meet for disaster drills Interview on 4/18/24 the Licensee reported: - they had 3 shifts: 7am - 3pm, 3pm - 11pm, & 11pm - 7am - "I guess I'm ultimately responsible for checking fire and disaster drills" - had a lot of things going on and hadn't been checking to make sure fire and disaster drills were being completed and paperwork filled out properly	V 114	Fire and Disaster drills were completed more frequently than the policy requirement (on a monthly basis) however staff failed to complete the hard-copy form with time of day (AM/PM). An in-service was completed upon exit of state auditor on 4/17/24 for all EH3 Staff. A handout of Disaster Policy was given to staff to aid in compliance of policy rules. Training included: documentation, completion of documentation, importance/ relevance of drills during a natural or man-made disaster. Drills demonstrated via Media, hand-outs, and other resources by QP. Fire and Disaster Drills will be completed with the staff and clients on all 3 shifts quarterly by Designated Trainer, QP, or Admin/Management Staff. State Policy Review of DHSR regulations completed with each individual staff to assure state compliance with Disaster and Emergency Protocols. Monitoring will be completed by Provider - [redacted] An Electronic format via the Agency's EMR system will be configurated and completed within the next 60 days to create a digital footprint that will contain a date and timestamp within the system. All staff will be trained in the EMR system in the next 60 days.	

V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 118		

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V 118 Continued From page 2 V 118

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 review and interview the facility failed to administer medications on a physician's order for 3 of 3 audited clients (#1, #3 & #5) &

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V 118	Continued From page 3 failed to keep the MAR current for 2 of 3 audited clients (#1, #5). The findings are: A. Review on 4/17/24 of client #1's record revealed: - admitted: 4/10/20 - diagnoses: Autism Spectrum Disorder, Moderate Intellectual Delay, and Unspecified Depressive Disorder with Mixed Features - physician's order dated 12/26/23 revealed: - Lantus Solostar 100units, inject 10 units subcutaneously at bedtime (diabetes) - Losartan Potassium 25mg (milligram) tablet (tab), 1 tab daily (high blood pressure) Review on 4/17/24 of client #1's March 2024's MAR revealed: - Losartan Potassium being initialed by staff for the month as being administered Observation on 4/17/24 at approximately 12:40pm of client #1's medication box revealed: - Solostar U100, inject 15 units subcutaneously at bedtime - No Losartan Potassium Observation on 4/17/24 at approximately 12:45pm revealed: - The facility's consultant removing all of the insulin that read 15 units subcutaneously at bedtime from out of the refrigerator Interview on 4/17/24 staff #3 reported: - 10 units of insulin was in the refrigerator for client #1 - Insulin remained in the refrigerator but once it was used, it could be kept in the medication box until it was empty then they would get a "fresh one" out of the refrigerator	V 118	A: Client #1 does not have Autism Disorder however diagnosed with TBI. Client #1 had listed on the MAR and documented prescription onsite of 10 units Solostar at bedtime. QP, Alliance MCO, Admin Staff, and other representatives (including HealthPark pharmacy) communicate weekly regarding changes to Client #1's medical needs. There is no evidence that staff had been giving the wrong dosage prescribed as all documentation (MAR and Prescription on file) displayed 10 units. The pharmacy provided Ziploc bag which held the insulin to be stored in the refrigerator displayed the wrong dosage amount of 15 units The unused device found in the medication refrigerator displayed the label of 15 units. During investigation, the pharmacy was contacted regarding the need for a new label and to ensure all parties had the correct prescription on file. Label has been updated on the Ziploc bag – no further changes needed at this time as the only change requested was a new bag with a label with directions – inject 10 units at bedtime. Medication - Losartan Potassium: staff have been retrained re changes to orders and notifying the pharmacy if medications are missing. During investigation pharmacy rep stated that several hospital MDs and hospitals that have recently closed were not able to refill orders, she further stated that the pharmacy has no way to discontinue orders without a discontinuation order. The Group Home and Pharmacy discussed the difficulty of requesting another doctor to override another doctor's orders.

