STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNRISE AT UNC HORIZONS	207, 209 & 211 CONNOR DRIVE CHAPEL HILL, NC 27599

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V 000	INITIAL COMMENTS An annual survey was completed on 10/7/24. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .4100 Residential Recovery Programs for Individuals with Substance Abuse Disorders and Their Children. This facility is licensed for 30 and has a current census of 19. The survey sample consisted of audits of 3 current clients and 1 former client.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's	V 105		

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

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement adoption of standards that ensured operational and programmatic performance meeting applicable standards of practice for the use of Urine Drug Screen (UDS) Testing including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are:

Review on 10/3/24 of client #1's record revealed:
-Admission date of 5/29/24.
-Diagnoses of Opioid Use Disorder, Bipolar Disorder, Anxiety Disorder and Depression.

Review on 10/3/24 of client #2's record revealed:
-Admission date of 5/31/24.
-Diagnoses of Stimulant Use Disorder, Amphetamine Type Disorder, Opioid Use Disorder, Cannabis Use Disorder, Mood Disorder and Borderline Personality Disorder.

Review on 10/3/24 of client #3's record revealed:
-Admission date of 8/12/24.
-Diagnoses of Cocaine Use Disorder and Bipolar Disorder.

Review on 10/3/24 of former client (FC) #20's record revealed:
-Admission date of 6/17/24.
-Diagnoses of Opioid Use Disorder, Stimulant Use Disorder, Alcohol Use Disorder, Sedative Use Disorder, Unspecified Depressive Disorder, Unspecified Anxiety Disorder, Type II Diabetes, Asthma and Hypertension.
-Discharge date of 9/20/24.

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V 105	Continued From page 3 Review on 10/4/24 of the facility's UDS log revealed: -Completed UDS for client #1 on 9/27/24, 9/26/24, 9/24/24, 9/23/24, 9/21/24, 9/20/24, 9/16/24, 9/14/24, 8/29/24, 8/24/24, 8/21/24, 8/20/24, 8/19/24, 8/15/24 and 8/14/24. -Completed UDS for client #2 on 9/6/24, 9/2/24, 8/6/24, 8/5/24, 8/3/24, 7/4/24 and 7/2/24. -Completed UDS for client #3 on 10/2/24, 9/6/24, 9/5/24, 9/2/24 and 9/1/24. -Completed UDS for FC #20 on 8/29/24, 8/23/24, 8/15/24 and 8/13/24. Review on 10/3/24 of facility records revealed: -CLIA waiver dated 6/7/22 to 6/6/24. -The facility had no documentation of a current CLIA waiver. Interview on 10/3/24 with Office Manager #1 revealed: -Facility staff did UDS for clients. -They don't always send out the urine samples. -They did a rapid urine test onsite. -They send the results to a company outside of the agency if a client test for something that was not prescribed. Interview on 10/3/24 with the Clinical Compliance Officer revealed: -She was aware the CLIA waiver expired in June 2024. -She thought they sent a request for the CLIA waiver. -She confirmed the facility failed to have a current CLIA waiver in order to complete urine drug screens. Interviews on 10/3/24 and 10/7/24 with the Program Manager revealed:	V 105		

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V 105	Continued From page 4 -Facility staff did the UDS for clients on site. -Staff collect client's urine 3 days a week. -They did an additional UDS if they suspect a client used an illicit substance. -Those additional UDS were sent to a company outside of the agency. -She didn't realize the CLIA waiver expired for the facility. -She confirmed the facility failed to have a current CLIA waiver in order to complete urine drug screens.	V 105		
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, the American Heart Association or their	V 108		

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V 108	Continued From page 5 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 reviews and interviews, the facility failed to ensure two of five audited staff (the Program Manager and staff #3) had training in Cardiopulmonary Resuscitation (CPR) and First Aid (FA). The findings are: Review on 10/4/24 of the facility's personnel records revealed: The Program Manager- -Date of hire was 1/28/19. -CPR and FA training expired 4/22/23. -No documentation of current CPR and FA training. Staff #3- -Date of hire was 10/2/17. -She was hired as a Residential Advisor. -CPR and FA training expired on 9/14/23. -No documentation of current CPR and FA training. Interview on 10/4/24 with staff #3 revealed: -She worked alone with the clients "occasionally." -She was aware her CPR and FA training expired last year. -She was waiting on a training to be scheduled by	V 108		