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V 118	Continued From page 4 Interview on 4/17/24 the Facility's Consultant reported: - the staff was giving client #1 10 units of insulin as prescribed by the doctor - "how do you know he (staff) was giving the 15" - "you weren't here to see him give the med (medication)" - "he signed off on the 10 so that's what he gave him" - client #1's Losartan was a short term prescription from the hospital and his primary doctor wouldn't override it and discontinue the medication - she thought that the last time he took the Losartan was around the end of February 2024 - staff should not have initialed for March if the medication was not in the facility B. Review on 4/17/24 of client #3's record revealed: - diagnoses: Bipolar, Autism & Attention Deficit Hyperactivity Disorder (ADHD) - A FL2 dated 9/15/23: - Seroquel 25mg as needed (Bipolar) - Hydroxyzine 25mg bedtime (anxiety) During interview on 4/17/24 the facility's consultant reported: - Client #3's father took him to his physician's appointments - He does not always give the facility's staff the physician's orders - Client #3's parents were supposed to get the Seroquel refilled - Parents were the guardians and the physician's office waiting for their approval - The physician that prescribed the Hydroxyzine, office closed permanently - The current physician said he could not	V 118	B: The Group Home has coordinated request for both medications with the parents and awaiting documentation on how to proceed with medications. The Father of Resident states he had requested a discontinuation order in February as he no longer wishes his son to take the medication. The father had also requested no more refills to be sent to the facility. Father states his request "must have fallen through the cracks" and once received the Guardians (Mom and Dad) will submit to the group home. Father states the primary care team will not change the order and he is waiting for contact from the Psych Team on what they suggest if the previous prescribing physician worked for a now closed facility. Emmanuel Homes has communicated with Pharmacy Rep – an Order and Clarification were requested from Pharmacy – Pharmacy has discontinued medication from the Crisis Center on 4/17/24 – a new MAR was sent to the facility to reflect changes. QP will follow up with a review of MAR, Prescriptions/Orders within the next 60 days.	

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V 118	Continued From page 5 discontinue the Hydroxyzine because he did not prescribe it - They (facility's management) have reached out to the parents and waiting to hear back C. Review on 4/17/24 of client #5's record revealed: - Admitted 6/6/23 - Diagnoses: Autism, ADHD, Moderate Intellectual Developmental Disorder & Seizures - A physician's order dated 10/5/23: Miralax 17gram everyday Observation on 4/17/24 at 1:03pm of client #5's medications revealed: - No Miralax Observation on 4/17/24 at 4:17pm revealed: - the facility's consultant hand staff #2 a medication bag - staff #2 looked in the medication bag and stated "its the Miralax" Review on 4/17/24 of the April 2024 MARs revealed: - Miralax was initialed by staff the entire month of April During interview on 4/17/24 staff #2 reported: - client #5's Miralax had been out for a week - was not sure why staff initialed the MAR for the Miralax During interview on 4/18/24 the facility's Consultant reported: - was not aware the Miralax was out for a week - had requested the pharmacy to put the Miralax on hold due to the facility had "2 big bottles" of Miralax - the pharmacy was contacted yesterday & the	V 118	C: MiraLAX was ordered on-site prior to the closing of Annual Audit. Medication was placed on hold due to the large quantity/bulk supply upon admission to the facility. Medications were delivered while Auditors were on-site. Medication was requested and delivered later the same day, hold on medication was lifted while Auditors were on-site. During the Interview with staff the Auditor was present. Staff member stated that Resident had medication onsite and had completed his last dosage when medication was due to arrive the same week. Medication was delivered on-site without MiraLAX. MiraLAX request was called-into pharmacy and delivered within an hour of phone call. Auditors present on-site to witness delivery of medication. On 4/17/23 Auditor [redacted] looked into the pharmacy back for compliance of medication being onsite. There is no evidence that medication was not administered, however the QP discussed with each staff the importance of notifying the Management team when medication supply is nearing low quantity and requiring a refill/renewal order. A Med Training has been completed by [redacted] RN. A follow-up medication training is scheduled for May 18th 2024.	

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V 118	Continued From page 6 Miralax arrived 4/17/24 Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.	V 118		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure Health Care Personnel Registry (HCPR) was completed for 2 of 3 staff (Qualified Professional (QP) & #1). The findings are: Review on 4/17/24 of staff #1's record revealed: - employed since Jan. 2019 - no documentation of the HCPR check being completed around his hire date Review on 4/17/24 of the QP's personnel record revealed: - no signed job description - no documentation of the HCPR check being	V 131		

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V 131	Continued From page 7 completed around her hire date During interview on 4/18/24 the QP reported: - started at the facility 2 1/2 years ago - management was responsible for completion of the HCPR - confirmed she did not have a copy of the HCPR check During interview on 4/18/24 the Licensee reported: - moved from their facility's office - the HCPR checks may have been in storage but they had 5 storage units - they had some boxes at home that the HCPR checks could be in but she was not sure	V 131	On 4/17/24 – HR consultant stated that documentation was in a storage building and unable to be reached. The auditor requested a copy. Due to the closing of the EDEH office – records have been archived with records from previous and current long-term staffing personnel. Electronic copies are usually available within the background portal however portal site archives records older than 5 years which staff with missing records have been employed long-term. New records have been completed, printed, and saved to an electronic file for personnel record keeping. HR and Admin staff will review staffing records each quarter – Admin, QP, and HR will be responsible for record audits.	
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 was not maintained in a safe & attractive manner. The findings are: Observation on 4/15/24 at 1:32pm of the facility revealed: - several pieces of tile from the kitchen floor was missing in front of the kitchen sink - the kitchen floor was uneven in front of the kitchen sink During interview on 4/15/24 staff #1 reported:	V 736		

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V 736	Continued From page 8 - the kitchen floor was like that when he started in October 2023 - no one had repaired the kitchen floor since he started at the facility During interview on 4/18/24 the Qualified Professional reported: - the kitchen floor needed to be repaired - patches of the floor had been fixed but not the entire kitchen floor - management informed her they were cited due to repairs needed to the kitchen floor - she informed management to get the kitchen floor repaired During interview on 4/17/24 the Licensee reported: - the kitchen floor was previously repaired - the floor was damaged again so she was having new tile put down - they were having difficulty finding the accurate size tile to resemble tile currently on floor This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736	Prior to 4/17/24 – Auditor [redacted] stated to staff that she had informed Admin to fix the floor and the floor was "still in terrible shape." Admin Consultant onsite phone maintenance to fix the flooring – maintenance reported that the floor had been fixed however a new site was found during audit. Auditor continued to discuss the view of the floor and the varied color of the tile which was not attractive to her. Admin staff assured Auditor that the change was proof of a repair as it was difficult to find the 13x13 tile size as the size is rare and requires a special order that Home Depot and Lowes Home Improvement did not carry at the moment. While Auditor was onsite – Admin requested maintenance to attempt to fix the flooring. A repair was started on the same day. On 4/17/24 – [redacted] and another auditor arrived and wanted to conduct their interviews in the kitchen area, however the flooring had now been pulled up at the request of Auditor during her previous visit. Emmanuel Homes has collaborated with Empire flooring to complete the flooring repair at EH#3. An estimate has been completed and repairs are scheduled to start on 5/23/24. A signed contract from Empire today is enclosed. Estimated completion date – 30 days from the start date.	

V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit.	V 752		

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V 752	Continued From page 9 This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain water temperatures between 100 - 116. The findings are: Observation 4/15/24 at 1:32pm of the kitchen sink water temperature revealed: - water temperature was 132 degrees Fahrenheit During interview on 4/17/24 client #1 reported: - "water fine" During interview on 4/17/24 client #3 reported: - he filled the kitchen sink with water when he assisted with meals - was able to adjust water temperatures during showers & during meal preparations During interview on 4/15/24 & 4/17/24 staff #1 reported: - he had worked at the facility since October 2023 - had not checked the water temperature since being at the facility - Licensee told him to check the water temperatures but "kinda didn't know how to" - was not sure what the water temperatures were supposed to be - he assisted the clients with their baths that were not capable of adjusting the water temperatures - maintenance came 2 days ago (4/15/24) to adjust water temperatures During interview on 4/17/24 staff #2 reported: - she checked the water temperatures monthly - it was between 116 & 117	V 752	The water temperature had been completed up to Feb 2024. Staff have been retrained on Water Temperature, and how to take the temperature and to take the temperature at different sites of the home. Staff were trained in the importance of water safety – a video demonstration was provided as well as disaster/fire training. Staff were trained in the safe water temperature range of 100 – 116 degrees. Water temperature will be checked quarterly with fire drills. Random checks will also be completed by staff. A log will be obtained (hard-copy and digital). Staff have been requested to notify Admin Staff, QP, and Maintenance if adjustments are needed in accordance with approved temperature range. The State Auditor did not let the water run for a long amount of time and the degree in question on the previous visit was never verified as the Auditor called out several numbers out loud to the two staff onsite. During the second visit with both Auditors the water temperature had been checked and fixed to a normal range and the temperature displayed by the new auditor was 110 degrees in the upstairs bathroom. Water Temperature has been fixed and observed by auditors onsite. A cover box for the water heater has been ordered to ensure Residents and other Staff members are not tampering with the water heater. This is due to the inability to lock the common area (Laundry Room) according to Disability Rights and available access for others to change water temperatures without Admin Staff's recognizing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-579	A. BUILDING: ______ B. WING ______	R 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMMANUEL HOME III	5212 SWEETBRIAR DRIVE RALEIGH, NC 27609

(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

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V 752	Continued From page 10 - clients had not complained of the water being too hot During interview on 4/15/24 the Facility's Consultant reported: - staff were supposed to check the facility's water temperature - she would have someone to turn the water temperatures down	V 752		