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V 108	Continued From page 6 management staff. Interview on 10/4/24 with the Program Manager revealed: -She worked alone with the clients during therapy sessions. -She knew her CPR and FA training expired last year. -She was scheduled for the CPR and FA training, however she had a death in her family. -They were also "short staffed and had no time to do the training." Interview on 10/4/24 with the Clinical Compliance Officer revealed: -She was aware the CPR and FA training was not current for some of the staff. -"We have been going back and forth about the training with [Name of the agency]." -She confirmed the Program Manager and staff #3 had no documentation of current training in CPR and FA.	V 108		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans 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	V 114		

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V 114	Continued From page 7 repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure fire and disaster drills were done quarterly on each shift. The findings are: Review on 10/7/24 of the facility's fire and disaster drill log from January 2024-September 2024 revealed: Perinatal portion of the program- Office Manager #1 documented the following drills: 9/30/24-1st shift fire 8/8/24-1st shift disaster 7/9/24-1st shift fire 6/17/24-1st shift disaster 6/30/24-1st shift fire 5/30/24-1st shift disaster 4/20/24-1st shift fire 4/15/24-1st shift fire 3/4/24-1st shift disaster 2/1/24-1st shift fire 1/30/24-1st shift disaster Casa portion of the program- -There were no fire or disaster drills conducted by 2nd and 3rd shifts for the third quarter (July, August, September) of 2024.	V 114		

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V 114	Continued From page 8 -There were no fire or disaster drills conducted by 2nd and 3rd shifts for the second quarter (April, May, June) of 2024. -There were no fire drills conducted by 1st and 2nd shifts for the first quarter (January, February, March) of 2024. -There were no disaster drills conducted by 1st and 3rd shifts for the first quarter (January, February, March) of 2024. -There were no fire or disaster drills conducted during the 4th quarter (October, November, December) of 2023. Interview on 10/4/24 with client #1 revealed: -She was admitted about 4 months ago. -They had not done any fire or disaster drills at the facility with staff. Interview on 10/4/24 with client #2 revealed: -She was admitted to the facility on 5/31/24. -She didn't recall staff doing fire and disaster drills with them. Interview on 10/4/24 with client #3 revealed: -She was admitted to the facility on 8/12/24. -Staff never did fire and disaster drills with them. Interview on 10/4/24 with client #4 revealed: -She was admitted to the program in June 2024. -They never did any fire or disaster drills with staff. Interview on 10/4/24 with client #5 revealed: -She had been with the program since March 15, 2024. -Staff had not done any fire or disaster drills with them at the facility. Interview on 10/4/24 with client #6 revealed: -She was admitted to the program 4 months ago.	V 114		

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V 114	Continued From page 9 -They had not done any fire or disaster drills with staff. Interview on 10/3/24 with staff #3 revealed: -She had not done any fire or disaster drills with clients. -Office Manager #1 did fire and disaster drills with clients. Interview on 10/7/24 with staff #2 revealed: -She did fire and disaster drills with clients. -They went outside in the parking lot for fire and disaster drills. -She was told by another Division of Health Services Regulation surveyor the drills should be done once a quarter. -There were no fire or disaster drills completed for the 4th quarter of 2023. -She confirmed the facility failed to conduct fire and disaster drills quarterly on each shift. Interview on 10/7/24 with Office Manager #1 revealed: -She talked with clients about the procedure for fire or disaster drills. -"I showed them (clients) what to do during a fire or disaster drill in their apartment." -She did not simulate the fire or disaster drills with clients. -"I didn't know we were supposed to be simulating drills with clients." -She confirmed the facility failed to conduct fire and disaster drills quarterly on each shift. Interview on 10/7/24 with the Program Manager confirmed: -The facility failed to conduct fire and disaster drills quarterly on each shift.	V 114		

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V 118	Continued From page 10	V 118		
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 with a physician. This Rule is not met as evidenced by:	V 118		

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V 118	Continued From page 11 Based on record reviews and interviews, the facility failed to keep the MARs current affecting one of three audited clients (#2) and failed to follow the written order of a physician affecting one of three audited clients (#1). The findings are: 1. Review on 10/3/24 of client #2's record revealed: -Admission date of 5/31/24. -Diagnoses of Stimulant Use Disorder, Amphetamine Type Disorder, Opioid Use Disorder, Cannabis Use Disorder, Mood Disorder and Borderline Personality Disorder. -Physician's order dated 7/8/24 Buspar 15 milligrams (mg) (Anxiety), one tablet twice a day. -Physician's order dated 7/1/24 Buspar 10 mg, 1.5 tabs in morning and evening. -Physician's order dated 6/5/24 for Sertraline 100 mg (Depression), one tablet in the morning; Trazodone 50 mg (Sleep), one tablet at bedtime. Review on 10/3/24 of MARs for client #2 revealed: No staff initials to indicate the medication was administered for the following- -September 2024: Sertraline 100 mg on 9/17 -August 2024: Buspar 15 mg on 8/8 am dose; 8/11 pm dose; 8/12 pm dose and 8/15 pm dose Trazodone 50 mg on 8/29 -July 2024: Buspar 10 mg on 7/16 am dose; 7/19 and 7/20 pm doses; 7/23 am dose; 7/26 pm dose; 7/27 and 7/28 am/pm doses; 7/30 and 7/31 am doses.	V 118		

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V 118	Continued From page 12 Interview on 10/3/24 with staff #3 revealed: -"If there are blank boxes on the MARs it probably means clients refused to take that medication." -Staff possibly forgot to put "R" for the refusal. -She confirmed the MARs were not kept current for client #2. 2. Review on 10/3/24 of client #1's record revealed: -Admission date of 5/29/24. -Diagnoses of Opioid Use Disorder, Bipolar Disorder, Anxiety Disorder and Depression. -Physician's order dated 9/16/24 for Metformin 500 mg (Diabetes), one tablet daily with evening meal. -Physician's order dated 6/27/24 for Lyrica 100 mg (Nerve and muscle pain), one capsule in the morning, one capsule at noon, and two capsules in the evening. -Physician's order dated 6/24/24 for Metoprolol Tartrate 25 mg (High Blood Pressure), one tablet twice daily. Review on 10/3/24 of MARs for client #1 revealed: October 2024- -Metoprolol Tartrate 25 mg on 10/1 was documented as a refusal. September 2024- -Metoprolol Tartrate 25 mg on 9/15, 9/17, 9/19 and 9/20 was documented as a refusal. -Metformin 500 mg on 9/15, 9/17 and 9/19 was documented as a refusal. August 2024- -Metoprolol Tartrate 25 mg on 8/8, 8/20, 8/28 and 8/29 was documented as a refusal. -Lyrica 100 mg on 8/2 was documented as a	V 118		

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V 118	Continued From page 13 missed dose. Interview on 10/4/24 with client #1 revealed: -She did not refuse any of her medication. -The Metoprolol, Metformin and Lyrica ran out a few times. -"One staff said clients should be calling in when the medication was low to the pharmacy for a refill." -"Another staff said staff should be calling the pharmacy for the refill." -"I was confused and wasn't sure about who should be contacting the pharmacy for medication refills." Interview on 10/4/24 with Office Manager #2 revealed: -Client #1 ran out of her medication a few times. -She (client #1) had to complete the medication refills through her medical chart online. -Staff had no access to client #1's online medical chart. -She (client #1) had to refill the medication for herself. -She confirmed the facility failed to follow the written order of a physician. Interview on 10/7/24 with the Program Manager revealed: -Some of the medication clients took were not prescribed by the Nurse Practioner. -Client #1 had to refill her medication through her medical chart online. -She just recently reminded client #1 she (client #1) needed to refill some of her medications. -She confirmed the facility failed to follow the written order of a physician.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-128	A. BUILDING: _____ B. WING _____	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE AT UNC HORIZONS	207, 209 & 211 CONNOR DRIVE CHAPEL HILL, NC 27599

(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 752	Continued From page 14	V 752		
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. This Rule is not met as evidenced by: Based on observation and interviews, the facility's water temperature was not maintained between 100-116 degrees Fahrenheit. The findings are: Observation on 10/4/24 of the facility at approximately 12:48 pm revealed: -Client #4's apartment-Bathroom #1 water temperature was 120 degrees Fahrenheit. Bathroom #2 water temperature was 120 degrees Fahrenheit. Interview on 10/4/24 with Office Manager #1 revealed: -She thought they noticed the water was too hot in those bathrooms in September 2024. -She thought the rental office was contacted about that issue. -She confirmed the facility failed to maintain the facility water temperature between 100-116 degrees Fahrenheit. Interview on 10/4/24 with the Program Manager confirmed: -The facility failed to maintain the facility water temperature between 100-116 degrees	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL068-128	A. BUILDING: _____ B. WING _____	10/07/2024

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V 752	Continued From page 15 Fahrenheit.	V 752		